Franklin Medical Center

514 route 33 west, suite 6
Millstone, n.j. 08535
Office: 732-851-7007 fax: 732-786-0012

Today's date:_____

Patient name:_____
Last name first name middle initial

Date of birth_____ Age_____ Male/Female SS#_____

Address:_____
Street city state zip

Home phone_____ Cell phone_____

Marital status: Single / Married / Divorced / widowed

Occupation: _____

Emergency contact:_____relationship:_____phone:_____

Insurance information

Primary insurance:_____

Primary insurance claims address:_____

_____ _____

Subscriber id #_____

Group #_____

Policy Holder:_____
Last name first name middle initial

Relationship to patient:_____ policy holders d.o.b._____

Policy holders SS#_____

Policy holder's employer_____

Secondary Insurance

Secondary insurance:_____

Secondary insurance claims address:_____

Subscriber id #_____ effective date_____

Group #_____

Policy Holder:_____
Last name first name middle initial

Relationship to patient:_____ policy holders d.o.b._____

Policy holders SS#_____

Authorization and release

I authorize the release of any information of this patient's to his/her referring doctor and to his/her insurance company, third party administrators, payers and other managed care entities who insure the patient.

I herby authorize payment directly to Franklin medical care, llc of insurance benefits otherwise payable to me. A photo copy shall be considered as valid as the original.

_____ _____

Authorized signature date

I understand payment is expected in full at the time of service. I also understand that if my insurance does not cover services provided, I am personally responsible for this payment. It will be my responsibility to keep updating Franklin medical center about my current insurance.

_____ _____

Authorized signature date

Consent for treatment

I hereby voluntarily consent for examination and treatment by the physicians of Franklin medical center.

_____ _____

Authorized signature date

professional services are rendered to and charged to the patient directly. The patient is responsible for all fees regardless of insurance coverage. The patient is solely responsible for hmo referral requirements. Necessary forms will be completed by our office to expedite insurance carrier requirements. We request payment for all services when they are rendered unless other arrangements have been made with our office staff.

Medical History

Where have you been receiving your medical care?
Name and address of Physician:
_____
_____
_____

Have you ever been hospitalized? Yes No
If yes, please list dates and reason(s):
_____
_____
_____

Have you had any surgeries? Yes No
If yes, please list date(s) and type(s):
_____
_____
_____

Please list any medications you take (including prescription drugs, over-the-counter drugs, vitamins, etc.):

Name of Medication	Strength	How often you take it

Have you ever had an allergic reaction to a medication? Yes No
If yes, please list the medication:
_____
_____
_____

Please check any illnesses or conditions which you or any member of your family has or has had:

CONDITION	SELF	FAMILY
Anemia		
arthritis		
Asthma/COPD		
Blood Disorders		
Cancer Type(s):		
Depression		
Diabetes		
Drug/Alcohol dependency		
Epilepsy/Seizures		
Heart disease/conditions		
Hepatitis		
High blood pressure		
High Cholesterol		
Immune disorders		
Intestinal problems		
Kidney disease		
Liver disease		
Skin disease		
Strokes		
Stomach ulcers		
Thyroid conditions		
Alzheimers/Dementia		
Other :		

ACKNOWLEDGEMENT

I understand that, under the health insurance portability and accountability Act 1996 (hippa), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to;

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I understand that this organization has the right to change its notice of privacy practice from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by new restrictions.

Patient name:_____

Relationship to patient:_____

Signature of patient:_____

Date:_____

I agree that you may contact me regarding results, medical condition, or other information by way of;

Leaving a message on the answering machine:

Yes **no**

Leaving a message with who ever is answering the phone:

Yes **no**

You may discuss my medical issues with the following people:

Name:_____

Relationship:_____

Phone #:_____

Name:_____

Relationship:_____

Phone #:_____

Name:_____

Relationship:_____

Phone #_____

Patient Signature:_____ **Date:**_____

Notice of Information Practices and Privacy Statement
For Franklin Medical Center

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Policy: **Franklin Medical Center** is committed to ensuring the rights of our patients to privacy. Privacy includes, but not limited to, Protected Health Information (PHI), a person's physical or mental health, the provision of healthcare or the payment for healthcare. PHI includes patient identity, address, age, social security number, the reason the patient is being seen, treatments and medications the patient may receive, and observations about the patient's condition as well as past medical history.

Privacy considerations include verbal, written or electronic communications. It is **Franklin Medical Center's** responsibility as a covered entity to maintain confidentiality and ensure that those business associates receiving PHI, such as insurance companies, billing companies and laboratories, also adhere to appropriate privacy standards as defined by the Health Insurance Portability and Accountability Act (HIPAA).

This notice applies to all of the records of your care generated by the practice, whether made by the practice or an associated facility.

Patients have the right to control who will see their PHI. PHI communication will be limited to those who need the information to provide treatment (the practice will share information with any doctor to whom we refer you to for additional care), obtain payment or to complete healthcare operations. **Franklin Medical Center** is required to release information in a limited number of situations to comply with the law. In these cases, the patient will be informed unless prohibited by law. **Franklin Medical Center** may also share information for the purpose of research, to avert a serious health or safety threat, organ/tissue donation, workers compensation, public health risks, investigation, government activities and lawsuits/disputes. **Franklin Medical Center** notifies patients one day in advance of their scheduled appointments.

Patients have the right to review their medical records upon request. This review is to be done with the attending physician or designee in order to assist the patient's understanding. The patient has the right to request copies of or corrections to the medical record. The patient is to make these changes in writing. Request for corrections and action taken are to be maintained in the patient's medical record. The practice may deny the request for correction if the information to be corrected: (a) was not created by the practice (unless the person or entity that created the information is no longer able to make the amendment), (b) is not part of the medical information kept by or for the practice, (c) is not part of the medical information the patient would be permitted to inspect and copy, or (d) is accurate and complete. If the physician reasonably determines the disclosure of the medical information to the patient will be detrimental to his/her physical and/or mental health, the physician may refuse to furnish the record. In this event, (s)he must document the reason for the decision and, on written request, should furnish the medical record to another physician designated by the patient.

Patients have the right to an accounting the disclosures the practice makes to third parties (other than disclosure for treatment, payment and operations). Patients also have a right to request restrictions/limitations on use/disclosure of information as well as the right to request confidential/alternative communications.

Franklin Medical Center will have a designated Privacy Officer. The Office Manager (or alternate assigned by the corporation) will serve as the Privacy Officer. Patients having a complaint related to privacy/confidentiality should request to speak with the Privacy Officer or they may contact the Secretary of Health and Human Services. The practice will not penalize the patient for filing a complaint. For the latter option, complaints in NJ should be directed to:

Region II, Office for Civil Rights
US Dept. of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza- Suite 3312
New York, NY 10278
Voice: 212.264.3313 Fax: 212.264.3039 TDD: 212.264.2355

A copy of this notice will be provided to patients.