JAMES LEE, MD
514 Joyce St.
Orange, NJ 07050

DATE ____________

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER ____________

PATIENT INFORMATION

SOCIAL SECURITY # ____________

FIRST NAME ____________ MIDDLE ____________

LAST NAME ____________

SEX ____________ DATE OF BIRTH ____ / ____ / ____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT

☐ OTHER ____________

EMPLOYER ____________

HOME ADDRESS ____________

CITY ____________ STATE ______ ZIP ______

EMAIL ____________

HOME PHONE (______) ____________

WORK PHONE (______) ____________

REFERRING PHYSICIAN ____________

HOW DID YOU HEAR OF US? ____________

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other ____________

INSURANCE COMPANY ____________

INSURED / CARD HOLDER'S NAME ____________ RELATIONSHIP ____________

POLICY # ____________ GROUP # ____________ PHONE (______) ____________

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other ____________

INSURANCE COMPANY ____________

INSURED / CARD HOLDER'S NAME ____________ RELATIONSHIP ____________

POLICY # ____________ GROUP # ____________ PHONE (______) ____________

WORKERS' COMPENSATION INFORMATION

COMPANY NAME ____________ COMPANY PHONE (______) ____________

SUPERVISOR'S NAME ____________ SUPERVISOR'S PHONE (______) ____________

EMERGENCY CONTACT

SOCIAL SECURITY # ____________ SEX ____________ RELATIONSHIP TO PATIENT ____________

FIRST NAME ____________ MIDDLE ____________ HOME PHONE (______) ____________

LAST NAME ____________ WORK PHONE (______) ____________

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # ____________ SEX ____________ DATE OF BIRTH ____ / ____ / ____

RELATIONSHIP ____________ DAYTIME PHONE (______) ____________

FIRST NAME ____________ MIDDLE ____________ EMPLOYER ____________

LAST NAME ____________ ADDRESS ____________

ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

CITY ____________ STATE ______ ZIP ______

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent if Minor) ____________ DATE ____________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE ____________ DATE ____________

TO BE COMPLETED BY ALL PATIENTS MAKING A "NO FAULT CLAIM" (CAR RELATED INJURY)

NAME OF POLICY HOLDER: ______________________ TELEPHONE#: __________
ADDRESS (IF DIFFERENT FROM POLICY HOLDER): ______________________
NAME OF INSURANCE CARRIER: ______________________ TELEPHONE#: __________
ADDRESS: ______________________
NAME OF CLAIMS ADJUSTER: ______________________
DATE OF ACCIDENT: __________ POLICY #: __________ CLAIM #: __________
HISTORY OF ACCIDENT: ______________________
ARE YOU WORKING?: YES ____ NO ____
IF NOT, WHEN DID YOU STOP WORKING?: ______________________
IF WORKING FULL OR PART TIME?: ______________________
ATTORNEY: __________ FIRM NAME: __________
ADDRESS: ______________________

IN CONSIDERATION OF SERVICES RENDERED TO ME, I HEREBY AUTHORIZE PAYMENT DIRECTLY TO JAMES M. LEE, M.D. OF ANY AND ALL FIRST PARTY NO-FAULT AUTOMOBILE INSURANCE BENEFITS TO WHICH I MAY OTHERWISE BE ENTITLED FOR SERVICES RENDERED BY THE PROVIDER, BUT NOT EXCEED THE PROVIDER'S REGULAR CHARGES FOR SUCH SERVICES.

IN THE EVENT, THE PROVIDER'S CHARGES ARE OUTSTANDING AND I FAIL TO FILE AN APPLICATION FOR BENEFITS UNDER THE NEW JERSEY STATE NO-FAULT INSURANCE LAW, I HEREBY AUTHORIZE THE PROVIDER TO FILE SUCH CLAIM IN BEHALF SO THAT THE PROVIDER MAY REALIZE PAYMENT OF ITS CHARGES. I UNDERSTAND THAT, IF THE PROVIDER DOES NOT RECEIVE PAYMENT FROM THE ISSUER, I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF THE PROVIDER'S CHARGES.

SIGNATURE: ______________________ DATE: __________

I HEREBY AUTHORIZE JAMES M. LEE, M.D. TO RELEASE MEDICAL INFORMATION ON MY INJURY TO THE NO-FAULT CARRIER.

SIGNATURE: ______________________ DATE: __________

TO BE COMPLETED BY ALL PATIENTS REPORTING A WORK INJURY

WORKER'S COMPENSATION INSURANCE CARRIER: ______________________
ADDRESS: ______________________
NAME OF CLAIMS ADJUSTER: ______________________ TELEPHONE #: __________
WCB CASE #: __________ POLICY OR CLAIM #: __________
DATE OF INJURY: __________ LOCATION: __________
DATE REPORTED TO EMPLOYER: ______________________
NAME AND TELEPHONE # OF WHOM YOU REPORTED IT TO: ______________________
HISTORY OF INJURY: ______________________
ARE YOU WORKING?: YES ____ NO ____
IF NOT WHEN DID YOU STOP?: ______________________
IF WORKING FULL OR PART TIME?: ______________________
ATTORNEY: __________ FIRM NAME: __________
ADDRESS: ______________________

I HEREBY AUTHORIZE JAMES M. LEE, M.D. TO RELEASE MEDICAL INFORMATION ON MY INJURY TO THE WORKER'S COMPENSATION INSURANCE CARRIER ______________________.

SIGNATURE: ______________________ DATE: __________

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKER'S COMPENSATION FOR THIS ILLNESS OR CONDITION OR IT IS DETERMINED BY THE WORKER'S COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKER'S COMPENSATION CASE.

I, ______________________, HEREBY AGREE TO PAY JAMES M. LEE, M.D. THEIR USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED CASE.

SIGNATURE: ______________________ DATE: __________

MEDICAL INFORMATION FORM

NAME: ______________________________ DATE OF BIRTH: __________

SEX: _______ OCCUPATION: ______________________________

WHY ARE YOU HERE TODAY? ______________________________

____

LIST ALL AREAS OF PAIN OR INJURY: ______________________________

____

HOW DID INJURY OCCUR? ______________________________

IS THIS THE RESULT OF A MOTOR VEHICLE ACCIDENT? ______________________________

IS THIS THE RESULT OF A WORK ACCIDENT? ______________________________

DATE OF INJURY? ______________________________

I CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

X ______________________________ ______________
PATIENT'S/GUARDIAN'S SIGNATURE DATE

DO YOU HAVE ANY HISTORY OF (CIRCLE Y FOR YES / N FOR NO)?

DIABETES	Y	N	HEART PROBLEMS	Y	N
ULCERS	Y	N	HIGH BLOOD PRESSURE	Y	N
STOMACH PROBLEMS	Y	N	BLEEDING TENDENCY	Y	N
SEIZURES	Y	N	URINARY INFECTIONS	Y	N
THYROID DISEASE	Y	N	LIVER DISEASE	Y	N
NERVE DISORDER	Y	N	BREATHING PROBLEMS	Y	N

DESCRIBE ANY OTHER MEDICAL PROBLEMS: ______________________________

____

LIST ALLERGIES: ______________________________

DO YOU SMOKE?	Y	N	IF YES, HOW MUCH A DAY? __________
DO YOU DRINK?	Y	N	IF YES, HOW MUCH A DAY? __________

LIST ANY MEDICATIONS OR VITAMINS/SUPPLEMENTS: ______________________________

____

____

LIST ANY PRIOR SURGERIES YOU HAVE HAD:

______________________________(DATE/YEAR)
______________________________(DATE/YEAR)
______________________________(DATE/YEAR)

FAMILY HISTORY (include any pertinent related history to your present problem):

____

____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

X ☐ Home Telephone ______________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone ______________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other ______________________
____

X ______________________ X ______________________
Patient Signature Date

X ______________________ X ______________________
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name ______________________________ Birthdate ______________

Signature ____

Date ____

INSURANCE ASSIGNMENT AND RELEASE

JAMES M. LEE, M.D., P.A.
514 Joyce Street
Orange, NJ 07050

Telephone: 973-672-2214

I certify that I, and/or my dependent(s), have insurance coverage

with ______________________________ and assign directly
Name of Insurance Company(ies)

to Dr. James M. Lee, M.D., P.A. all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

In the event of default, I am responsible for any fees incurred, including collection fees, attorney fees and/or finance fees.

______________________________ ______________
Signature of Patient, Guardian or Personal Representative — Date

______________________________ ______________
Please print name of Patient, Guardian or Personal Representative — Relationship to Patient

NOTICE OF PRIVACY PRACTICES

JAMES LEE, MD
514 Joyce St.
Orange, NJ 07050

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on 4-14-03 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. <u>We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization</u>. <u>Any specific written authorization you provide may be revoked at any time by writing to us</u>.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $ 1.00 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.