NJ Allergy MD
Allergy, Asthma & Immunology Care

Dr. Satya Narisety MD
www.njallergymd.com

PATIENT INFORMATION

Patient ID No. _____ Date_____

Last First M.I.

Patient's Name _____ Date of Birth ____/ ____/ _____
Address _____ Home Phone (____)____-_____
City _____ State ____ Zip Code _____ Cell Phone (____)____-_____
Pharmacy Name_____ Pharm Phone (____)____-_____
Pharmacy Address: _____

Gender: M F Marital Status: S M W D SEP
Spouse's Name _____ Date of Birth ____/ ____/ _____

Emergency Contact Person_____ Relationship _____
Home Phone (____)____-_____ Work Phone (____)____-_____

Family Doctor/Primary Care Physician_____
Address_____
City _____ State ____ Zip Code _____ Phone No. (____)____-_____
Referred by:_____

RESPONSIBLE PARTY / SUBSCRIBER INFORMATION

Relationship
Name _____to Patient_____ Date of Birth ____/ ____/ _____
Address _____ Home Phone (____)____-_____
City _____ State ____ Zip Code _____ Work Phone (____)____-_____
E-mail address_____ Social Security No. _____

EMPLOYMENT INFORMATION
Company Name _____
Address _____ Phone No. (____)____-_____
City _____ State ____ Zip Code _____

INSURANCE

Primary Company _____
ID No. _____
Group No. _____
Subscriber _____
Copay $ _____ Effective Date _____
Referral Required Yes No

Secondary _____
ID No. _____
Group No. _____
Subscriber _____
Copay $ _____ Effective Date _____
Referral Required Yes No

155 Prospect Avenue, Suite 108
West Orange, NJ 07052
Tel: 973-424-1300
Fax: 973-424-1722

200 Belleville Turnpike, 1st floor
North Arlington, NJ 07031
Tel: 973-424-1300
Fax: 973-424-1722

FINANCIAL POLICY - PATIENT/GUARANTOR AGREEMENT

1. On my own behalf and on behalf of my spouse and minor children, including step-children, I hereby authorize treatment by NJ Allergy MD, LLC.
2. I accept responsibility and guarantee payment of all services rendered to me and my family. I understand payment of the required co-pay is due at the time of service. Upon default of any payment due to NJ Allergy MD, LLC, agree to pay all cost of collections including collection agency fees and attorney fees. I understand there is a $30.00 returned check fee should a check be returned for any reason.
3. I hereby authorize the release of any and all medical and/or charge information as is necessary for third-party reimbursement from Medicare, Blue Cross Blue Shield, and/or any other agency (ies) involved in the payment of my treatment.
4. I also direct and assign payment from said third parties to NJ Allergy MD, LLC. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to NJ Allergy MD, LLC, for any charges not covered by insurance. If payment from my insurance is not received within 120 days, my account will be due and payable by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. Charges not payable by my insurance carrier are due immediately.
5. Should my insurance company require a specialist referral from my primary care physician before I can be seen by the physicians at NJ Allergy MD, LLC, it is my responsibility to obtain that referral prior to my appointment as contracts with the insurance companies prohibit me from seeing the doctors without a referral. In the event that services are provided and my insurance is not in effect that day, or if my contract contains a pre-existing clause, I am responsible for payment as the patient - guarantor.
6. The possibility exists (during treatment) for healthcare workers to become directly exposed to my blood or body fluids. In the event of such direct exposure, State laws require a sample of my blood to be tested for the presence of infectious diseases. The results of these tests will be released to me and my family and to the healthcare workers who suffered exposure.
7. The assignment/obligations and authorizations set forth in this statement and the insurance assignment shall be binding upon me both for the present treatment and that which may be rendered to me and my family in the future by NJ Allergy MD, LLC.
8. I authorize a copy of my NJ Allergy MD, LLC. medical record to be forwarded to my Primary Care Physician as well as any and all attending or consulting practitioners.

Signature of Patient/Responsible Party:_____
Relationship to Patient: _____ Date: _____
Witness: _____ Date: _____

I hereby acknowledge that I was presented with a copy of NJ Allergy MD, LLC.'s Notice of Privacy Practice

Signature _____ Date:_____
Printed Name of Patient
_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for NJ Allergy MD, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by NJ Allergy MD, LLC describes such uses and disclosures more completely). A copy of the Notice of Privacy Practices is available on our website and in all of our offices in an easy to read format.

By signing this form I attest that I have received, read and understand the Notice of Privacy Practices.

NJ Allergy MD, LLC reserves the right to revise its Notice of Privacy Practices at any time. I have the right to request that NJ Allergy MD, LLC restrict how it uses or discloses my PHI to carry out TPO.

❒ **YES** ❒ **NO** With this consent, NJ Allergy MD, LLC may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, amongst others.

❒ **YES** ❒ **NO** With this consent, NJ Allergy MD, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

❒ **YES** ❒ **NO** With this consent, NJ Allergy MD, LLC may email to me any information or notices that assist the practice in carrying out TPO.

The following person (s) may contact NJ Allergy MD, LLC inquiring in regards to my health information. You have my permission to release my health information to them.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NJ Allergy MD, LLC may decline to provide treatment to me.

Patients Name: _____ Date:_____
Print

Patient/Legal Guardian: _____
Print

Patient/Legal Guardian: _____
Signature