Date ____________________

PATIENT REGISTRATION FORM

Last Name ____________________ First Name ____________________ MI ______

Date of Birth __________ Age ______ SS# ______________ Sex ____ Marital Status ______

Address ____

City ____________________ State __________ Zip __________

Home Phone ______________ Cell ______________ Email ______________

Primary Care Physician ____________________ Phone ______________

Referring Physician ____________________ Phone ______________

RESPONSIBLE PARTY (If different from patient)

Last Name ____________________ First Name ____________________ MI ______

Address ____

City ____________________ State __________ Zip __________

Date of Birth __________ SS# ______________ Sex ____ Relationship to Patient ______________

Home Phone ______________ Cell ______________ Email ______________

PRIMARY INSURANCE

Insurance Name ____________________

Policy/ID# ____________________

Policy Holder Name ____________________

Policy Holder Date of Birth __________ Sex ____

Relationship to Patient ____________________

SECONDARY INSURANCE

Insurance Name ____________________

Policy/ID# ____________________

Policy Holder Name ____________________

Policy Holder Date of Birth __________ Sex ____

Relationship to Patient ____________________

ASSIGNMENT OF INSURANCE AND FINANCIAL AGREEMENT

I authorize payment of my insurance benefits to Jersey Coast Nephrology & Hypertension Associates (JCNHA) for medi services received. It is my responsibility to provide JCNHA with my current insurance information. If my claim is deni I give JCNHA permission to appeal my claim on my behalf. I accept responsibility for payment of any amounts (copa deductibles and coinsurance) that are not covered by my insurance(s). I understand that if my insurance requires a refer it is my responsibility to obtain one and/or verify that one exists. If I do not have a valid referral, my appointment may cancelled or rescheduled. If I am without insurance coverage, I will pay JCNHA at the time of my visit. If my perso check is returned by the bank, I will be responsible for a $35.00 returned check fee in addition to the amount of my che I understand that after three (3) attempts to collect any balance owed by me, my account may be turned over to a collect agency.

I have read the above statement and fully understand and agree to these terms.

____________________ Print Patient Name

____________________ Responsible Party/Guardian

____________________ Patient Signature

____________________ Date

Last Name: ________________ ***First Name:*** ______________

Reason for being seen today: _______________________________________

____

____

Past medical history: (Check that all apply)

___ Diabetes ___ High blood pressure___ Stroke ___Kidney Stones __ Seizures

___Blood Transfusions___ Asthma ___Cancer ___Heart Attack

Are you being seen by any other physicians? __ Yes __ No

If yes who? ____

____

Have you had any operations? ______________________________________

____

____

Family History: ___ Diabetes ___ Cancer ___ Kidney Stones ___ High Blood pressure___ Stroke ___ Heart Disease

Do you have an advanced heath care directive (DNR/DNI) and/or health care proxy surrogate decision maker? ___ YES ___NO

Do you have any medication allergies? ________________________________

____

Jersey Coast Nephrology and Hypertension Associates

Dr. Joseph Albanese Dr. Keshani Jain Dr. Robert Bruno Dr. Rajat Kapoor

Dr. Priya Anantharaman Dr. Leonard Weiner Dr. Amy Patel

1541 Route 88, Suite A Brick NJ 08724
Phone: 732- 836-3200
Fax: 732-836-3201

1008 Commons Way, Bldg G, Toms River NJ 08755
Phone: 732-818-0700
Fax: 732-818-0730

Patients name: ______________________________

Date of birth: _____/______/_____

Please forward my medical records to Jersey Coast Nephrology and Hypertension Associates.

____

Patient Signature

Jersey Coast Nephrology and Hypertension Associates

Dr. Joseph Albanese Dr. Keshani Jain Dr. Robert Bruno Dr. Rajat Kapoor

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We now have a patient portal available for you to review some of your chart information. If you wish to be invited to the portal, please give your email address and we will have a link sent to you.

Patient Name: ________________________________

Email: ____

I do not wish to have access to the patient portal _____

Jersey Coast Nephrology & Hypertension Associates, LLC
Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights t 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 b involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the use and disclosures of my health information. I understand that this organization has the right to change the Notice of Privac Practices from time to time and that I may contact this organization at any time at the address above to obtain a curren copy of the Notice of Privacy Practice.

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

Print Name ______________________________ Today's Date ______________

Patient/Parent/Representative Signature ______________________________

Name of Representative, if applicable ______________________________

Relationship to Patient ______________________________

Authorization for Release of Information

Many of our patients allow family members such as their spouses, parents or children to call and request results of tes and procedures. Under the requirements of HIPAA we are not allowed to give this information to anyone without th patient's written consent. If you wish to have your test results or prescriptions released to family members you must sig this form.

I authorize Jersey Coast Nephrology & Hypertension Associates to speak with the person(s) listed below regarding offic visits, lab and imaging results, prescriptions, appointment scheduling, collection of demographic information, an insurance or billing inquires. Please list all person(s) below whom we are to release this information to, and their relatio to you:

Name ______________________________ Relation ______________

Name ______________________________ Relation ______________

Name ______________________________ Relation ______________

Print Patient Name ______________________________

Patient Signature ______________________________ Date ______________

Witness/Office Staff Member Signature ______________________________

HIPAA Privacy and Disclaimer Statement

Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Your Health Information Rights: The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of this Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact this office in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercise your rights. You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Our Responsibilities:

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact:

Office Manager
Jersey Coast Nephrology & Hypertension
PO Box 3146
Pt. Pleasant, NJ 08742

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the above address. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

NOTE: We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses Notification:

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family: Using our best judgment, we may disclose to a family member, other relative, close friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health: As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect: We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions: If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight: Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses: Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.