Bassin Endocrinology
Sandy Bassin, M.D.

14 Woodward Drive, Suite A, Old Bridge, NJ 08857
Tel: (732) 334-5800 Fax: 732-360-4888

Patient Information

(Please answer all questions)

Name (As it appears per your insurance)	**Date of Birth**	Age	Marital Status	Sex	**Cell Number**
Mailing Address	City	State	Zip Code	Home Phone	
Employer	City	State	Zip Code	Work Phone	
Email Address					
Referring Doctor:			Referring Doctor Phone Number:		

Insurance Information (EVEN THOUGH WE ARE COLLECTING YOUR CARD FILL OUT COMPLETELY)

Primary Insurance Company	Subscriber's Name, Date of Birth	Relationship	Policy/ID # /Group #	Copay
Second Insurance Company	Subscriber's Name, Date of Birth	Relationship	Policy/Id. # 'Group #	Copay

Pharmacy Name and COMPLETE ADDRESS:	**Pharmacy Phone Number:**

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims, I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature:_____**Date**:_____

(Signature of insured or authorized person, patient or parent if minor)

BASSIN ENDOCRINOLOGY

New Patient Health History Form

Patient name:_____ Height:_____ Weight:_____

Chief Complaint: **What is the main reason(s) you are seeking an endocrine evaluation?**

_____

Social History:
Alcohol: ☐ Yes ☐ No (If yes, what kind? How many drinks/week?) _____
Tobacco: ☐ Yes ☐ No If yes, Cigarettes- Pks/day_____ # of Years: _____
Recreational Drugs: _____ **Allergies:**_____

Past Medical History : Please check Yes or No

	YES	NO		YES	NO
Diabetes			Depression		
High Blood Pressure			Anxiety		
High Cholesterol			Stroke/Heart Attack		
Thyroid Disease			Sleep Apnea		
Cancer (Please specify)					
Other					

Surgical History:

_____

Family Medical History: List disease(s) and the family member(s) with the disease(s).

_____

Current Medications: Please list dose and frequency

_____ _____

_____ _____

_____ _____

_____ _____

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IN THE EVENT MY PHYSICIAN SHOULD NEED MY MEDICAL RECORDS FROM A HOSPITAL OR ANOTHER MEDICAL OFFICE, I HEREBY GIVE MY AUTHORIZATION TO HAVE THIS INFORMATION RELEASED TO:

Sandy Bassin, M.D.

PATIENT NAME:

_____

PATIENT D.O.B.:

_____

PATIENT SIGNATURE:

_____

DATE:

_____

I AUTHORIZE THE FOLLOWING FAMILY MEMBER, SIGNIFICANT OTHER, ETC. ACCESS TO MY MEDICAL RECORDS AND INFORMATION:

AUTHORIZED PARTY NAME: _____

PATIENT SIGNATURE: _____

DATE:_____

HIPPA NOTICE OF PRIVACY PRACTICES

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 of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services . for example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission

Health Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in, a civil, criminal , or administrative action or proceeding, and protected health information that is subject to law that prohibits access to proceed health information.

You have the right to request a restriction of your protected health

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right (to request to receive confidential communications (from us by alternative means alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have you physician amend your protected health

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____ Signature_____ Date_____

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PATIENT AGREEMENT

1. Co-pays must be made at the time of your appointment. Dr. Bassin accepts cash, check or credit cards (Visa or Mastercard).
2. There will be a returned check fee of $30.00 for any check returned for insufficient funds.
3. Medication refills are to be requested AFTER the patient has confirmed there are no refills at the pharmacy.
4. Patient is responsible to obtain a referral from the insurance if it's required. Otherwise, the patient will be responsible for charges and must reschedule when a referral is obtained.
5. Patient is responsible for notifying the office of any insurance changes or personal information changes (i.e. phone numbers, address).
6.
7. The office is not responsible for lost or stolen medications or prescriptions. Please do not call to have them replaced.
8. If you need to change your appointment, please call to cancel or reschedule, failure to provide proper cancellation notice, can/will result in your being discharged in the practice.
9. Please allow 5 business days for prior authorizations to be processed.

Patient Signature_____ Date _____

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Dear Patient,

We participate with many health insurance carriers and each has its own regulations. You must be familiar with the benefits and exclusions of your insurance contract.

Bassin Endocrinology cannot guarantee all services provided by our specialty will be covered. Any rejected services will be billed directly to the patient. Please know your insurance.

We do not participate with: GHI, Medicaid (inc. Family Care, Community Plan, Horizon NJ Mercy), Multiplan, or any commercial United Health Care (inc. Oxford, UMR), Amerihealth, or Humana.

If your insurance requires a referral from your primary care physician, you must have the referral with you at the time of your appointment. This is the patient's responsibility. We do not obtain referrals from the primary care physician. If you do not have a required referral at the time of your visit, your appointment will be rescheduled. Your insurance company will not process any claims for a specialist without the referral if one is required. Your referral may have restrictions (limited visits, testing, expiration dates). Please be aware of these restrictions. They are insurance regulations and not determined by Bassin Endocrinology.

Please contact your insurance and your primary care physician before your appointment.

Thank you for your cooperation.

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"I have read the above information"

Patient Signature:_____ Date:_____

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