

**HIGHLAND PARK FAMILY PRACTICE, LLC**  
**ARTHUR H. MILLER MD, FAAFP**  
505 RARITAN AVENUE  
HIGHLAND PARK, NJ 08904  
TEL: 732-393-1331  
FAX: 732-393-0575  
[www.hpfamilypractice.com](http://www.hpfamilypractice.com)

**PATIENT INFORMATION:**

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_ Sex: M/F Martial Status \_\_\_\_\_ Social Security# \_\_\_\_\_  
Birthdate \_\_\_\_\_ Email \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work# \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**RESPONSIBLE PARTY:**

Guarantor's Name \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work# \_\_\_\_\_  
Patient Relation to Guarantor \_\_\_\_\_ Guarantor Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Guarantor's SS# \_\_\_\_\_ Guarantor's Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION:**

Name of Insurance Company \_\_\_\_\_ Policyholder \_\_\_\_\_  
Pt. Relationship to Policyholder \_\_\_\_\_ Policy/Id # \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Insurance Co. Phone # \_\_\_\_\_ Policyholder Birthday \_\_\_\_\_ Sex \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION:**

Name of Insurance Company \_\_\_\_\_ Policyholder \_\_\_\_\_  
Pt. Relationship to Policyholder \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Insurance Co. Phone # \_\_\_\_\_ Policyholder Birthday \_\_\_\_\_ Sex \_\_\_\_\_

**IN CASE OF EMERGENCY:**

Name of Local Friend or Relative (not living at the same address)  
\_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Highland Park Family Practice, LLC or insurance company to release any information required to process my claims. I consent to treatment for the care of the above patient.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_

Medical History

1. Do you have any allergies to any medications, X-rays, dyes or other substances

Name Medication if yes \_\_\_\_\_  
\_\_\_\_\_

2. Please list all the medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What Pharmacy do you use: \_\_\_\_\_

4. Please list and supply dates of any operations:

\_\_\_\_\_  
\_\_\_\_\_

5. Family History – Has Any member of you family ever had the following:

	Family Member	Age of Diagnosis
Cancer	_____	_____
High Blood Pressure	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental Illness	_____	_____
Bleeding Diseases	_____	_____
Drug or Alcohol Abuse	_____	_____

PERSONAL HISTORY

	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
High Blood Pressure	Yes	No
Heart Trouble, Palpitations	Yes	No
Lungs	Yes	No
Bronchitis, Pneumonia, T.B.	Yes	No
Asthma, Hayfever, Sinusitis	Yes	No
Liver Problem, Jaundice, Hepatitis	Yes	No
Kidneys, Bladder, Urinary	Yes	No
Skin Disorder	Yes	No
Thyroid, Endocrine, Lymphatic	Yes	No
Epilepsy, Seizures	Yes	No
Migraines, Headaches, Dizziness	Yes	No
Stroke	Yes	No
Emotional/Mental Illness	Yes	No
Anemia Blood Disorders	Yes	No
Back Disorders	Yes	No
Eye, Ear, Nose, Throat	Yes	No

The Last time You Had A:

	YEAR
FLU Vaccine	_____
Tetanus Shot	_____
Hepatitis Shot	_____
Pneumonia	_____
T.B.	_____
Stool Blood Test	_____
Eye Exam	_____
Dental Exam	_____
Cholesterol Exam	_____

Do you drink alcohol?.....Yes No If yes, what kind? \_\_\_\_\_  
 How many drinks per week? \_\_\_\_\_  
 Do you use tobacco?.....Yes No How many cigarettes/cigars per day \_\_\_\_\_  
 Do you currently use recreational or street drugs?.....Yes No  
 Have you ever given yourself street drugs with a needle?.....Yes No

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**PROFESSIONAL SERVICES POLICY**

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Prompt payment allows us to control costs. Outstanding accounts cost both us time and money: therefore, all patients will be required to establish financial arrangements for payment of their account.

By law all patients' accounts are due and payable within 30 days of services rendered. As a courtesy, our practice will establish a reasonable monthly/weekly payment plan to accommodate your needs. All new patients will be required to remit full payment to establish an account.

It should be mentioned that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your claim and insure your carrier remits payment. If a problem occurs with your claim, you will be required to establish written financial arrangements with our practice until your insurance problem is resolved.

Each month you will receive a monthly statement for services, which is due and payable within 15 days. If your payment is late, or if you have not previously made financial arrangements, then we will mail a reminder notice or call you indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.

All patients refusing to remit payment after 61 days of notice without pending insurance or financial arrangements will force us to limit their future credit until the previous balance is paid in full or written financial arrangements are accomplished. All patients will be required to sign a written legal agreement with our practice to alleviate any current delinquency. Please notify us immediately if a mistake appears on the statement.

You may be asked to sign a waiver of liability for a particular service (i.e. EKG, Complete Medical Examination, minor surgery, etc.) that may or may not be covered by your insurance. This will be done to avoid any confusion regarding payment for a service that you may be required to pay.

Please read your insurance policy. Most patients do not know what their policy covers. Please inform yourself about the particulars of your insurance coverage. Every plan is different. We do not know what your coverage is until the service is rendered, billed and processed by your insurance carrier. This will avoid any surprise bills for non-covered services, deductibles, coinsurance, and/or co-pays due and payable by the patient.

I have read the above policy.

Patient's Signature \_\_\_\_\_

# HIGHLAND PARK FAMILY PRACTICE

## NOTICE OF INFORMATION

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

- There are legal requirements that require us to protect the privacy of patient’s Personal History Information (referred to as PHI from this point on in this notice). There are legal requirements that require us to provide a Notice of Information and abide by the terms of the Notice of Information.
- Highland Park Family Practice (referred to as HPFP in this notice) will not use or disclose a patient’s PHI for purposes not listed in the Notice of Information without the patient’s authorization.. A patient can authorize a disclosure of their PHI, by requesting an Authorization for Disclosure from our staff. Disclosures are subject to the patient’s control, and the patient may revoke the authorization.
- We will disclose a patient’s PHI without patient authorization for treatment, payment or healthcare operations only. Permitted disclosures include but are not limited to; emergency circumstances; identification of the body of a deceased person, or the cause of death; public health needs; research, generally limited to when a patient has previously agreed to participate in a pharmaceutical drug trial; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.
- We will leave messages on a patient’s answering machine regarding billing matters, or to make patient aware that test results are available, or to remind a patient of an upcoming appointment. Patients have the right to opt out of these phone messages by requesting this in writing on the consent form.
- Patients have a right to request restriction of certain uses and disclosures of their PHI. HPFP is not required to agree to such a request. Patients may restrict certain uses and disclosures of their PHI on the consent form each patient will be required to sign.
- Patients are required to sign consent. If a patient refuses to consent to the use or discloses of their PHI to carryout treatment, payment or health care operations, HPFP may refuse to treat patient.
- Patients have the right to access their PHI for inspection and copying. There is a copying charge of \$.50 per page. Patients may make an appointment with the Privacy Officer to inspect their PHI. Requests for an appointment may be made with the receptionist.
- Individuals have the right to an accounting of any disclosures of their PHI (consulting physicians, HMO’s, labs, etc.)
- Individuals have the right to request an amendment or correction of PHI.
- An individual may request and complete an amendment form obtained from the Privacy Officer. (Patient histories in chart cannot be changed unless making a correction.)
- HPFP may revise our policies and procedures with respect to the uses or disclosures of PHI at any time, and that revision could result in additional uses and disclosures without the individual’s authorization. That revision will also be updated and posted in our office in this Notice of Information and be indicated by highlighting any new policy or procedural changes. Patients may request a copy from the receptionist
- Patients have the right to complain the HPFP and o the Secretary of DHH if they believe their privacy rights have been violated. They may notify the Privacy officer in this office of their complaint or by calling 732-393-1331 and asking to speak with the Privacy Officer (Liz Tesi).
- This notice was created on March 3, 2002. Amended on 02/01/2010



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DATE:

**MEDICAL RECORDS RELEASE AUTHORIZATION**

From: \_\_\_\_\_  
Name of Doctor or Hospital  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
Town or City State Zip Code

I hereby authorize and request you to release a complete copy of my medical records, including test results.

To: Dr. Arthur Miller  
505 Raritan Ave.  
Highland Park, NJ 08904

Patient Information:

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

SIGNATURE \_\_\_\_\_  
Circle One Self Spouse Child

**Highland Park Family Practice, LLC  
Arthur H. Miller, MD, FAAFP  
505 Raritan Avenue  
Highland Park, NJ 08904  
732-393-1331**

**MEDICARE PATIENTS**

We are a participating provider for Medicare. In order to clarify any confusion about coinsurance due and services not covered by Medicare please read the following.

**Please read your Medicare handbook.**

Medicare does not cover Annual Preventive Medical Examinations. You the patient is therefore responsible for all charges associated with any Annual Medical Examination sometimes referred to as a Complete Physical Examination (CPE).

However, Medicare does allow payment for medical conditions concurrently addressed during the CPE. Medicare allows us to bill them for that portion of the visit, which will reduce the balance of your annual physical exam charge. Therefore, you will receive a bill for the balance, which becomes your responsibility. Because of the extended time involved in taking a thorough history and performing an extensive physical examination the fees are higher than our average office visit fee.

All Medicare patients have an annual \$155 deductible starting on January 1<sup>st</sup> of each year. You the patient are responsible to pay the first \$155 billed to Medicare for medical services each year. We will bill you for any deductible that is not paid by your insurance company.

All Medicare patients are responsible and required to pay 20% of the Medicare allowable fee for any Medicare covered service performed in our office. If you have a secondary insurance that is a crossover from Medicare, we will await for payment from that carrier. If that carrier does not pay, you will be billed for the 20% due.

We do not submit to secondary insurance companies that do not crossover from Medicare. You will be responsible to make payments directly to our office for any amount due by you within 15 days of receipt of our bill. You may submit to your secondary insurance company for possible reimbursement.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. If you have any questions please feel free to ask any of our staff. We will make ourselves available to you in order to clarify any misunderstanding you have concerning your balance.

I have read the above statement.

Patient signature \_\_\_\_\_