KENILWORTH PRIMARY CARE
66 South 21st Street, Kenilworth, NJ 07033
Phone: (908) 276-9595 Fax: (908) 276-6807

PATIENT REGISTRATION FORM

PLEASE PRINT & BRING WITH YOU

DATE: _____

PATIENT INFORMATION

PATIENT LAST NAME | FIRST | MIDDLE | ☐ MR ☐ MRS ☐ MISS ☐ MS

DATE OF BIRTH _____/_____/_____ | SEX Male - Female | SOCIAL SECURTIY | MARITAL STATUS Single/Mar/Div/Sep/Wid

STREET ADDRESS | CITY, STATE & ZIP | HOME & CELL NUMBER

EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE NO.

OTHER FAMILY MEMBERS SEEN HERE? ☐ NO ☐ YES NAME_____
WHO RECOMENDED YOU

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO RECEPTIONIST)

IS THE PATIENT COVERED BY INSURANCE? ☐ YES ☐ NO

SUBSCRIBER NAME _____ DATE OF BIRTH _____/_____/_____

SUBSCRIBER ID # _____ GROUP # _____

INSURANCE CO _____ RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTH

IS THIS A JOB RELATED INJURY? ☐ YES ☐ NO IF YES, DATE OF INJURY_____/_____/_____
CLAIM NO. _____ PLACE OF INJURY: ☐ WORK ☐ MVA ☐ OTHER _____

IS PATIENT COVERED BY SECONDARY INSURANCE? PATIENT'S RELATIONSHIP TO SUBSCRIBER

INSURANCE NAME _____ ☐ SELF ☐ SPOUSE

SUBSCRIBER NAME _____ ☐ CHILD ☐ OTHER

ID # _____ GROUP# _____ DATE OF BIRTH _____/_____/_____

CONTACT IN CASE OF EMERGENCY (LOCAL FRIEND OR RELATIVE)

NAME _____ TELEPHONE NO. _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Kenilworth Primary Care. I understand that I am financially responsible for any balance due from me. I also authorize Kenilworth Primary Care to release any information required to process my claims.

_____ _____
PATIENT SIGNATURE DATE
(Guardian's signature if patient is a minor)

Patient Name: _____ Date of Appointment: _____

Reason for the Visit:

What brings you in today:

_____

_____

How is your health?

☐Excellent ☐Good ☐Fair ☐Poor

Do you any other concerns today?

_____

_____

Past Medical History:

☐ Allergies	☐Cancer	☐ Hepatitis- A,B,C	☐ Pneumonia
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Polio
☐ Asthma	☐ Depression	☐ High Cholesterol	☐ Rheumatic Fever
☐ Arthritis	☐ Ear Problems	☐ Joint Disorder	☐ Stroke
☐ Anxiety Disorder	☐ Eating Disorder	☐ Kidney Disorder	☐ Skin disorder
☐ AIDS/HIV	☐ Epilepsy	☐ Liver Disorder	☐ Stomach Ulcer
☐ Back Problems	☐ Glaucoma	☐ Lung Disease	☐ Substance Abuse
☐ Bleeding Disorder	☐ Gout	☐ Measles	☐ Thyroid Disorder
☐ Blood Disease	☐ Heart Disease	☐ Migraines	☐ Tuberculosis

Hospitalizations and Past Surgical History:

_____

Reason Date

_____

Reason Date

_____

Reason Date

Women Only:

_____

# of Pregnancies # of Miscarriages

_____

# of Abortions # of Living

_____

Last Pap Smear Last Mammogram

Allergies:

Are you allergic to any of the following:

☐ Antibiotics ☐ Adhesive Tape ☐ Aspirin

☐ Codeine ☐ Sulfate

Do you have any other allergies?

_____

Name Reaction

_____

Name Reaction

Current Medications:

_____

Name Dose Frequency

_____

Name Dose Frequency

_____

Name Dose Frequency

_____

Name Dose Frequency

Family History:

Patient Name: _____ Date of Appointment: _____

Has anyone in your family ever had any of the following?

☐ Arthritis	☐ Cancer	☐ High Cholesterol	☐ Stroke
☐ Alcoholism	☐ Depression	☐ High Blood Pressure	☐ Substance Abuse
☐ Asthma	☐ Diabetes	☐ Joint Disorder	☐ Thyroid Disorder
☐ Alzheimer's	☐ Epilepsy	☐ Kidney Disorder	
☐ AIDS/HIV	☐ Genetic Disorder	☐ Lung Disease	
☐ Anemia	☐ Glaucoma	☐ Migraines	
☐ Bleeding Disorders	☐ Heart Disease	☐ Psychiatric Disorder	
☐ Blood Disorders	☐ Hepatitis	☐ Osteoporosis	

Details:

_____

_____

Social History and Life Style factors:

Are you sexually active:

☐ Yes ☐ No # of sexual partners in past year: ____

Do you wish to be checked for STD's?
☐ Yes ☐ No

Has anyone in your home physically or verbally hurt you?
☐ Yes ☐ No

Have you ever smoked?
☐ Yes ☐ No #of years_____ #packs/day_____

Do you smoke now?
☐ Yes ☐ No #of cigarettes/day _____

Do you use recreational drugs?
☐ Yes ☐ No
Types _____

# of times/week _____

How much alcohol do you drink per week?
# of drinks _____

How much caffeine do you drink per day?
# of cups/day _____

How often do you exercise?
# of times/week _____

Occupation: _____

Marital History:
☐ Married
☐ Widowed
☐ Divorced

# of children _____

Patient Name: _____ Date of Appointment: _____

KENILWORTH PRIMARY CARE LLC.

DR. BHAVANI JEEREDDY

66 SOUTH 21ST STREET

KENILWORTH, NJ 07033

908-276-9595

Please be advised that if Dr. Bhavani Jeereddy accepts and/or participates with your insurance, that you are still responsible for any co-pay, deductible, and/or coinsurance that may apply.

It is also your responsibility to notify the office if your insurance requires a referral, precertification or authorization for any procedure or office service.

We may also be contacting your health insurance carrier for any pre-certifications that need to be done and will also be advised of your benefits including your deductible, coinsurance, etc.

If you have any questions, please call the office manager or the billing manager.

Thank you.

_____

Signed

_____

Print Name

Patient Name: _____ Date of Appointment: _____

_____

Date

KENILWORTH PRIMARY CARE LLC.

DR. BHAVANI JEEREDDY

Board Certified In Internal Medicine

66 South 21st Street

Kenilworth, NJ 07033

Phone: 908-276-9595 | Fax: 908-276-6807

Date:_____

Name: _____

WE HAVE BEEN ASKED BY YOUR INSURANCE COMPANY TO CHECK WHETHER YOU HAVE A LIVING WILL OR NOT.

PLEASE CHECK ONE.

YES, I HAVE A LIVING WILL. I WILL FORWARD A COPY TO YOUR OFFICE FOR MY CHART. _____

NO, I DO NOT HAVE A LIVING WILL. _____

SIGNATURE: _____

Patient Name: _____ Date of Appointment: _____

KENILWORTH PRIMARY CARE LLC.

DR. BHAVANI JEEREDDY

66 SOUTH 21ST STREET

KENILWORTH, NJ 07033

908-276-9595

Financial Policy

Patient Name: _____

Date of Birth: _____

SSN: _____ - _____ - _____

BASIC POLICY: Payments for service is due in full at the time service is provided in our office.

NO SHOW: Appointments that are not cancelled within 24 hours are subject to a $25.00 fee. New patient appointments are subject to a $45.00 fee. Cosmetic Consults are subject to a $60.00 fee. This not payable or billable to any insurance company. Any patient with 3 NO SHOW charges may be discharged from the practice.

MOTOR VEHICLE ACCIDENTS: Payment is due in full when services are rendered. It is your responsibility to provide this office with all the information needed. Example: name of insured, Insurance company, policy number, claim number, telephone number, and address of insurance company and name of person handling claim.

FOR PATIENTS WITH INSURANCE: We bill most insurances carriers for you if paperwork is provided to us. 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 permits repayments.

HMO PLANS: All co-pays must be satisfied each and every visit. You are responsible for getting proper referral information in advance of your appointment.

Patient Name: _____ Date of Appointment: _____

PPO PLANS: We have agreed to accept the discounted rate from plans we participate in, however, all coinsurance is your responsibility. We will estimate co-pays to the best of our ability. Since the co-pays are estimates only, we will bill you or credit you for your balance.

NON-CONTRACTED OR IDEMNITY INSURANCE PLANS: We will bill your insurance as a courtesy. We will estimate co-pays to the best of our ability. Since the co-pays are estimates only, we will bill you or credit you for your balance.

Medicare: As a participating provider we will bill your Medicare carrier. You are responsible for your 20% copayment for the initial appointment and for any follow up visits and we may collect it each and every visit.

Secondary Insurers: Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We will bill your secondary carrier as a courtesy. You are responsible for any balances after you insurance(s) has cleared.

Divorce Decrees: This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Minor Patients: The adult accompanying a minor on the initial visit will be responsible for full payment or insurance copayments. For unaccompanied minors, the initial visit, non-emergency treatment will be denied.

Payment for services performed:

Our office accepts Cash, Check, Visa, Mastercard, Discover, and American Express. All payments are expected at the time of service. If your co-pay or coinsurance is not paid at the time of service, there will be a $5.00 change to bill it. Any outstanding balances are due within 30 days of the statement. Interest for bill not paid within 30 days of the statement may be charged 1.5% per month unless prior arrangements have been made. If you experience circumstances out of your control, please call our office and we will be happy to make payment arrangements. All balances that reach 90 days past due will be sent to collection agency. Should your account be sent to a collection agency, you would be financially responsible for all collection fees and legal fees that our office includes through the process utilized to collect the outstanding delinquent balance. The collection fee will be a minimum of $50.00 or 40% of the total amount due, whichever is greater amount.

Patient Name: _____ Date of Appointment: _____

I HAVE READ AND FULL UNDERSTAND THE FINANCIAL POLICY SET FORTH BY KENILWORTH PRIMARY CARE LLC AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATOIN TO THE PATIENT.

_____ _____

Signature of Patient/Guardian Date

PHYSICIAN PRACTICE'S NOTICE OF PRIVACY PRACTICES

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

ALL PATIENTS MUST READ AND SIGN

We are required to provide you with this notice about our privacy practices. It explains how, when and why we use and disclose your PHI and our legal responsibility to protect your health information.

We call this information "protected health information", or "PHI" for short. It includes information that can be used to identify you and that we've created or received about your past, present, or future health condition, and the provision of health care to you, or the payment for this health care.

Uses and Disclosures, Which Do Not Require Your Authorization:
We may use and disclose your PHI without your authorization for the following reasons:
We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplant. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death. For example, we may disclose PHI when a law requires that we report information to government personnel about victims of abuse, neglect, or domestic violence; identifying or location of suspect, fugitive, when dealing with gunshot or other wounds; for the purpose of material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure.

For treatment: We may disclose your PHI to hospitals, physicians, nurses, a pharmacy and other health care personnel, to fill a prescription, or to a laboratory to order a blood test. In order to avoid harm, a serious threat to the health or safety of you, another person, or to the public, to provide, coordinate or manage your health care or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally funded drug or alcohol abuse treatment.

For research purposes: In certain circumstances, we may provide PHI in order to conduct medical research.

For specific government functions: We may disclose PHI of military personnel and veterans in certain situations. We may disclose PHI for national security and intelligence activities.

Patient Name: _____ Date of Appointment: _____

To obtain payment for treatment: We may use and disclose your PHI in order to bill and collect payment for the treatment and share portions of your PHI to our billing staff and your health plan to get paid for the health plan to get paid for the health care services we provided, Or may provide to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

For worker's compensation purposes: We may provide PHI and services provided to you in order to comply with workers' compensation laws.

Appointments and health-related benefits or services: We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact at a different telephone number or address.

For health care operations: We may disclose your PHI, as necessary to evaluate the quality of care, or to operate this facility.

Uses and Disclosures and Where you have the opportunity to object: We may provide your PHI to a family member, friend, or other person that you have indicated is involved in your care or the payment for your health care, unless you object in whole or part.
You have the right to a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a byproduct of an otherwise permitted use or disclosure. However, such incidental uses or disclosures are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI:

1) **The right to request limits on uses and disclosures of your PHI**: You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate your agreement for restrictions.
2) **The right to choose How We Send PHI to you**: You have the right to ask that we send information to you at an alternate address (for example: sending information to your work address rather than your home address) or by alternate means (for example: via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.
3) **The right to see and get copies of Your PHI:** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. I we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your request. If we do, we will tell you, in writing, our reasons for the denial and reasonable fee for the cost of copying, mailing, or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and the cost in advance.
4) **The right to get a list of the disclosures we have made:** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or healthcare operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosure made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003. We will respond within 60 days of receiving your written request. The list will not include the date of the disclosure, to whom PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for disclosure. We will provide (1) list during 12-month period without charge. Subsequent requests may be subject to reasonable cost-based fees.
5) **The right to correct or update your PHI**: If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request in writing. We may deny your request if the PHI is (i) correct and complete (ii) not created by us (iii) not allowed to be disclosed (iv) not

part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the changes to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI

6) **The right to get this notice by E-mail**: you have the right to get a copy of this notice by e-mail, if available. Even if you have agreed to receive notice via e-mail, you have the right to request a paper copy of this notice.

How to complain About Our Privacy Practices: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person in the next section below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independent Ave. SW Room 615F Washington DC, 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

Person to contact for Information About this notice or To Complain about Our Privacy Practices: If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the secretary of the Department of Health and Human Services, please contact the office manager of this medical practice immediately.

Effective Date of this Notice: This notice is effective April 14, 2003.

PHYSICIAN PRACTICE'S NOTICE OF PRIVACY PRACTICES

PRINT NAME: _____ acknowledges receipt of the Dr. Bhavani Jeereddy M.D. Notice of Privacy Practices.

Signature: _____ Date: _____

Patient Name: _____ Date of Appointment: _____

KENILWORTH PRIMARY CARE
DR. BHAVANI JEEREDDY
66 SOUTH 21ST STREET
KENILWORTH, NJ 07033

HIPPA COMPLIANCE FORM

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical practice named at the top of the page.

PRINT NAME OF PATIENT: _____
DATE:_____

SIGNATURE OF PATIENT: _____
DATE:_____

For personal representative of the patients (If applicable)

PRINT NAME OF REPRESENTIVE : _____
DATE:_____

SIGNATURE OF REPRESENTATIVE: _____
DATE:_____

Please be advised of the following….

If we need to reach you regarding test results, we will make every effort to reach you personally. If we are unable to reach you, at what number may we leave the message?

HOME _____ CELL _____

WORK _____ EMAIL _____

Policy for discussing your medical information with family members:
Our office will not discuss your medical information with a family member unless you have authorized us to do so. Please indicate the family members authorized to discuss your medical care by checking items that apply to you and providing the name.

___ Spouse: _____
___ Parents: _____
___ Children: _____
___ Siblings: _____
___ Other: __ _____