# PATIENT REGISTRATION PLEASE PRINT AND COMPLETE ALL ENTRIES

TITY, STATE    ZIP   HOME PHONE   CELL PHONE	PATIENT NAME (LAST	FIRST MIDDLE INITI			ADDRESS				
### PATIENT EMPLOYER NAME AND ADDRESS    PATIENT EMPLOYER NAME AND ADDRESS   EMPLOYER PHONE	CITY, STATE			ZIP	HOME P	HONE		CELL PHONE	
INSURED/RESEONSIBLE PARTYENIFORMATION  NAME (FIRST LAST MIDDLE INITIAL)  ADDRESS (if different from patient)  ADDRESS (if different from patient)  ADDRESS (if different from patient)  INSURANCE INFORMATION  PRIMARY INSURANCE NAME  ADDRESS (STREET - CITY - STATE - ZIP)  PHONE  GROUP NUMBER  ID NUMBER  EMPLOYER  EMPLOYER  EMPLOYER PHONE  SECONDARY INSURANCE NAME  ADDRESS (STREET - CITY - STATE - ZIP)  PHONE  GROUP NUMBER  ID NUMBER  EMPLOYER  EMPLOYER PHONE  EMPLOYER PHONE  REFFERING DOCTOR  IN CASE OF EMERGENCY CONTACT  RELATIONSHIP  PHONE NUMBER  ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.  SIGNATURE (Patient or, if minor Signature of parent or guardian)  DATE  AUthorization to release health information to:  Name(s)  ADDRESS  CITY, STATE  ZIP  HOME PHONE  DAYTIME PHONE  DAYTIME PHONE  AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)  PROM:  TO:  Release the following information:  All Records  All Records  All Records  ALL HOME PHONE  DAYTIME PHONE  AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)  PROM:  TO:  Release the following information:  Release the following information to a third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosur my health information maintained at this facility as provided in the Federal Physical or applicable maintained at this facility as provided in the Federal Physical or note: This facility as provided in the Federal Physical or note of the Medical Record Department.  EMAIL  BEALL DATE:  BAIL  BEAL TOTOR  ADDRESS  BERTTOR TO ATTEMENT ON L	PATIENT DATE OF BIRTH PATIENT SSN			_					
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RELEASE OF INFORMATION  I understand that:  once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure my health information.  I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).  my records are protected and cannot be disclosed without written permission  this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.  SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE  DATE  EMAIL									
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<ul> <li>I understand that:         <ul> <li>once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure my health information.</li> <li>I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).</li> <li>my records are protected and cannot be disclosed without written permission</li> <li>this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.</li> </ul> </li> <li>SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE</li> <li>DATE</li> <li>EMAIL</li> </ul>	RELEASE OF INFORMAT	TTON							
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21 OZONES ST. EEGNE NET NEGETIATIVE, NEENTZONGITAT TO FATIENT 32GNATORE OF WITHESS (OPCIONAL).				TIFNT		OF WITNE	es (Ontional)		
	I. JIGHLD DI LLGAL REI	RELATI	CHOILF TO PA		SIGNATURE		.co (optional)	<del>.</del>	

## **PATIENT MEDICAL HISTORY**

PATIENT NAME (LAST FIRST MIDDLE INITIAL)								
*** Preferred Pharmacy:								
Allergies								
NONE/No Known Allergies	Adhesive	•	Anesthesia		Aspirin		Codeine	
☐ Dairy Products		hellfish/Contrast Dye	☐ Latex		■ Morphine		☐ Penicillin	
☐ Sulfa Drugs	☐ Wheat							
OTHER:								
FAMILY HISTORY - PIG	ease indicate	e if any of your imm		have had a	ny of the following by		( in the appropriate box.  [BLING (Brother/Sister)	
Anesthesia Problems	ĺ	1-101111			IAIILK		DELITO (Brother/Sister)	
Arthritis								
Cancer								
Diabetes								
Heart Problems								
Hypertension								
Stroke								
Thyroid Disorder								
SOCIAL HISTORY  Marital status: □ Single □ Married □ Divorced □ Widowed □ Separated  Occupation: □ □ Retired □ Disabled (reason)  □ Yes □ No - Do you drink alcohol? □ Daily □ Weekly □ Infrequently □ Recovering Alcoholic  □ Yes □ No - Do you use tobacco? □ Smoke ( packs per day) □ Chew								
Surgical History: Pleas TYPE OF	e list any <u>h</u> SURGERY		urgeries, fractu YEAR or I		<u>jor illnesses</u> you hav <b>DOCTOR</b>		LOCATION	
<b>Medical History:</b> Have			owing?	_		_		
NONE of the problems listed		chest pain		hyperlip		organ		
allergies		CHF congestive hea		hyperte		osteor		
<ul><li>anemia</li><li>arthritis conditions</li></ul>		chronic fatigue syno depression	drome	hypogo	nadism male	•	nary embolism/blood clot in legs e disorders	
artificis conditions  asthma		diabetes		infection			e disorders ness of breath	
arterial fibrillation		drug/alcohol abuse		insomni	•	_ 55. 4.	conditions	
bleeding problems		erectile dysfunction			bowel syndrome	stroke		
□ врн		fibromyalgia		kidney		syndro	ome X	
CAD coronary artery diseas	e $\square$	Gerd		☐ menopa	iuse	□ tremo	rs	
☐ cancer		☐ heart disease		migraines/headaches		wheat	☐ wheat allergy	
cardiac arrest		high cholesterol		neuropathy				
celiac disease		hyperinsulinemia		onychoi	nycosis			
Medications: List any medications you are currently taking (please include over the counter medications): PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE								
MEDICAT:			DOS	AGE		PERSCI	RIBING DOCTOR	
						<u> </u>		
							<del></del>	

# HIPAA Notice of Privacy Practices

Name

# 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.

#### 1. Uses and Disclosures of Protected Health Information

#### 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 health care 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.

<u>Treatment:</u> 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.

<u>Payment:</u> 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.

Healthcare 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 name 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 authorizati
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 information. 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 protected health information.

You have the right to request a restriction of your protected health information. 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 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 or at an 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 may have the right to have your physician amend your protected health information. 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 contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and become	nes effective on/or before April 14, 20	003.
		NAME AND ADDRESS AND THE PART AND THE PART AND THE
duties and privacy practices with	respect to protected health information	viduals with, this notice of our legal ation. If you have any objections to in person or by phone at our Main
Signature below is only acknowled	edgement that you have received the	nis Notice of our Privacy Practices:
Print Name:	Signature	Date

## PLAINSBORO - PRINCETON MEDICAL ASSOCIATES, PC

# OFFICES OF DR. ARUNA CHAKRALA, MD & DR. SANGEETA BUDDALA, MD

666 Plainsboro Road, Suite 1020 Plainsboro, NJ 08536 369 Applegarth Road, Suite 3 Monroe, NJ 08831

## MEDICAL RECORD RELEASE FORM

Patient Name:	DOB:
I authorize my previous doctor/facility _ to release the following medical informat	
To: Plainsboro – Princeton Medical Asso	ciates, PC
Entire Medical Records	
Prior records from previous	physicians
Specific information	
I give special permission to release any in	nformation regarding:
Substance Abuse/Addiction	
Psychiatric conditions	
Signed	Date

Ph: (609)799-5000 • Fax: (609)799-8170