# HIPAA Notice of Privacy Practices

**UROLOGY CARE OF CENTRAL**
**NEW JERSEY**
**Binod Sinha, M.D.**
**4 Progress St Suite A9**
**Edison, N.J. 08820**
**(908)754-9280**
**(908)754-9287**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS**

**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.

**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 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 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 becomes effective on/or before **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_____

# Urology Care of Central N


## DR. BINOD K SINHA, MD

4 Progress St. Ste A-9
Edison, New Jersey 08820
Tel: 908-754-9280
Fax: 908-754-9287

81 Veronica Ave. Ste 205
Somerset, New Jersey 08873
Tel: 732-227-9110
Fax: 732- 659-6951


**Appointment and Surgery Cancellation Policy**

We strive to render excellent urological care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

**Our policy is as follows:**

We require that you give our office 48 hours' notice in the event that you need to reschedule your appointment or Surgery. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Urology Care Policy Associates Appointment Cancellation Policy.

# Forma de Registro del Paciente

**Binod Sinha, M.D., F.A.C.S., F.I.C.S.**

## Información del Paciente

Apellido del Paciente:_____ Primer Nombre:_____ I:_____

Dirección:_____ Número de Apartamento_____ Ciudad _____ Estado_____ Código _____

Número Teléfono (  ) _____ Número de Trabajo (  ) _____ Extensión _____

Contacto de Emergencia _____ Relación:_____ Teléfono (  ) _____

Seguro Social _____-_____-_____ Fecha de Nacimiento:_____/_____/_____

Email: _____

Género: ☐ Masculino ☐ Femenino Estado Matrimonial: ☐ Soltero ☐ Casado ☐ Enviudado ☐ Separado

Razón para la primer visita: _____

Nombre farmacia:_____ Teléfono (  )_____

Nombre del doctor que te recomendó:_____ Dirección:_____

Ciudad_____ Estado_____ Código_____ Teléfono (  )_____

## Información de Empleador

Nombre de Empleador:_____ Dirección:_____

Ciudad:_____ Estado_____ Código _____ Teléfono (  )_____

¿Nos da permiso para llamar a su trabajo? ☐ Sí ☐ No Ocupación:_____

## *Información del Asegurado

*Persona responsable del pago (s).

Nombre del Asegurado: _____ Relación del Paciente: Propio o Esposo (a) o Hijo o Otro o _____

Dirección: _____ Ciudad_____ Estado_____ Código_____

Empleador:_____ Dirección _____ Ciudad_____ Estado _____ Código_____

Número de Trabajo (  ) _____ Extensión_____ Número Teléfono de su casa (  )_____

## Seguro Primario

Nombre del Seguro Primario: _____ Teléfono (  ) _____

Dirección: _____ Ciudad_____ Estado _____ Código_____

Número de Póliza _____ Número de Grupo _____ Cantidad de Co-pago$_____ Efectivo___/___/___

Nombre del Asegurado: _____ Relación del Paciente: ☐ Propio ☐ Esposo(a) ☐ Hijo ☐ Otro ☐ _____

Fecha de Naciminto del Asegurado: _____/_____/_____ Seguro Social del Asegurado _____-_____-_____

## Seguro Secundario

Nombre del Seguro Secundario: _____ Teléfono (  )_____

Dirección: _____ Ciudad_____ Estado _____ Código _____

Número de Póliza _____ Número de Grupo_____ Cantidad de Co-pago $ _____ Efectivo___/___/___

Nombre del Asegurado:_____ Relación del Paciente: ☐ Propio ☐ Esposo(a) ☐ Hijo ☐ Otro ☐ _____

Fecha de Nacimiento del Asegurado _____/_____/_____ Seguro Social del Asegurado _____-_____-_____

1. Yo autorizo a Millennium Practice Management que revelen mi información médica a mi seguro de salud para el proceso de pago.
2. Yo autorizo el pago de beneficios médicos a los doctores de **Binod Sinha, M.D., F.A.C.S., F.I.C.S.**
3. Yo estoy de acuerdo que una fotocopia de este formulario puede ser usada en lugar de la orginal.
4. Yo estoy de acuerdo de pagar todo lo que mi seguro no cubra, que incluya estos cargos pero no esten limitados a deducible, co-pago, seguro secundario y servicios no cubiertos.

X_____ _____/_____/_____

**Firma del Paciente** **Fecha**

# Patient Registration Form (Please Print)

**Binod Sinha, M.D., F.A.C.S., F.I.C.S.**

## Patient Information

Patient's Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt # _____ City _____ State _____ Zip _____

Home Phone #( ) _____ Work Phone # ( ) _____ Ext. _____ Cell Phone # ( ) _____

Social Security # _____-_____-_____ Date of Birth: _____/_____/_____

Email: _____

Gender: ☐M ☐F Marital Status: ☐Single ☐Married ☐Widow ☐Separated

Emergency Contact: _____ Relationship: _____ Telephone # ( ) _____

Reason for Initial Visit: _____

Pharmacy Name: _____ Pharmacy Telephone# ( ) _____

Name of Referring Doctor/Person: _____ Address: _____

City _____ State _____ Zip _____ Ref Doctor Telephone # ( ) _____

## Employer Information

Name of Employer: _____ Address: _____

City _____ State _____ Zip _____ Telephone # ( ) _____

May we contact you at work? ☐Yes ☐No Occupation: _____

## Guarantor Information

Responsible Party for Bill(s)
Guarantor's Name: _____ Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other _____

Address: _____ City _____ State _____ Zip _____

Employer: _____ Address _____ City _____ State _____ Zip _____

Work Phone # ( ) _____ Ext. _____ Home Phone # ( ) _____

Insured Date of Birth: _____/_____/_____ Insured S.S. # _____-_____-_____

## Primary Insurance

Primary Insurance Name: _____ Telephone # ( ) _____

Address: _____ City _____ State _____ Zip _____

Policy# _____ Grp# _____ Co-pay Amt $_____ Effective Date___/___/___

Name of Insured: _____ Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other _____

Insured Date of Birth: _____/_____/_____ Insured S.S. # _____-_____-_____

## Secondary Insurance

Secondary Insurance Name: _____ Telephone # ( ) _____

Address: _____ City _____ State _____ Zip _____

Policy# _____ Grp# _____ Co-pay Amt $ _____ Effective Date___/___/___

Name of Insured: _____ Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other _____

Insured Date of Birth _____/_____/_____ Insured S.S.# _____-_____-_____

1. I authorize the release of any medical information necessary to process my insurance claims(s), to Millennium Practice Management Associates, Inc.
2. I authorize and request payment of medical benefits directly to my Physician **Binod Sinha, M.D., F.A.C.S., F.I.C.S.**
3. I agree that a photocopy of this form may be used in lieu of the original.
4. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles, co-payments, co-insurance and non-covered services.

X _____ _____/_____/_____

**Patient/Authorized Signature** **Date**