PATIENT INFORMATION SHEET: PLEASE PRESENT INSURANCE CARD, CO-PAY AND PHOTO ID

PLEASE PRINT
NAME_____ DATE OF BIRTH_____ SS#_____

ADDRESS_____ CITY_____ STATE _____ ZIP _____

TELEPHONE INFORMATION:
HOME ( )_____ WORK ( )_____ CELLPHONE( ) _____

EMAIL ADDRESS:_____

SEX (PLEASE CIRCLE ONE) MALE FEMALE RACE: (optional)_____

STATUS (PLEASE CIRCLE ONE) SINGLE MARRIED WIDOWED DIVORCED

NAME AND TELEPHONE OF PERSON(S) TO NOTIFY IN CASE OF EMERGENCY:_____

IF YOU WOULD LIKE TO RELEASE YOUR MEDICAL INFORMATION TO ANOTHER PARTY PLEASE PROVIDE THE FOLLOWING INFORMATION:
NAME:_____
TELEPHONE #_____RELATIONSHIP _____ INITIAL _____
I DO NOT WANT TO SHARE MY INFORMATION WITH ANYONE OTHER THAN MYSELF _____INITIAL _____

NAME OF PHARMACY_____ TOWN_____ PHONE_____
NAME OF SECOND PHARMCY_____

PRIMARY CARE PHYSICIAN_____ PHONE_____

REFERRED BY _____

INSURANCE INFORMATION:
PRIMARY INSURANCE CO._____ START DATE_____

SUBSCRIBER_____DATE OF BIRTH_____ SS #_____

ID#_____GROUP #_____

EMPLOYER_____ OCCUPATION_____

ADDRESS_____BUSINESS PHONE _____

SECONDARY INSURANCE CO._____

SUBSCRIBER_____DATE OF BIRTH_____ SS #_____

ID#_____GROUP #_____

EMPLOYER_____ OCCUPATION_____

ADDRESS _____ BUSINESS PHONE_____

NAME OF SPOUSE/PARENT_____

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO DR. PAUL ROSSOS, M.D. FOR ANY SERVICES FUNISHED TO ME BY HIM. I AUTHORIZE ANY HOLD OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINSTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELAT SERVICES. PLEASE BE ADVISED THAT IF YOUR INSURANCE CARRIER DENIES PAYMENT OF THESE SERVICES FOR ANY REASON, YO WILL BE RESPONSIBLE FOR PAYING THESE CHARGES.

SIGNATURE_____ DATE_____

DR. PAUL ROSSOS, M.D
DIPLOMATE OF AMERICAN BOARD OF OTOLARYNGOLOGY
OTOLARYNGOLOGY – HEAD & NECK SURGERY
FACIAL PLASTIC SURGERY

CENTER CITY OFFICE PARK
1542 KUSER ROAD SUITE B-5
HAMILTON, NJ 08619
(609) 581-0500

501 IRON BRIDGE RO/
SUITE I I
FREEHOLD, NJ 0772
(732) 409-2500

DEAR PATIENT:

THIS OFFICE IS COMMITTED TO EXCELLENT SERVICE, OPTIMAL CARE AND COMPASSION FOR ALL OF IT PATIENT IS COMMITTED TO HEIGHTENING AWARENESS OF HIPAA COMPLIANCE REGULATIONS AND ISSUES, AND TO PROVIE ALL EMPLOYEES THE TOOLS AND KNOWLEDGE TO ENSURE THAT ALL CLAIM SUBMISSION TO HCFA WILL BE ACCURATE, TIMELY AND COMPLETE TO THE BEST OF THEIR INFORMATION.

IT WILL BE POLICY TO COLLECT CO-PAY AND DEDUCTIBLES AT THE TIME OF SERVICE. BILLING TO INSURANCE COMPANIES WILL BE WEEKLY AND MONTHLY TO PATIENTS.

THE PRACTICE AGREES TO COMPLY WITH ALL APPLICABLE LEGAL STANDARDS PERTAINING TO FRAUD AND AB INCLUDING THE FOLLOWING:
FALSE CLAIMS ACT, PROGRAM FRAUD CIVIL REMEDIES ACT, MAIL AND WIRE FRAUD, & HEALTH CARE FRAUD.

I HAVE READ THE ABOVE AND UNDERSTAND IT AS STATED.

PATIENT (OR GUARDIAN, IF A MINOR) _____ DATE _____
If you require a full copy of the HIPAA Policy, notify the front desk.

FCC ROBOCALL RULES:
I AGREE TO ALLOW APOSTOLOS ALEX PAUL ROSSOS, MD. AND HIS STAFF, TO LEAVE MESSAGES, EITHER ELECTRONICALLY OR VERBALLY TO THE FOLLOWING: HOME TELEPHONE, CELLULAR PHONE & EMAIL.

PATIENT (OR GUARDIAN, IF MINOR) _____ DATE _____

IF NO, PLEASE LIST WHAT IS **NOT** PERMITTED & SIGN _____

NOTICE TO OUR PATIENT

WE HAVE NOTICED AN ALARMING INCREASE IN THE NUMBER OF PATIENTS WHO DO NOT KEEP APPOINTMENTS WHI HAVE BEEN SCHEDULED. IN ORDER FOR APPOINTMENTS TO BE AVAILABLE FOR PATIENTS WHO NEED PROMPT ENT CARE, WE HAVE INITIATED THE FOLLOWING POLICY:

***PATIENTS WHO CANNOT KEEP A SCHEDULED APPOINTMENT NEED TO TELEPHONE ANY OF OUR OFFICES T CANCEL OR RESCHEDULE AT LEAST 48 HOURS BEFORE THE SCHEDULED APPOINTMENT.

***AFTER THE FIRST "NO SHOW" INCIDENT, PATIENTS WHO DO NOT KEEP APPOINTMENTS, AND WHO DO NOT CONTACT OUR OFFICES IN ADVANCE WILL BE ASKED FOR A CREDIT CARD NUMBER TO SECURE THE NEXT APPOINTMENT. A $50.00 FEE WILL BE CHARGED TO THE PATIENT'S CREDIT CARD IF THEY DO NOT KEEP THE APPOINTMENT. PATIENTS WHO REPEATEDLY DO NOT KEEP APPOINTMENTS WILL BE REFERRED TO ANOTHEF ENT PRACTICE FOR CONTINUATION OF THEIR CARE.

EACH PATIENT WHO HAS AN APPOINTMENT WITH OUR DOCTOR WILL CONTINUE TO BE CONTACTED TWO DAYS ADVANCE OF SCHEDULED APPOINTMENTS.
WE ENCOURAGE YOU TO ENROLL IN OUR PATIENT PORTAL SYSTEM TO RECEIVE REMINDER EMAILS!
THANK YOU,
DR. PAUL ROSSOS, M.D.

PATIENTS SIGNATURE _____ DATE _____

CREDIT CARD # _____ EXP. DATE _____ 3 DIGIT SECURITY CODE _____