Allergic & Asthmatic
COMPREHENSIVE CARE OF NEW JERSEY
Your home for focused one-on-one solutions

Eric S. Applebaum, M.D., FACAAL, Medical Director
3799 Route 46 East, Suite 205, Parsippany, NJ 07054-1101 ◆ Telephone (973) 335-1700

Important Notice to all Patients

As you are no doubt aware, drastic and progressive cuts in reimbursement for medical services have continued by both private insurance companies and governmental agencies. While we have attempted to minimize the effect of these cuts on you in the past, we can no longer ignore the economic reality that they have created for our office.

Please note the following office procedures that may affect you.

- You must notify us of any changes to your health insurance prior to your receiving any medical services to allow the claim to be submitted to the proper carrier. **Claims submitted to a carrier with which you are no longer covered will be subject to a fee of $15.00 per claim submitted.**
- Co-pays must be paid at the time of service and co-insurance must be paid within 30 days of receiving a balance statement from our office. A $25.00 late fee will apply to all co-pays not paid at the time of service. Any patient account that carries a balance of patient responsibility for 6 months or longer will be sent to our collection agency. Patient will be responsible for a 25% collection fee plus an interest charge of 1.5% per month that the account is overdue.
- **Medical forms for school, camp or work will require a fee of $15.00 per form if filled out by the Nurse.** If the Doctor's time is required, the fee will be commensurate with the time required to complete the form.
- **Prior or special authorization for medications not covered** by your insurance plan **will require a fee of $15.00** per telephone call for form filled out.

While we appreciate the difficulty that these policies may pose for you, it has become impossible for us to continue to absorb these costs without them. We apologize for any hardship this may cause and look forward to continuing to provide you with the highest levels of medical care and service.

Dr. Applebaum & Staff

_____ _____
Patient Signature Date

_____
Witness

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Patient Information

Last Name: _____ First Name _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Date of Birth: _____ Sex: Male Female Marital Status: S M D W

Social Security #: _____-_____-_____ Ethnicity: _____

Primary Language: _____ Email Address: _____

Student: Yes No If yes, school name: _____

Employer Name: _____

Address: _____

Work Phone: ( ) _____-_____ Ext. _____

Occupation: _____

Primary Care/Family MD Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: ( ) _____-_____

Referred to be seen by: _____

Insurance Information

Primary Insurance Company Name: _____

Identification# _____ Group#: _____

Subscriber: _____ Subscribers Birth date: _____

Sex: Male Female Relationship to Patient: Self Spouse Parent

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Social Security #: _____-_____-_____

Employer Name: _____

Secondary Insurance Information: Relationship to Patient: Self Spouse Parent

Primary Insurance Company Name: _____

Identification# _____ Group#: _____

Subscriber: _____ Subscribers Birth date: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Social Security #: _____-_____-_____

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Please complete the appropriate authorizations:

1. I authorize the release of medical information when necessary to process insurance claims.

   Signature: _____ Date: _____

2. I hereby agree to pay my account as services are provided. If for any reason there is a balance owing my account, I agree to pay promptly upon receipt of the monthly statement.

   Signature: _____ Date: _____

3. For Medicare Insurance: I request that payment for authorized Medicare benefits be made either to me or on my behalf to Allergic & Asthmatic Comprehensive Care of NJ, PA for any services furnished to me by that physician. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

   Signature: _____ Date: _____

4. For CHAMPUS/CHAMPVA Insurance: I request that payment of authorized benefits be made either to me or on my behalf to Allergic & Asthmatic Comprehensive Care of NJ, PA, for any services furnished me by that physician. I authorize any holder of medical information about me to release to OCHAMPUS and its agents any Information needed to determine these benefits or the benefits payable for related services.

   Signature: _____ Date: _____

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Eric S. Applebaum, M.D., FACAAI, Medical Director
Diplomate, American Board of Allergy & Immunology
3799 Route 46 East, Suite 205, Parsippany, NJ 07054-1101
Telephone: 973.335.1700 · Fax: 973.335.4711
www.AllergyCareOfNewJersey.com

Dear Dr. Applebaum:

I _____ give you and your office staff permission to discuss the following checked information

- ☐ Medical Plan of treatment, short and long term, diagnostic procedures performed and medications prescribed, including associated information pertinent to my treatment
- ☐ Financial Information and Responsibility
- ☐ Insurance Claim Detail

to the person(s) I have listed below.

_____

Name Relationship

_____

Name Relationship

Should this change for any reason, I understand it is my responsibility to advise your office.

Sincerely,

_____

Signature Date

_____

Staff Witness Date

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Appointment Cancellation Policy

It is our desire to provide the best care possible to all of our patients at all times. Furthermore, we strive to be on time for all scheduled appointments and avoid the long waiting times commonly occurring in the other medical offices. To accomplish these objectives, we do not overbook appointments except in cases of emergency. Unfortunately, this does mean that regularly scheduled appointments are a scarce commodity that must be accorded their proper value. When an appointment is cancelled without adequate time to fill the time slot or when an individual fails to present for an appointment without cancelling that appointment, it interferes with the care available to all patients and impairs the proper functioning of the office. To avoid having to undertake changes that would radically change the way we deliver our medical care, the following policy is effective immediately and in all circumstances:

1. It is the responsibility of the patient or their legal guardian to be aware of the correct time and date of any scheduled appointment. A reminder phone call from our office is a courtesy and not a requirement for adherence to this policy.
2. It is the responsibility of the patient or their legal guardian to be aware of their Insurance company requirements and to meet those requirements, including obtaining all required referrals and preauthorization, prior to presenting for an appointment.
3. Appointments must be cancelled by 12 noon of the working day prior to the appointment to avoid incurring a **Cancellation Fee**. Any patient cancelling an appointment after 12 noon of the working day prior to the appointment will be responsible for a **Cancellation Fee of $50**, payable prior to receiving further treatment.
4. Patients failing to present for a scheduled appointment without cancelling will be assessed a **No-Show Fee of $75**, payable prior to receiving further treatment.
5. Patients who fail to present for any appointment or who cancel 2 or more appointments without adequate notice will need to leave a credit card as security prior to receiving further treatment or scheduling further appointments. The credit card will be charged the corresponding fee if the scheduled appointment is not kept or cancelled appropriately.
6. Patients who fail to present for an appointment or who cancel an appointment without adequate notice on a total of 3 or more occasions may be discharged from the practice and asked to seek alternative medical care with another physician without further warning.
7. Patients who present for an appointment without a required referral, may choose to be seen without a referral and pay for services at the time of the visit or will be assessed a **No-Show Fee of $75**.

Eric S. Applebaum, M.D. FACAAI

I understand these policies and have been given the opportunity to discuss them with the office staff or seek care with an alternative physician. I accept the conditions spelled out in these policies and will abide by the financial and logistical requirements they impose.

_____ _____
Printed Name Signature

_____ _____
Staff Witness/Signature Date

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HIPAA Notice of Privacy Practices

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 our 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.

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 disclosed, 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.

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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 respected to your protected health information.

You have the right to inspect and copy our 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 restrictions 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 disclose 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 this 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: _____

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Dear Dr. Applebaum:

I understand and accept any requirements or limitations placed upon me by my specific Managed Care Organization or Insurance Plan. I understand that I am solely responsible to know such limitations and/or requirements in order to receive medical services in your office. It is my responsibility to:

1. Obtain all necessary referrals/authorizations and present them to your staff prior to any medical services rendered to me.

2. Keep track of the number of services authorized in order to provide your office with a new authorization/referral when necessary prior to receiving any medical services in your office.

3. Know what services are or are not covered under my plan/contract with my insurance company. I will be responsible for any services that may be denied by my health plan. I will contact my insurance company should there be any disagreement over authorizations or payment for services rendered denied.

4. Should your staff allow me to delay payment for services rendered, I understand that this is a courtesy and that payment may be required in the near future.

5. Under no circumstances do I expect that your staff will obtain required authorizations or referrals for services rendered and while they may assist me occasionally in obtaining these required and necessary authorizations or provide me with helpful information, any such assistance is a courtesy and is not expected under most circumstances.

I have had the opportunity to ask any questions about the above statements and have such questions answered.

Signature: _____

Print Name: _____

Staff Witness: _____

Date: _____