NJUI NEW JERSEY UROLOGIC INSTITUTE

Jules M. Geltzeiler, M.D., F.A.C.S.* Y. Samuel Litvin, M.D., F.A.C.S.*
Ira G. Keselman, M.D., F.A.C.S.* Ilan Waldman, M.D.*

N.J.U.I ID#: _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City State Zip Code

S. S. #: ___-___-_____ E-mail: _____

Driver's License# _____

Primary #: _____ Secondary #: _____ Other Tel. #: _____ (Cell # Preferred)

Sex: M / F DOB: _____ Age: _____ Marital Status: S / M / CU / D / W

Referred By: _____ Primary Care Physician: _____

Ref. By Tel. #: _____ PCP Tel. # _____

INSURANCE INFORMATION:	Primary Carrier	Secondary Carrier
Insurance Company Name:		
Name of Subscriber:		
Relationship to Patient:		
Subscriber's D.O.B.:		
Subscriber's SS#:		
Insured's I.D.#:		
Group #:		

Pharmacy:	**Mail Order Pharmacy:**
Address:	Address:
City:	City:
Tel. #:	Tel. #:
Fax #:	Fax #:

Ethnicity: _____ Race: _____ Language of Preference: _____

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Patient Name: _____ N.J.U.I. ID#: _____

Medicare Lifetime Signature on File:

I authorize payment of Medicare benefits to the New Jersey Urologic Institute, P.A. for services rendered to me. I understand that I am financially responsible for balances cont covered by insurances. I authorize release of medical information about me to the Centers for Medicare and Medicaid Services and to my insurance company to determine benefits.

PLEASE NOTE: URINE CULTURES, CYTOLOGIES & PATHOLOGY STUDIES MAY BE SUBJECT TO ADDITIONAL TESTING BY OUTSIDE LABORATORIES. YOUR INSURANCE COMPANY WILL BE BILLED SEPARATELY BY THESE OUTSIDE LABS.

X_____
Sign Date

All Other Insurance Signature on File:

I authorize payment of any insurance benefits to the New Jersey Urologic Institute, P.A. for services rendered to me or my dependent. I understand that New Jersey Urologic Institute will submit claims to my insurance company and that I am responsible for all co-pays, deductibles and charges for service no covered by my insurance company. I authorize the release of medical information to my insurance company in order to evaluate and pay medical claims.

PLEASE NOTE: URINE CULTURES, CYTOLOGIES & PATHOLOGY STUDIES MAY BE SUBJECT TO ADDITIONAL TESTING BY OUTSIDE LABORATORIES. YOUR INSURANCE COMPANY WILL BE BILLED SEPARATELY BY THESE OUTSIDE LABS.

X_____
Sign Date

Employer Name_____ Occupation_____

Address: _____

Employer Tel. #:_____ Contact Name: _____

Emergency Contact Name_____ Tel. #_____

10 Industrial Way East, Suite 101, Eatontown, NJ 07724 | Telephone: 732.963.9091 Fax: 732.963.9092
25 Kilmer Drive, Building 3, Suite 214, Morganville, NJ 07751 | Telephone: 732.536.8880

NEW JERSEY
NJUI UROLOGIC
INSTITUTE

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Patient Name: _____ N.J.U.I. ID#: _____

Your care and our records for your care are considered confidential. If you wish us to release information to your spouse, child, parent, or friend, please list these name(s) below and sign your name.

I authorize New Jersey Urologic Institute, P.A. to release records and information on my care to the following people:

X _____
Signed Date

NO SHOW FEES:

I'm aware a NO SHOW fee will be charge to my account if I fail to cancel any appointment prior to 24 hours. I understand that the NO SHOW fees are **$250** for initial office visit, **$50** for follow-up office visits exists, **$250** for an in office procedure and **$500** for a procedure at an outside facility.

"Failure to sign this acknowledgment will not prevent this policy from becoming effective."

X _____
Signed Date

Patient Liability Agreement

I understand that I am financially responsible for all bills incurred while under the care of the New Jersey Urologic Institute, P.A. In the event that my account is not paid in full, I shall be liable for any and all cost of collection, including, but not limited to a 35% fee of the outstanding balance if my account is forwarded to a collection agency for collection; and if my account is forwarded to an attorney for legal proceedings I agree to be liable for an additional attorney fee making a total collection and attorney fee of 50% of the outstanding balance.

X _____
Signed Date

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NOTICE OF PRIVACY PRACTICES

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of 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 have created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. 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. 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. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in each office's reception area. You can also request a copy of this notice from the contact person listed in Section VI below at any time and can view a copy of this notice on our Web site at www.njurologic.com.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization

1. For treatment. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order 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 abuses treatment facilities or where otherwise prohibited pursuant to State or Federal law. For example, we may disclose PHI to a pharmacy to fill a prescription or to a laboratory to order a blood test.
2. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. For example, we may disclose your demographic information to anesthesia care providers for payment of their services.
3. For health care operations. We may disclose your PHI, as necessary, to operate this facility and provide quality care. For example, we may use your PHI in order to evaluate the quality of health care services you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants and others in order to make sure we are complying with the laws that affect us.
4. When a disclosure is required by Federal, State or local law, judicial or administrative proceedings, or law enforcement. For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.
5. For public health activities. For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease, as authorized by law.
6. For health oversight activities. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.
7. To coroners, funeral directors and for organ donation. We may disclose PHI to organ procurement organizations to assist them in organ, eye or tissue donations and transplants. We may also provide coroners, medical examiners and funeral directors necessary PHI relating to an individual's death.
8. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.
9. To avoid harm. In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
10. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.
11. For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.
12. Appointment reminders 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 you at a different telephone number or address.

B. Uses and Disclosures Where You Have the Opportunity to Object:

Disclosures to family, friends or others. We may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing, except to the extent that we have taken action in reliance upon your authorization.

D. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or 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 disclosure 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.

IV. YOUR RIGHTS REGARDING YOUR PHI.

A. 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 our agreement to a restriction.

B. 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 fax instead of regular mail). We must agree to your requests so long as we can easily provide it in the manner requested.

C. 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. If 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 written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for denial and explain your right to have the denial reviewed.

If you request a copy of your information, we may charge you a reasonable fee for the costs 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 to the cost in advance.

D. 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 health care 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 disclosures 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 we will give you will include disclosures made in the last six years unless you request a shorter time. The list will 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 the disclosure. We will provide one list during any 12 month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

E. 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 and your reason for the request in writing. We will respond within 60 days of receiving your 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, or (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 do not 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 change to your PHI, tell you that we have done it and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive the notice via e-mail, you also have the right to request a paper copy of this notice.

V. 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 listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue SW, Room 615F, Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. 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 Gary Feller, MPH; NEW JERSEY UROLOGIC INSTITUTE, 279 Third Avenue, Long Branch, NJ 07740, (732) 222-2111, via e-mail at shoreurology@aol.com.

VII EFFECTIVE DATE OF THIS NOTICE.

This notice is effective April 14, 2003.
modified 7/23/2008.

I acknowledge receipt of NEW JERSEY UROLOGIC INSTITUTE, P.A., Notice of Privacy Practices:

_____

Patient Name, Printed

_____ **Date** _____

Patient Signature

NJUI NEW JERSEY UROLOGIC INSTITUTE

Jules M. Geltzeiler, M.D., F.A.C.S.*
Ira G. Keselman, M.D., F.A.C.S.*
Y. Samuel Litvin, M.D., F.A.C.S.*
Ilan Waldman, M.D., F.A.C.S.*
*Diplomates of the American Board of Urology

Information on Credit Card on File

Thank you for your cooperation with our implemented credit card on file policy. As you know the insurance industry makes patients responsible for high deductibles, co-payments and non-covered services. Although some plans may not require this, we find that most plans do. That is why we require every patient to comply with this policy. We also needed an automated way to receive payment from you for the services already provided.

Please be advised that once your insurance carriers have paid their portion, any balance left on the account is your responsibility. Once you receive an EOB from your insurance company as well as a bill from us, if a payment isn't made in a timely matter your credit card on file will be charged.

Once the credit card has been charged, we will mail you a receipt and the explanation of benefits your carrier provided to us which explains their payment and your responsibility.

Please call our billing department to discuss your options.

Although our agreement advises that you can cancel your credit card on file, we will be unable to continue your care without an active credit card on file.

Thank you for your assistance.

-New Jersey Urologic Institute

Signature:_____ Date:_____

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