Hamilton Behavioral MDPA

294 State Street, Hackensack, NJ 07601
Tel: 201-490-5150 Fax: 201-696-3955

Our financial policy

Thank you for choosing us for your medical care. The following is a statement of our Financial Policy which we ask you to read and sing prior to any treatment.

If you belong to an insurance or managed care plan, please let us know beforehand.

- We accept cash, checks, or credit cards
- If you belong to an HMO or PPO that requires a co-payment, you will be asked to pay this prior to your seeing the doctor.
- IF YOU NEED TO CANCEL/RESCHEDULE AN APPOINTMEN WE REQUEST A 24 HOURS NOTICE.

OUR OFFICE WILL BILL A SUM OF $60 FOR MISSING APPOINTMENTS

REGARDING MEDICAL INSURANCE…

Your health insurance policy is a contract between you and your insurance company. Any disputes regarding medical coverage should be addressed directly to them

- If you have commercial insurance (indemnity plan), we ask that you pay the charge for services rendered. We will assist you in filing your insurance claim for you. Any remaining balance will be your responsibility.

- If you belong to an HMO, PPO, or any other managed care plan in which we participate, we will automatically file your insurance claim for you. You are responsible for obtaining any required referrals, authorizations, or pre-certifications prior to your visit. If a treatment or procedure is performed here and is not deemed payable by your insurance company, you will be held responsible for payment in full.

- It is your responsibility to know your health insurance coverage and benefits. If you do not know your benefit coverage, we recommend that you contact your insurance company directly for any questions and/or concerns that you may have.

- It is your responsibility to present to us with your most current insurance coverage. Failure to do so may result in the denial of your claim, and you will be held responsible for payment in full.

- If you are Medicare beneficiary, we will file your claim directly to Medicare for you. If you have a supplemental insurance, we will balance bill them for the portion Medicare does not pay. However, you remain responsible for the annual deductible as well as any remaining co-payments.

- Should you receive a check or other form of remuneration form an insurance company or other third party payer for services rendered at our office, you agree to immediately release that payment Dr. Yasir Ahmad's office with a copy of the explanation of benefits provided. Failure to do so may construed as "Theft of Services" pursuant to Title 2C:20-8 of the NJ Permanent Statute Law and will be procedure to the fullest extent of the law.

Patient's Signature_____Date_____

PRINT NAME_____

ASSURANCE OF PRIVACY FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national causing patients Inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis of the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any though of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rules" to help ensure that personal health care information is protected for privacy. The Privacy Rules was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry our treatment, payment or health operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment or heath care operations, in order to provide health care that is in your best interest.

We also want you know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required of obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, as some future time, you may refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed out privacy notice.

Please sign this form to acknowledge that you have read this notice.

Print name:_____ Signature:_____Date:_____

If minor, signature of parent of legal guardian:_____

Thank you for being one of our highly valued patients

For office use

A "good faith effort" was made to get a signature from a patient. Signature was not attained due to the following:

_____

_____

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GENERAL INFORMATION

SS#_____ TODAY'S DATE_____

NAME_____
(FIRST) (MIDDLE) (LAST)

SEX_____ DATE OF BIRTH_____ MARITAL STATUS_____

EMPLOYER_____
(NAME) (ADDRESS)

WORK PHONE (_____)_____ OCCUPATION_____

HOME ADDRESS_____
(STREET) (TOWN) (STATE) (ZIP CODE)

EMAIL ADDRESS_____

HOME PHONE (_____)_____ CELL (_____)_____

REFERRED BY_____

HOW DID YOU HEAR OF US?_____

INSURED SS# _____ INSURED'S NAME_____

SEX____ DATE OF BIRTH_____ MARITAL STATUS_____ RELATION TO INSURED_____

INSURED EMPLOYER _____
(NAME) (ADDRESS)

INSURED HOME ADDRESS _____
(STREET) (TOWN) (STATE) (ZIP CODE)

INSURED HOME PHONE_____ OTHER PHONE_____

EMERGENCY CONTACT_____ RELATION_____

HOME PHONE_____ OTHER PHONE_____

ASSIGNMENT OF BENEFITS AUTHORIZATION

I request that payment of authorized benefits be made to Hamilton Behavioral for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services. This authorization may be canceled on my request any time.

PATIENTS SIGNATURE_____

This paper shows that we have your signature on file and we will submit your insurance claim for services rendered at our office.

Please submit your insurance cards for photocopying.