Office Policies

Welcome to our practice! It is an honor to care for you and your family. Please take a few minutes to read this document and sign the reverse side. We are glad to answer questions regarding our office policies.

Appointments

Timeliness:
Please arrive 15 minutes prior to your scheduled appointment. We strive to keep on schedule and we do our best to notify our patients if there is a delay in one of our doctors' schedules. We ask for your patience and understanding in the event that there is an emergency while you are here for your appointment. If you are late for your appointment time, we reserve the right to reschedule your appointment.

Documentation:
At the time you schedule your appointment, our office staff will review the documentation that you will need to bring with you (ex: insurance card, referral and/or out of network authorization, driver's license, and any change of your personal information). You are required to have this documentation at the time of your visit. Please inform the receptionist of any changes to your address, phone number or other patient information. Not having the proper documentation may cause you to be **financially responsible for your office visit**.

Cancellations, Charges for Missed Appointments:
Cancellations for office appointments require 24 hours notice and for surgeries require a minimum of 72 hours notice. Failure to provide such advanced notice to the office may result in a charge of $50 to your account for a missed office visit and a charge of $750 for a missed surgery.

Minors:
Children under the age of 18 must be accompanied by a parent or an adult guardian who has appropriate documentation, such as a written parental permission. Our staff is not permitted to watch your child while you are receiving care at the practice. Please make arrangements prior to arriving at the practice for your appointment and/or X-ray.

Follow-up:
Please schedule your follow-up appointment before leaving the office, as this will enable us to better accommodate any special needs.

Divorced Parents/Separated Parents:
Our office will not get involved in divorce settlements. We will accept a copy of the divorce decree for the patient's chart to avoid confusion. Our office recommends questions pertaining to the patient (child) come from the parent who presented with the patient.

Pre-certifications

Prior to scheduling an appointment for an MRI, CT Scan or Ultrasound, patients must contact our office to begin the pre-certification process. This process can take up to 3-5 business days.

Study Results
It is your responsibility to contact our office once your study (whether it be blood work, CT Scan or other study) has been completed. Please provide us with the name of the facility where the study was performed and the date of the study. We

will obtain your results directly from the facility. It may take up to 5 business days for us to receive these results, unless they were marked urgent. Upon receipt, we will call you to follow-up.

X-Rays

Minors or Children with Special Needs:

Children under the age of 3 and those who have special needs may require adult supervision while receiving an X-ray. Please make necessary arrangements as our staff is not permitted to hold your child during an X-ray. Pursuant to our office's policy, minors (unless they are receiving an X-ray) and pregnant women are not allowed in the X-ray room.

Release of X-rays:

We may provide you, another provider, or a third party, with a copy of your X-rays for consultation, further diagnostic testing, or other purposes. In certain circumstances, you may incur a cost for the release of your X-rays. We are not responsible for the maintenance of xrays from outside facilities. If you need your original CD or films, please ask for them back at the end of treatment.

Copies of Medical Records:

Please be advised that original medical records are the property of the provider. Copies can be reproduced for a copy charge of $1.00 per page or if the record is less than 10 pages $10.00. If you are requesting copies of X-rays there is an additional cost. You can request copies in writing or complete our medical record release form and we will have them copied for you within 30 days of the request.

General Information

Cell Phone Usage:

Please refrain from using cell phones in our office.

Prescription Refills:

We will not refill any prescriptions over the phone if you are overdue for your office visit.

Administrative Forms:

We may charge up to $25 for completing administrative forms (ex: school, life insurance, disability, DMV). This fee is not covered by insurance and is due upon completion of the form.

DME Products (CPT 97760):

If you opt to receive a DME product there will be a charge for dispensing and training. We will bill your insurance; however, any balance will be your responsibility.

Acknowledge and Agreement to the terms and conditions of this document:

_____ _____

Patient's Name **Date**

_____ _____

Patient/Parent/Guardian Signature **Printed Name**

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HIPAA Acknowledgement

Notice of Privacy Practices

Print Name of Patient _____

Patient Date of Birth _____

We at Advocare are required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices with respect to protected health information. I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Signature of Patient/Legal Representative _____

Today's Date_____

Email Address of Patient/Legal Representative _____

Cell Phone of Patient/Legal Representative (_____) _____ - _____

Please let us know which number you would like us to call regarding your medical information. *Note that this is the number where we will leave a message if we do not reach you.*

☐ Home phone ☐ Cell phone ☐ Both

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IDX Account #:_____

Assignment of Benefits/Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Advocare Payment Policy and Notice of Privacy Practices for more information)

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

New Jersey Vaccine Registry (if applicable)

Please be advised that our office submits information of your child's vaccinations to the NJIIS (New Jersey Immunization Information System). The purpose of this program is to keep a central record of your child's immunization history.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

_____ X _____
Patient Name (Please Print) Patient Signature

_____
Guarantor/Parent/ Guardian completing this form (Please Print) Date

X _____
Guarantor/Parent/ Guardian Signature Date

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	☐ Y ☐ N	Has treatment been authorized by the V.A.?	☐ Y ☐ N
Do you or your spouse have other insurance?	☐ Y ☐ N	Are you covered under the Black Lung Program?	☐ Y ☐ N
Are you disabled or have end stage renal disease?	☐ Y ☐ N	Is there Medigap coverage secondary to Medicare?	☐ Y ☐ N
Is illness/injury the result of an auto accident?	☐ Y ☐ N	Is there insurance coverage primary to Medicare?	☐ Y ☐ N
Did illness/injury occur at work?	☐ Y ☐ N	Is there employer supplemental coverage secondary to Medicare?	☐ Y ☐ N

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ X _____
Patient Name (Please Print) Patient Signature

_____
Guarantor/Parent/ Guardian completing this form (Please Print) Date

X _____
Guarantor/Parent/ Guardian Signature Date