South Orange OB/GYN & Infertility Group
106 Valley Street
South Orange, NJ 07079
TEL: 973-763-4334 FAX: 973-763-4355
Michael T. Dresdner, MD, FACOG Stanley R. Simon, MD, FACOG
Beth L. Sosin, MD, FACOG

Financial Policy

Due to recent and upcoming changes in many insurance plans, patients need to be aware of their benefits. Many of the new insurance plans feature copays, deductibles, and co-insurance payments that their old plans did not require. Also, many of the insurances have changed to automation for Precertifications an Authorizations. This means that even if the doctor receives authorization to perform a procedure, if the insurance does not cover the procedure, the patient is responsible for the charges incurred.

We are urging you, the patient, to check your benefits. Located on your insurance card is a phone number for Member Services. Please call the number as soon as possible if you are unaware of what your coverage actually provides. This is especially important for prenatal patients, surgical patients, infertility patients, and patients being referred to us by another doctor's office, hospital or facility for any procedure. Please be informed and prepared in advance of what your insurance policy covers.

Many insurance plans require their members to pay a coinsurance fee for certain office visits and procedures. If there is an outstanding balance of under $50 for which you are liable for a particular date of service after your insurance carrier has processed and dispensed payment, such payment will be charged to the credit card on file.

Please note that there is a returned check fee of $25.00. Our bank charges us a fee for any check that is returned for "insufficient funds" and this will be added to your bill if this occurs. There will also be a $50 fee for appointments cancelled less than 24 hours in advance of the scheduled appointment.

Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process. Accounts that go to collection will be subject to a 25% charge.

I, the undersigned, have read the above and fully understand that ***I am responsible for being aware of what my benefits cover and that I am responsible for any charges my insurance policy does not cover.*** I have read the above South Orange OB/GYN & Infertility Group Financial Policy. I understand and agreed to abide by its terms.

____
(Signature of patient or authorized guardian)

____
(Date)

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Patient Contact Information

Name ____

Current Address ______________________________________

City, State, Zip _______________________________________

Cell ____

Work ____

Email Address _______________________________________

Social Security # ____________________________________

Emergency Contact Name ____

Emergency Contact Home ________________ Emergency Contact Cell ______________________

Pharmacy Name and Address

____

Primary Care Physician Name and Address ____

____

____

Primary Care Physician Phone Number ____

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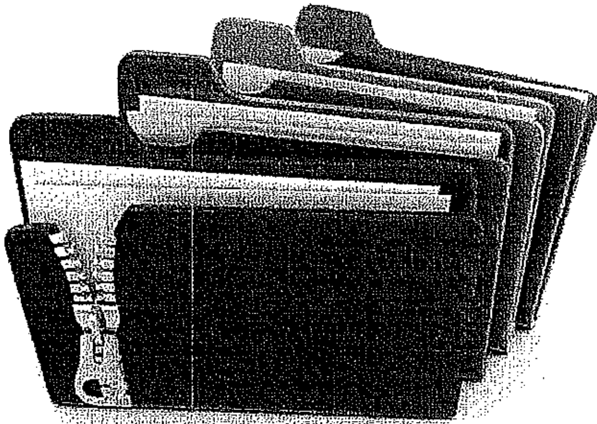
Cindi Dresdner, Privacy Officer
973-763-4334



Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

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Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or manage a hospital directory.

We will never share any substance abuse treatment records without your written permission.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

September 4, 2014

This Notice of Privacy Practices applies to the following organizations.

Not Applicable.

I, the undersigned, have read and understand and agree with the privacy notice above.

_______________________________ _______________________

Signature of Patient or Legal Guardian *Date*

____

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Patient Portal Authorization Form

The patient portal method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) The secure message must reach the correct email address, and
2) Only the correct individual or someone authorized by that individual must have access to the message.

Only you can make sure that these two factors are present. It is imperative that our practice has your correct email address and that you inform us of any changes to your e-mail address. You will also need to keep track of who has access to your email account so that only you can see your medical file You are responsible for protecting yourself from unauthorized individuals learning your password. If you think that someone has learned your password, you should promptly go to the website to change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at login. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth on the Home Screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address ____

Print Name ______________________________ DOB ________________

Patient Signature __________________________ Date ________________

Please complete the following if the email does not belong to the patient: Please note; portal access is not available for patients under 18 year of age.