The Rubino OB/GYN Group Notice of Privacy Practices/HIPAA

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.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How we use your Patient Health Information (PHI)

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services.

For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. When you provide a check as payment, you authorize The Rubino OB/GYN Group to use information from your check to make a one time electronic funds transfer from you account or to process the payment as a check transaction.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness. In any other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop and future uses and disclosures.

Individual Rights

You have the following rights with regard in your health information. Please contact the person listed at the end of this notice to obtain the appropriate form for exercising those rights.

Request Restrictions: You may request restrictions to certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidentiality Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There will be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to so request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint. If you have any questions, requests, or complaints, please contact: Margaret Santo: 101 Old Short Hills Road, Suite 101, West Orange, NJ 07052 V12-1-16

THE RUBINO OB/GYN GROUP
Advanced Solutions for a Healthier Life

101 Old Short Hills Road, # 101
West Orange, NJ 07052

33 Overlook Road #108
Summit NJ 07091

731 Broadway
Bayonne, NJ 07002

67 Walnut Avenue, # 101
Clark, NJ 07066

340 Main Street
Madison, NJ 07940

The Rubino OB/GYN Group Patient Information Sheet

(Please Print)

Date:_____

Name:_____
Last Mi First Refer to as

Address: _____
Apt City St Zip

DOB: ___/_____/_____ AGE: _____ SS#: _____

Home phone#: _____Cell phone #: _____Work #: _____

Preferred contact #: (please circle one) Home - Cell - Work

E-Mail address:_____

Please circle: Single / Married / Divorced / Separated / Widowed

Occupation: _____ Religion: _____

Employer: _____

Business address: _____
Street City ST Zip

Business phone #: _____

Spouse's name: _____ Work #_____ Cell#_____

Parent's name (if minor)_____Work#_____ Cell#_____

Person to contact in case of emergency: _____

Emergency phone #_____ Relationship:_____

What is the reason for your visit today?

_____

_____

Persons authorized to receive my health and medical information: _____

_____ V12-1-16

THE RUBINO OB/GYN GROUP
Advanced Solutions for a Healthier Life

The Rubino OB/GYN Group Patient Medical History:

Family physician: _____Phone:_____

Do you have any medical problems? _____

_____

have you ever had any surgeries?_____ If yes, please list:_____

_____

Do you or any family member (parent/sibling) have a history of any medical issues?

If yes, please explain:_____

_____

Do you smoke?_____ If yes, how much?_____Do you drink?_____ If yes, how much?_____

Number of pregnancies: _____Number of deliveries:____ Miscarriages ____ Terminations ____

Date of last menstrual period:____/____/____ Periods are: ___Regular ___Irregular

Do you have any allergies to any foods or medications?_____ If Yes, please explain
Reaction:_____

Please list all medications (including vitamins or birth control) that you are presently taking:_____
_____

Nearest relative not living with you: _____Phone# _____

How did you hear of our practice/who referred you (place an X next to 1 item and provide name):

1 ☐ NJTopDocs.com	**2** ☐ Existing Patient Referral Name:_____	**3** ☐ Our Office Name:_____	**4** ☐ Drive By / Walk By Location:_____
5 ☐ New Jersey Monthly Top Doc Magazine	**6** ☐ Newspaper/Magazine Name:_____	**7** ☐ Physician Name: _____	**8** ☐ Other Please be specific:_____
9 ☐ Zoc Doc	**10** ☐ Internet Search Which Site:_____	**11** ☐ Insurance Company Name:_____	**12** ☐ Welcome Wagon Town: _____
13 ☐ Facebook			

V12-1-16

THE RUBINO OB/GYN GROUP
Advanced Solutions for a Healthier Life

Please provide the following information so that we may be in compliance with new Federal Government Health laws. Thank you for your cooperation.

Race:
____ American Indian or Alaskan Native
____ Asian
____ Asian Indian
____ Black or African American
____ Hispanic
____ Native Hawaiian or other Pacific Islander
____ Refuse to report/unreported
____ White

Ethnicity:
____ Hispanic or Latino
____ Non Hispanic or Latino
____ Refuse to report/unreported

Preferred Language: _____

Preferred Pharmacy:

Name: _____

Address: _____

Phone Number: _____

I authorize The Rubino OB/GYN Group to review my medication history as available through the E-Prescribe Network. _____ Y/N

Please also provide this insurance information:

Insurance company_____ ID#_____

Subscriber name:_____

Relationship to subscriber _____Self _____Spouse _____Dependent

If other than patient – Date of birth & SS# :_____

Signature: _____ Date: _____

V12-1-16

The Rubino OB/GYN Group
ASSIGNMENT OF BENEFITS/FINANCIAL DISCLOSURE

Assignment of Benefits: I Authorize Payment of Medical Benefits To:
The Rubino OB/GYN Group, PA, 101 Old Short Hills Road, #101, West Orange, NJ 07052

I Authorize The Rubino OB/GYN Group (ROG) to submit claims to my primary insurance carrier on my behalf. I also authorize assignment of benefits directly to the office, and release of my medical records requested by my insurance carrier(s). I also acknowledge that if ROG does NOT receive payment from my Insurance carrier, I will be held responsible for the balance of my bill. I agree that I will be responsible for any coinsurance and/or deductible amounts assigned to me by my insurance carrier. I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I understand that ROG DOES NOT SUBMIT claims to secondary carriers.

I agree that I must pay any applicable copay at the time of my visit and that failure to pay will result in rescheduling of my appointment. I understand that my insurance company determines the proper copay amount for my visits and that I will be billed for an additional copay amount if my insurance company assigns that responsibility to me, or will be billed for copay on an office procedure if my insurance company deems so after processing my claim. I agree that if I do not present valid insurance information at the time of my visit I will pay the full charge for an office visit prior to receiving service. If valid insurance information is provided at a later date, ROG will reimburse me the appropriate amount following payment by my insurance carrier. I agree that if I fail to provide the proper insurance information at the time of the visit I will pay an administrative charge to refile insurance claims. I agree that any patient balances billed to me are due within 30 days of the statement date and that simple interest of 1% per month will be applied to outstanding balances that are not paid by the due date. I agree that I will pay a $50 charge for failing to cancel a scheduled appointment with 24 hour notice and a $100 charge for procedures. I agree that I will pay a collections fee of 35% if my account is forwarded to a collections agency. I agree that I will pay a combined collections/attorney of 50% if my account is forwarded to an attorney for legal proceedings and a favorable judgment is rendered to ROG. I agree that I will promptly inform ROG if my address changes and am subject to an administrative fee of $2 to cover USPS forwarding charges and/or returned mail charges imposed upon ROG by the USPS.

I understand that any laboratory tests not performed directly in a ROG office will be directed to an outside laboratory for processing, based on insurance coverage, or at direction of this office if patient has no insurance coverage; and further understand that I am responsible for any laboratory balances not covered by insurance. ROG will endeavor to assist patient with laboratory billing issues but in no way assumes any responsibility for laboratory bills unless the bill is a result of an error caused directly by ROG.

Effective October 1, 2012, ROG will begin processing checks received for payment electronically. This means we will send an image of each check to the bank for processing rather than the original check. When you provide a check as payment, you authorize the ROG either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction.

Failure to agree to all of the terms in this document, unless specifically authorized by ROG, and signed, will result in termination of the patient/physician relationship with all providers in the Practice.

Signature: _____Date:_____

Print Name:_____

The Rubino OB/GYN Group
ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES/HIPAA

Patient Acknowledgement

Our Notice of Privacy Practices/HIPAA provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice and ask any questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by The Rubino OB/GYN Group.

You have the right to request that we restrict how PHI and PBM (pharmacy benefit management/prescriptions) about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you acknowledge that you have been informed of our Notice of Privacy Practices.

_____
Name of patient

_____
Signature of patient

_____
Date