

*Middlesex Medical Care, PC*  
619 Union Avenue ~ Building 1, First Floor  
Middlesex, New Jersey 08846

Telephone: 732-356-3212    Facsimile: 732-356-5002    Referral Hotline: 732-302-1312

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: M   F    Social Security #: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Emergency Contact Name/Phone: \_\_\_\_\_

Email Address: (required) \_\_\_\_\_

\*\*\*\*\*

**Primary Insurance Information:** \*\* Please provide copy of card to receptionist if YOU are the subscriber. **If your spouse or a parent is subscriber – please furnish the information listed below:**

Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

---

**Secondary Insurance Information:** \*\* Please provide copy of card to receptionist if YOU are the subscriber. **If your spouse or a parent is subscriber – please furnish the information listed below:**

Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

---

*Middlesex Medical Care, PC*  
619 Union Avenue ~ Building 1, First Floor  
Middlesex, New Jersey 08846

Telephone: 732-356-3212    Facsimile: 732-356-5002    Referral Hotline: 732-302-1312

**Permission to Release Information**

I give my express permission for the following person(s) to have access to my personal health information to include reporting of test results, leaving messages with them to forward to me, release of referrals and other paperwork and any other necessary information regarding my healthcare.

Please list the name(s) of the entity you wish to give permission for us to communicate with:

---

---

This authorization provides that:

I may revoke this authorization at any time, provided that revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of insurance coverage.

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA privacy rules.

This practice will not condition treatment on my providing authorization for the requested use or disclosure.

I have the right to access my protected health information to be used or disclosed.

I will receive a copy of this completed and signed authorization form.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Middlesex Medical Care, PC*  
619 Union Avenue ~ Building 1, First Floor  
Middlesex, New Jersey 08846

Telephone: 732-356-3212    Facsimile: 732-356-5002    Referral Hotline: 732-302-1312

**Notice of Privacy Practices  
Patient Acknowledgement**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Type of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

\_\_\_\_\_  
Patient or representative signature

\_\_\_\_\_  
Date

*Middlesex Medical Care, PC*  
619 Union Avenue ~ Building 1, First Floor  
Middlesex, New Jersey 08846

Telephone: 732-356-3212    Facsimile: 732-356-5002    Referral Hotline: 732-302-1312

Authorization dated \_\_\_\_\_

**PLEASE READ THIS NOTICE IN IT'S ENTIRETY BEFORE SIGNING AS IT IS YOUR RESPONSIBILITY TO BE AWARE OF WHAT IS CONTAINED HEREIN**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize medical and or surgical treatment to be rendered by MIDDLESEX MEDICAL CARE, P.C., including any of the physicians or their assistants on staff. I assume full responsibility for any charges that may result from this treatment. I understand that a billing charge of 6% per annum will be added to my account if not paid in full within 60 day of the date of service, and if this account is sent to a third party for collection I will be responsible for any and all fees that are incurred for the collections process.

I understand that it is that Middlesex Medical Care may perform appointment reminder calls which are courtesy calls to remind me of my appointment. I can opt out of these reminder calls at anytime with written notice to the office listed above. I further understand that these calls are courtesies in nature only and it is my responsibility to remember my appointments. In the event I am unable to keep my appointment, I am aware that it is my responsibility to call the office 24 hours in advance to cancel or reschedule my appointment. In the event that I fail to call to reschedule or cancel my appointment, this notice bears witness that I have been informed in writing that there is a \$50.00 charge for each uncanceled missed appointment which is not reimbursable by my insurance and which will be due and payable from me.

There is a charge for completing any forms other than insurance forms generated from an office visit in our office. The charge schedule is as follows: \$10.00 per form for forms filled out with a week turn around time. Any form needing completion in an expedited manner will be charged at \$25.00 per form. All money for forms completion is due and payable at the time the form is picked up.

I understand that it is my responsibility to notify this office of any changes in my insurance coverage as soon as possible after the change takes place. I also understand that many carriers have timely filing limits and if I do not notify this office of the insurance change and my claim is denied for timely filing that it is my responsibility to pay that claim in full myself.

I authorize my primary insurance, \_\_\_\_\_, and my secondary insurance, \_\_\_\_\_ (if any) to process claims on my behalf and authorize payment to MIDDLESEX MEDICAL CARE and/or Perry L. Leong, M.D. I also authorize release of any medical information necessary to above listed primary insurance and/or my secondary insurance (if any) to process any claims and request benefits in accordance with their program policy. All payments from above primary insurance and/or my secondary insurance (if any) should be made directly to MIDDLESEX MEDICAL CARE or Perry L. Leong, M.D.

A copy of this authorization may be kept on file and may be used in place of the original.

I understand that I may revoke this authorization at any time in writing to the above listed address. Otherwise, this authorization will remain in effect until I revoke it in writing.

\_\_\_\_\_  
Patient Name or Representative

\_\_\_\_\_  
Today's Date