Advanced Medicine P.C

186 Route 520 Suite 1 Morganville, NJ 07751
Phone: (732) 851- 4955 Fax: (732) 851 - 4957

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____

Address: _____

City: _____ State: _____Zip Code: _____

Cell Phone: _____ Home Phone: _____Work Phone: _____

Date of Birth: _____ Marital Status: M / S / D /W Race: _____ Ethnicity: _____

Email Address: _____

□Yes, I want to participate in the patient portal □No, I do not want to participate in the patient portal

EMERGENCY CONTACT

Name: _____Phone #:_____Relationship:_____

INSURANCE INFORMATION

Primary Insurance Company: _____

Policy/ID#:_____ Group #:_____

Guarantor Name: _____ Guarantor D.O.B_____Guarantor SSN: _____

Secondary Insurance Company: _____

Policy/ID#:_____ Group #:_____

Guarantor Name: _____ Guarantor D.O.B_____Guarantor SSN: _____

PHARMACY

Pharmacy Name: _____ Phone#:_____ □Local □Mail Away

Address: _____City:_____State:_____

Pharmacy Name: _____ Phone#:_____ □Local □Mail Away

Address: _____City:_____State:_____

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MEDICAL HISTORY

Anemia	Y	N	Anxiety	Y	N	COPD	Y	N	Diabetes	Y	N
Depression			Heart Disease			High Blood Pressure			High Cholesterol		
Liver Disease			Osteoporosis			Prostate Problems			Renal Failure		
Rheumatic Arthritis			Stroke			Seizure Disorder			Thyroid Disease		
Asthma											

Cancer: **Y N** If yes, please specify: _____

Have you ever had the pneumococcal vaccine: **Y N** If yes, when? _____

Any additional medical history you would like to add: _____

CURRENT MEDICATIONS

Please Indicate **ALL Medication/Vitamins with the dosage and directions per medication**

_____ _____ _____ _____

_____ _____ _____ _____

FAMILY HISTORY

	ILLNESS	AGE DIAGNOSED	ALIVE (A) OR DECEASED (D)
MOTHER			
FATHER			
SIBLINGS			
PATERNAL GRANDFATHER			
PATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
MATERNAL GRANDMOTHER			
Number of Siblings: _____Boys _____Girls		Number of Children: Boys _____ Girls _____	

SMOKING AND SOCIAL HISTORY

Tobacco Use: □Y □ N	If Yes, How Often? _____	ALCOHOL USE: □Y □ N	If Yes, How Often? _____	Illegal Drug Use? □Y □ N	If Yes, How Often? _____
If no, have you ever been a smoker in the past?	How long did you smoke? When did you quit?			What Drug(s)?	

HOSPILITALZATION/ SURGICAL HISTORY / ALLERGIES/REACTIONS

HOSPILITALZATION (Reason, Month, Year)	Surgical History (Reason, Month, Year)	Allergies/Reactions

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PAYMENTS

It is the responsibility of the patient to know his/her insurance policy in regard to physician participation, required referral and services covered. Advanced Medicine PC will bill the patient's insurance carrier directly; however, the patient is responsible for full payment upon request. Should the patient receive any payments directly from the carrier for services provided by Advanced Medicine PC, he/she agrees to forward those payments to the practice. The patient must pay any co-payments and/or deductibles as per his/her insurance plan. The patient is responsible for any balance his/her plan indicates is due as part of his/her explanations of benefits form. We will adjust the charges to coincide with the individual patient plan's UCR (Usual, Customary, and Reasonable) charges. The patient hereby authorizes his/her insurance company to pay the medical expense benefits allowable under his/her coverage plan directly to Advanced Medicine PC as payment toward the total charges due to the office. By law, we must collect your carrier designated co-payments. This payment is expected to be provided at the time of service, if not additional charges will incur. Payments from self-pay patients are expected at the time of service unless other financial arrangements have been made prior to visit. I agree to be financially responsible for all charges including my insurance deductibles, co-payments and any services rejected or not covered by my insurance company. I know the ultimate responsibility of any payment of service is mine. I authorize payment of medical benefits to Advanced Medicine PC for any services furnished. I also authorize any holder of medical information about me to release to my insurance company (or agent) information concerning health care, advised, treatment or supplies provided to me. This information is to be used for the purpose of evaluating and administering claims of benefits.

TESTING

During treatment, Advanced Medicine PC may recommend that patients have testing done. It is the responsibility of the patient to find out which laboratories/facilities are covered by his/her insurance and use them appropriately. Any prescriptions for blood word/imaging, whether done in the office or not, are subject to their own deductible or co-insurance by insurance companies. Should the laboratory/facility send an invoice to the patient, it is the sole responsibility of the patient and Advanced Medicine PC is not an active party in this matter.

PRIOR-AUTHORIZATIONS, PRE-CERTIFICATIONS, AND REFERRALS

It is the responsibility of the patient to provide Advanced Medicine PC with any additional information necessary for his/her healthcare. This information includes, but is not limited to, updated contact information, updated insurance information, and the necessity of prior-authorizations, pre-certifications and/or referrals. The patient is to notify Advanced Medicine PC if he/she needs a prior authorization form completed or a referral sent out. Advanced Medicine PC has seven (7) business days to send out the appropriate forms after the patient has given notice.

CONSENT TO TREAT

I, the patient, authorize the clinic to examine, perform, screening procedures and/or to prescribe or provide treatment as may be medically necessary. I understand that I have the opportunity to obtain an explanation of any prescription, health condition, or diagnosis that may be found, in terms that I understand, from Advanced Medicine PC. I also understand that I have the right to an explanation of benefits, risks, and alternatives of any recommended treatment, and to be advised of all reasonable treatment options, including no treatment, and to an explanation of the risks that are involved with each alternative. I understand that if I do not comply with the recommendations of Advanced Medicine PC, such failure may result in an adverse outcome. I further agree to notify Advanced Medicine PC if I become pregnant of I believe that I may have become pregnant. As a courtesy, upon review of received test results, Advanced Medicine PC will typically call the patients with the reviewed notes from Advanced Medicine PC. If I have done testing but have not received such a call within two weeks, it is my responsibility to all and follow up with the status. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient Signature: _____ **Date:** _____

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PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I _____(**Last Name**),_____(**First Name**), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand that it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT scan, this timely recommendation is important and essential in the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see the specialist, obtain the test(s), and/or follow up to ensure this office received the results for which I was referred immediately for; this can risk my current health or increase future health risks. I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any have bad health outcome from my failure to follow the advice of my doctors should be expected.

Patient Signature: _____ **Date:** _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

I have received a copy of this office's notice of privacy practices.

Patient Signature: _____ **Date:** _____

RELEASE OF MEDICAL INFORMATION AND TREATMENT / BILLING INFORMATION

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received and billing inquiries:

Name: _____Relationship: _____ D.O.B_____Phone #:_____

Name: _____Relationship: _____ D.O.B_____Phone #:_____

Name: _____Relationship: _____ D.O.B_____Phone #:_____

Patient Signature: _____ **Date:** _____

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AUTHORIZATION TO RELEASE AND OBTAIN COPIES OF MEDICAL INFORMATION

I authorize this office to release and obtain copies of medical records and testing information pertaining to my treatment of care. This authorization shall remain valid for the duration of my treatment with Dr. Ridlovsky.

Patient Name: _____

Date of Birth: _____

Patient Signature:_____

Previous Provider

Please provide all medical records, including, but not limited to:
History and Physical Examination, Consults, Progress Notes, Laboratory Tests, EKG's, Radiology Tests, and Immunization Records

Name: _____

Address: _____

Phone: _____

Fax: _____

If you would like records from a specialist, please list the doctors contact information below and mark off what you are requesting:

Lab Tests □Y □ N Radiology Tests □Y □ N EKG's □Y □ N

Surgeries/Procedures □Y □ N Consults □Y □ N Progress Notes □Y □ N

Name: _____

Address: _____

Phone: _____

Fax: _____

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ANNUAL PREVENTATIVE GUIDELINES

According to insurance, there are specific guidelines that are included during an annual preventative, the following are:

- A review of your medical and family history
- Developing or updating a list of current providers and prescriptions
- Height, weight, blood pressure and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options for you
- A screening schedule for appropriate preventative services
- Advance care planning

During your visit you have the time to discuss questions/concerns that do not pertain to an annual preventative, such as: any ongoing issues, refills, medications, bloodwork, referrals, acute issues, any health concerns, etc. However, depending on your insurance additional charges may be associated with your visit if it falls outside the parameters of an annual preventative.

Patient Signature: _____ **Date**: _____

LUDMILA RIDLOVSKY MD

Board Certified Internal Medicine
186 County Road 520 Suite 1 Morganville NJ 07751
Telephone: 732-851-4955 Fax: 732-851-4957

If you would like someone other that yourself to be able to obtain medical information and results, please fill out the following information.

Name: _____
Relationship: _____
Date of Birth:_____

Name: _____
Relationship: _____
Date of Birth:_____

Name: _____
Relationship: _____
Date of Birth:_____

Patient's Signature: _____
Patient's (Print Name):_____
Today's Date: _____

NOTICE OF PRIVACY PRACTICES*

We Care About Your Privacy

Advanced Medicine PC
Ludmila Ridlovsky MD
186 County Road 520 Ste 1
Morganville, NJ 07751

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:
We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:
We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:
We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:
In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:
Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:
We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:
We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:
We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:
We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:
To help them carry out their duties, we may share the med-

ical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reports of death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask us or our receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask our receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist if you wish to contact the Privacy Officer or request a written complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further