

Jeff Pan, M.D.
1101 Amboy Ave
Edison, NJ 08837
Tel: 732-205-9110
Fax: 732-205-9120

PATIENT REGISTRATION

DATE: _____

PATIENT NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____

ZIP: _____ OWN: RENT:

DATE OF BIRTH: _____ AGE: _____ SS #: _____

MARITAL STATUS: _____ SEX: _____

HOME PHONE: _____ CELL: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

OCCUPATION: _____ WORK PHONE: _____

SPOUSE/PARENTS' NAME: _____ RELATIONSHIP: _____

SPOUSE SS#: _____ SPOUSE DOB: _____

SPOUSE EMPLOYER: _____

SPOUSE EMPLOYER ADDRESS: _____

PRI: _____ MVA: _____ W/C: _____ DATE OF INJURY: _____

WHO MAY WE CONTACT IN CASE OF EMERGENCY?

NAME: _____

PHONE: _____ ADDRESS: _____

E-Mail Address: _____

I hereby authorize communication via email or texting between Dr. Jeff Pan, MD, PC and its authorized representative. I understand that I can revoke this agreement and must notify Jeff Pan, MD, PC in writing.

Signature: _____

Date: _____

INSURANCE INFORMATION

PRIMARY CARRIER: _____

POLICY OR CLAIM NUMBER: _____

INSURANCE ADDRESS: _____

PHONE NUMBER: _____

NAME OF INSURED: _____

RELATIONSHIP TO INSURED: _____

SECONDARY CARRIER: _____

POLICY OR CLAIM NUMBER: _____

INSURANCE ADDRESS: _____

PHONE NUMBER: _____

NAME OF INSURED: _____

RELATIONSHIP TO INSURED: _____

CLAIM NUMBER: _____

ADJUSTER: _____

INSURED NAME: _____

REFERRED BY: _____

ATTORNEY NAME AND

NUMBER: _____

PATIENT ACKNOWLEDGEMENT:

I ATTEST THAT ALL INFORMATION PROVIDED TO DR. JEFF PAN, MD, PC IS ACCURATE. IF ANY INFORMATION CHANGES, I WILL INFORM JEFF PAN, MD PC PRACTICE. _____ initials

PATIENT CONSENT FORM

The department of Health and Human Services has established a "privacy Rule" to help insure that personal health care information is protected for privacy. The privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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PAYMENT POLICY

When you had made your appointment with the office, the staff had notified you that “**Dr. Pan is out of Network**” for all managed care plans. As you are also aware the extent of insurance coverage for any particular treatment may vary between health plan packages, and even between employer groups covered by the same benefit program, depending on the particular plan you may have chosen.

We will cooperate with your insurance plan to supply necessary information and obtain authorizations when appropriate. **It is the responsibility of the patient to obtain the necessary authorization forms so that we can appeal your surgical/office reimbursement.** It is imperative this is done so that we can begin the appeal process in a timely manner in order to maximize the correct reimbursement from your insurance carrier. This will then help with your outstanding balance. However, it is important for you to know your financial obligations and understand that they may range from a small co-payment or coinsurance amount for an office visit or services, to the full charge for a procedure that is not covered by health insurance. Some information related to these obligations most likely is stated on your membership identification card; however you should contact your insurance company if you have questions related to specific treatment, associated coverage and your financial obligations.

You are responsible for your office visit at time of visit, if your treatment is covered by insurance, we will submit claims for these procedures on your behalf. We accept payment in the form of checks, cash and in the near future Visa and Master card. In the case of motor vehicle claims, you are responsible for all co-pays and deductibles. We do not accept letters of protection for these balances.

If payment is not made on a timely manner and legal actions are taken patient is responsible for cost of all legal fees and any interests I have incurred.

If you have concerns about your ability to pay for treatment, please ask to speak to our Billing Coordinator.

I have read and understand this financial policy, and I accept responsibility for my financial obligations related to treatment rendered by **Jeff Pan, MD.**

Name (please print) _____

Signature _____ Date _____

We request payment for office services and visits at the time the service is rendered.

Thank You

Assignment of Benefits

I, hereby authorize assignment and payment directly to Jeff Pan, MD, PC, Major Medical Benefits due me.

I hereby agree to pay any and all charges that exceed or that are not covered by insurance.

Signature: _____ Date: _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____
Date of Birth _____

Social Security _____

1. I authorize the use or disclosure of the above named individuals health information as described below:
2. The following individual or organization is authorized to make the disclosure to:

Address: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

ENTIRE RECORD

CERTIFIED RECORDS

- Problem list
- Medication list
- List of allergies
- Immunization record
- Most recent history and physical
- Most recent discharge summary
- Laboratory results from (date) _____ to (date) _____
- X-ray and imaging reports
- Consultation reports
- Other _____

4. This information may be disclosed to and used by the following individual or organizations:

Jeff Pan, M.D., P.C., 1101 Amboy Avenue, Edison, NJ 08837

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign the form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM director, privacy officer, or other office or individual's name or contact information.
7. I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness

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Irrevocable assignment of Benefits/Guarantee to Cooperate

In consideration of services rendered or to be rendered to the patient named below, I hereby authorize and assign payment directly to the office of **Jeff Pan, MD, PC**, of any and all first party no-fault automobile insurance benefits or liability, which I am otherwise entitled for services rendered by the provider. This medical office in turn agrees to comply with the requirements of the no-fault insurance carrier's pre-certification plan/decision point review plan.

I authorize, assign and direct payment of insurance benefits to the following provider office **Jeff Pan, MD, PC**, for monies due on bills, which relates to services rendered. I assign to the above provider's office, the right to prosecute the claim(s) against the insurance carrier who affords benefits and I agree to fully cooperate with this provider's offices efforts to prosecute a claim against the insurance carrier, if there is not timely payment on the claim.

I also authorize the above referenced provider to release any medical information necessary for the use of insurance companies.

As part of my assignment of benefits, I specifically request that my insurance carrier forward to the provider copies of any and all reports from Independent Examiners, Peer review Doctors and auditing companies, and PIP payout ledger.

Additionally, should I recover any money by virtue of any claims or legal cause of action, I hereby assign my right to payment directly to the health care provider named above and I direct my attorney or other legal representative to honor this irrevocable assignment as a lien on my file or any funds that may be due me. My attorney or legal representative is hereby authorized and directed to make such payment from the recovery in such claim or action up to the amount due to the above provider so as to be consistent with this assignment. This assignment will also serve as a letter or protection for the provider, which grants the provider the ability to recover outstanding balances, which are not due to fee scheduling reductions, from any and all settlements I may recover. This serves as a tolling agreement to protect the expiration of statute of limitation.

I understand that the above assignment may not be revoked or amended without the express written consent of the above-mentioned provider. Additionally, by signing this agreement I fully understand the terms contained therein. My signature also represents that I fully understand this agreement if I needed assistance interpreting it. I have not been coerced in any way to give this assignment. If any portion of this form is found to be invalid, the remainder shall remain in effect. A photocopy of this shall be deemed as valid as an original.

Patient assigns to Jeff Pan, MD, PC patient's right to sue any person or business entity for money damages accruing from failure to pay Jeff Pan, MD, PC under any contracts obligating insurance carriers, employers, third party administrators or any other entities to pay for medical services rendered to patient or to administer the process of payment for medical services rendered to patient. In some instances it may be necessary to sue the health plan. Some plans do not accept assignment of benefit. In such plans, it will be necessary to name the patient and or the guarantor as a plaintiff in the litigation against the health plan. I hereby authorize Dr. Jeff Pan MD, PC and his authorized representative and attorneys to name me and or the guarantor of payment as a plaintiff in any such litigations against the health plan. This assignment includes the assignment of all rights and benefit under the plan to Dr. Jeff Pan, MD, PC and its authorized representative.

Patient's Signature

Claim Number

Printed Name/Date

Date of Accident

Consumer Complaints Authorization

I, hereby authorize **Jeff Pan, M.D., P.C.** to report any delinquency in payment or processing of payment on the part of my insurance carrier(s) to the NJ Department of Banking and Insurance, Attorney General's Office and Department of Labor (ERISA), Office of Personnel Management for Federal Plans on my behalf.

Signature: _____ Date: _____

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Dear Patient,

Please be advised that as a specialty provider, **I AM NOT IN NETWORK**, in any managed care programs. If your insurance offers you "out of network benefits", as is the case with most insurance programs, I will utilize that portion of your insurance coverage.

As a courtesy, my office will bill your insurance carrier for services rendered and wait for payment. If there is a balance after your insurance pays their portion, you will be billed for any remaining balance.

Out of network benefits are usually subject to deductibles and coinsurance. If you are uncertain if your insurance offers you out of network benefits, or are uncertain of the specific amounts your insurance covers, you may either call your carrier, or have the office call for you.

If you are experiencing financial difficulties requiring financial arrangements, please let me know.

Sincerely,

Jeff Pan, M.D.

Signature: _____

Date: _____