PATIENT INFORMATION

NAME:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

HOME #: (_____)_____

DATE OF BIRTH:_____MALE _____ FEMALE _____ MARITAL STATUS: M S W D

SS#_____

STUDENT:_____FULL TIME _____PART TIME

WORK PHONE
(____)_____EXT:_____ CELL#:_____
EMERGENCY
NAME:_____PHONE(_____)_____RELATIONSHIP:_____

REFERRED BY:_____

INSURANCE INFORMATION

INSURANCE NAME:_____COPAY AMOUNT:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

ID#:_____GROUP#:_____PHONE:(____)_____

POLICY HOLDER:_____DATE OF BIRTH:_____

MALE_____ or FEMALE_____HOME #(_____)_____

SS#:_____WORK#(_____)_____EMPLOYER:_____

SECONDARY INSURANCE

INSURANCE:_____ID#:_____
ADDRESS:_____
CITY, STATE,
ZIP:_____

PHONE:
(_____)_____INSURED:_____

ID#:_____GROUP#:_____COPAY:_____
RELEASE & ASSIGNMENT:_____

"I hereby assign all medical and/or surgical benefits to include all major medical benefits to which I am entitled including Medicare, Blue Cross, all HMO's and any Commercial insurance to Doctor's Care Associates,L.L.C (Michael J. Baum, D.O.). I understand that I am financially responsible for all charges whether or not covered by said insurance. I hereby authorize said assignee to release any information necessary to secure payment on my behalf.

_____DATE:_____
SIGNATURE (if minor, than of parent or legal guardian)

PLEASE REVIEW & SIGN BOTH SIDES OF FORM

DOCTOR'S CARE ASSOCIATES, LLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent for Doctor's Care Associates, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). PHI includes individually Identifiable Health Information (IIHI) held or disclosed by our practice, regardless of how it is communicated (i.e., electronically, verbally, or written) as outlined in our Notice of Privacy Practices. (Doctor's Care Associates, LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Doctor's Care Associates LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Doctor's Care Associates, LLC's Privacy Officer at [*908 Oak Tree Road, Ste. L, So. Plainfield, NJ 07080*].

With this consent, Doctor's Care Associates, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Doctor's Care Associates, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Doctor's Care Associates, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Doctor's Care Associates, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, we will put any limitations in writing and abide by them except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

By signing this form, I am consenting to Doctor's Care Associates, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Doctor's Care Associates, LLC may decline to provide treatment to me.

I acknowledge receipt of **DOCTOR'S CARE ASSOCIATES, LLC's** Notice of Privacy Practices.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian