

**Princeton Hypertension– Nephrology Associates, LLC**  
**88 Princeton Hightstown Road, Suite 203**  
**Princeton Junction, NJ 08550**  
**609-750-7330**

*Welcome to our office*

PLEASE PRINT ---- PLEASE PRESENT INSURANCE CARD(S) AND DRIVER'S LICENSE TO RECEPTIONIST

**Patient Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_ Employer/School \_\_\_\_\_

**Marital Status:**  Married  Single  Divorced  Widow  Separated    **Student:**  Full Time  Part Time    **Race:**  Amer. Indian or Alaska Native  Asian  Black or African Amer.  Native Hawaiian or Other Pacific Islander  White  Decline  
**Primary Language:**  English  Spanish  Other  Decline    **Ethnicity:**  Hispanic or Latino  Non-Hispanic or Latino  Decline

**Spouse/Guarantor Info:** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Social Security # \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Pharmacy Information:** Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ Policy # \_\_\_\_\_  
Group # \_\_\_\_\_ Effective Date \_\_\_\_\_ Name of Insured \_\_\_\_\_  
Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_ Does your Insurance require a referral?  No  Yes

**Secondary Insurance Company** \_\_\_\_\_ Policy # \_\_\_\_\_  
Group # \_\_\_\_\_ Effective Date \_\_\_\_\_ Name of Insured \_\_\_\_\_  
Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_ Does your Insurance require a referral?  No  Yes

**\*If Medicare is your secondary insurance, please state why** \_\_\_\_\_

**Emergency Contact Information:** Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_  
**Referred By:**  Physician \_\_\_\_\_  Self  Friend/Relative  Yellow Pages  Internet  Other \_\_\_\_\_

I hereby authorize the release of any medical information necessary for the processing of insurance. This assignment will remain in effect until revoked by me in writing. This assignment is to be considered as valid as an original. I authorize the release of payment for services to **Princeton Hypertension-Nephrology Associates, LLC, Drs. Michael Ruddy, Grace Bialy, Vadim Finkelstein, Seema Basi and Srujana Polsani**. If you do not have health insurance or we do not participate with your plan, payment is expected at the time service is rendered.

**Signature of Patient/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

As a service to our patients, we will assist in filing insurance and obtaining reimbursement. However, all incurred charges remain the responsibility of the patient. In order to service your account or collect monies owed, our office and/or its agents may contact you using telephone numbers associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you via text messages or e-mails. I agree to these methods of communication being used to contact me regarding my account. I agree to pay all collection agency fees (up to 33.33%), in addition to necessary attorney fees and court costs. I waive now and forever my right of exemption under the laws of the constitution of the state of New Jersey and any other state.

**Signature of Patient/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Health History**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

**Symptoms**

Check [  ] condition you currently have or have had in the past year

**GENERAL**

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

**MUSCLE/JOINT/BONE**

- Pain, weakness, numbness:
- Arms  Hips
  - Back  Legs
  - Feet  Neck
  - Hands  Shoulders

**GERITO-URINARY**

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

**GASTROINTESTINAL**

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

**CARDIOVASCULAR**

- Chest pain
- High Blood Pressure
- Irregular heart beat
- Low Blood Pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

**EYE, EAR, NOSE, THROAT**

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Vision – Flashes
- Vision – Halos

**SKIN**

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

**MEN only**

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

**WOMEN only**

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful Intercourse
- Vaginal discharge
- Other

Date of last Menstrual Period : \_\_\_\_\_  
 Date of last Pap Smear : \_\_\_\_\_  
 Have you had a Mammogram ? \_\_\_\_\_  
 Are you Pregnant? \_\_\_\_\_  
 Number of Children: \_\_\_\_\_

**Conditions**

Check [  ] condition you currently have or have had in the past year

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Aids               | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Prostate Problem   |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> HIV Positive       | <input type="checkbox"/> Psychiatric Care   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Measles            | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts          | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal Disease   |

**Allergies**

\_\_\_\_\_  
 \_\_\_\_\_

**- Family History -**

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

**- Hospitalizations -**

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion?  Yes  No  
 If yes, please give approximate dates \_\_\_\_\_

Serious Illness/Injuries	Date	Outcome

**- Pregnancies -**

Year of Birth	Sex of Birth	Complications if any

**- Health Habits -**

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

**- Occupational -**

Check (✓) if your work exposes you to:

	Stress	Hazardous Substances
	Heavy Lifting	Other

Occupation \_\_\_\_\_

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date



# Acknowledgement of Office Policy

We would like to thank you for choosing Princeton Hypertension- Nephrology Associates as your provider. As one of our patients, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read and understand these policies.

## Payment

Payment is expected at the time of service. This is an insurance company rule. This includes co-payments for participating insurance companies. We accept cash, personal checks, VISA, Discover and MasterCard. *There is an additional fee of \$10.00 if co-payment is not paid at time of service.* There is a service charge of \$35.00 for returned checks.

Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments. Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

## Insurance

Please present your insurance card at the time of your appointment. Card must be present.

We participate in most major health plans. We have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare and Medicare Managed Care. Our billing office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information at time of check in and any new insurance you may have. As a courtesy if you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid. Tertiary (3<sup>rd</sup> carriers) claims are the responsibility of the patient to file. If there is a balance after the primary and/or secondary pays, the patient is responsible to pay this balance in a timely fashion. It is the patient's responsibility to comply with this request.

If a patient is a member of an insurance plan with which we do not participate, payment in full is due at the time of service.

Having insurance is not a guarantee of payment and eligibility does not negate the patient's responsibility with regards to the plan policy or guidelines.

## Referrals

The patient is responsible to know if his/her plan requires referral. If your plan does require referrals one must be available and valid prior to your visit. Otherwise the visit will be considered self pay and a waiver will have to be signed before seeing the doctor. Retroactive referrals are not considered as valid referrals.

## Not showing up for your visit

The patient is responsible for keeping track of their appointments. We do call two days in advance as a reminder, but it is a courtesy call for our patients. We request a **48 hour notice** if you are unable to make your appointment. *There is a "No Show" fee of \$100.00 for a New Patient and \$50.00 for an Established Patient.*

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) \_\_\_\_\_ Date \_\_\_\_\_

Responsible party member's name \_\_\_\_\_ Relationship \_\_\_\_\_

Responsible party member's signature \_\_\_\_\_ Date \_\_\_\_\_

# Princeton Hypertension– Nephrology Associates, LLC

## HIPAA AUTHORIZATION FORM

### HIPAA

The **Health Insurance Portability and Accountability Act** of 1996 (HIPAA) is a federal law, which contains rules about how we can use your medical information with, and without, your prior permission. It also gives patients new rights with respect to the privacy of their medical information. We are obligated by law to make available to you our Notice of Privacy Practices, which explains our duties and your rights, and to get a written acknowledgement from you that you have received this information. ***The Receptionist has copies of the Notice of Privacy Practices if you would like to review them. You also can go to our website at:***

***<http://hypertension-nephrology.com/>***

To learn more about HIPAA, visit the *United States Department of Health and Human Services* website at: <http://www.hhs.gov/ocr/privacy/hipaa/administrative>

I understand a copy of the Princeton Hypertension– Nephrology Associates, LLC Notice of Privacy Practices is available for my review.

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Patient's Signature

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Date