REGISTRATION INFORMATION ** Please Read & Complete **

(Please Print Neatly & Clearly)

PATIENT INFORMATION **Date:**_____ **Home Phone:**_____ **Cell:**_____

_____ _____ _____

Name Sex Date of Birth

_____ _____ _____ _____ _____

Address: Street Apartment # City State Zip

_____ _____

Employer Occupation {Circle: Part Time / Full Time }

_____ _____

Business Address Business Phone

_____ _____

E-Mail Address Web/Internet Address (Home page {ie: www.xxx})

Marital Status (circle)

Single Married Widowed Divorced Separated

INSURANCE INFORMATION: Do you have medical insurance?: Yes No

Patient Social Security Number:_____

Name of Insured:_____ **Insured's Date of Birth:**_____

Insured Social Security Number:_____

Insurance Company Name:_____ **Copay: $**_____

Spouse/Responsible Party Employed by:_____

Employer/Business Address and Phone #:_____

Policy Number:_____ **Group Number:**_____

Medicare Number:_____ **Medicaid Number:**_____

(It is required by law that you must disclose if you have Medicaid, please note that HRFP does not accept Medicaid)

MEDICAL INFORMATION:

Emergency Name and Phone #:_____ **Relationship:**_____

MAY WE CONTACT YOU BY PHONE TO CONFIRM APPOINTMENTS &/OR REVIEW TESTS:

Circle : YES NO **Phone Number preferred for contact:**_____

Drugstore Name and Phone :_____

Whom may we thank for referring you?:_____

Known Medical Problems:_____ **ALLERGIES:**_____

Present Medications:_____

Comments:_____

Payment is expected at time of service unless other arrangements have been made prior to services being rendered.

Signature of Patient:_____

(Legal Guardian if Minor)

OFFICE PAYMENT POLICY 2020: High Ridge Family Practice, LLC

Given the constant changes in insurance company payment policies, the following in-office policies have been established to help us continue to provide patients with the best quality medical care. These policies are not meant to offend or insult anyone, but only to serve as a guideline for greater understanding in all aspects of patient care. If you would like to discuss the office fee schedule, or these office policies please ask your doctor or the Office Manager.

1. **PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED**, unless other arrangements have been made prior to the services being rendered. This includes Co-pays. Accounts must be kept up to date, please address and pay balances at all visits.
   a. For the patient's convenience, the office accepts cash, check, money order, American Express, Visa, or MasterCard.
   b. The patient is responsible for all **NON-COVERED SERVICE CHARGES**. (For a listing of some routine non-covered services, see Practice Fees for Non-Covered Service Notice)
   c. A $30.00 processing fee will be charged for all returned checks.

2. **ANY CHANGES** to the material on the Registration Information form must be brought to the attention of the office, **BEFORE** the doctor's visit. Failure to do so may make the patient responsible in full for **ANY** & **ALL** charges for services rendered. The right information is critical especially for billing proper laboratory tests that may be required and ordered. ***If this information is incorrect and not current the patient will be responsible for the bill in its entirety***. Specifically, the patient's:
   a. Medicare and/or Medicaid cards **MUST** be **VALID** and **UP-TO-DATE**.
   b. Health Insurance ID cards must have **VALID UP-TO-DATE** patient ID numbers, and if a provider is required, it must have one of the **DR's. FALKOFF** or **BERKUN** on the card.
   c. Any Co-pay must be paid at the time of the visit. Co-pays not paid at the time of the visit will incur an additional $5.00 charge. Accounts must be kept up to date, please address and pay any balances at all visits.

3. If you have medical insurance, we will try to help you file your claims to speed up the processing. However, your insurance is a contract between you and your insurance company. Our office **CANNOT** guarantee that your carrier will pay your claim. ***If your claim or any portion of your claim with your insurance company is denied, the obligation for the payment is the responsibility of the patient***. Our office will **NOT** enter into a dispute with the insurance carrier over the claim. We will be happy to assist wherever possible. (Note: Your insurance is **REQUIRED** by CT State Law to pay your claims within 45 days – *Conn. Gen. Stat. 38a-816(15)(B)*)

4. If we agree to accept assignment from your insurance carrier, the patient must sign an Insurance Assignment Agreement. Each New Year **ALL MEDICARE PATIENTS** will be required to sign a new agreement.

   If the insurance (HMO, PPO, or carrier other than an indemnity insurance plan) payment is mistakenly sent to the **PATIENT** instead of the **OFFICE** for services rendered, ***the patient is expected to provide payment within 10 days of receipt*** along with the Explanation of Medical Benefit. Failure to produce this payment will result in your being billed by this office, according to the policy noted below. Contractual reductions will not apply. ***The bill will be issued for full services rendered***.

5. Outstanding payment for ***over 30*** days may incur Interest Charges of 1.5% for every 30 days that the payment remains overdue, up to an annual interest rate allowable by law to 18%. Billing statements are mailed every 4 weeks. If the patient's bill remains overdue ***over 60 days*** the following procedure will occur:
   a. Interest charges will continue to accrue.
   b. Postage and office charges of $10 will be added to the bill per pay period.
   c. The account will be turned over to a third party for collections and a collection fee of $25.00 plus any additional cost for third party collections will be added to the account.
   d. All outstanding bills must be settled prior to any future care.

6. ***All cancellations of an office visit MUST be made within 24 hours of scheduled visit***. Failure to do so will result in a penalty charge: the patient's office visit fee will be equal to **DOUBLE** the patient's Co-pay or $20.00 whichever is less, except in the case of a missed Physical Exam or Comprehensive Medical Evaluation, which will result in a charge of $50.00. This fee is **NOT** covered by insurance and payment will be the sole responsibility of the patient. You, the patient, will be billed accordingly. Please have the courtesy and respect to call our office for all appointments that cannot be kept. We work with you at every opportunity to provide you with the best quality health care.

7. In the case of financial hardship, this office will work with the patient to arrange a method of payment for services, with the required proof of these financial difficulties.

I have read all the information on this sheet and have completed the requested information on the registration form. I certify that this information is true and correct to the best of my knowledge. I have read and understand the Office Policies. Your signature on this form also acknowledges your understanding and Authorizes Payment of Benefits directly to this office.

Signature: _____
Print Name: _____ **Date:** _____

Pharmacy Preferences

High Ridge Family Practice uses E-Prescribing.

Please indicate your pharmacies below and we now have the capability to have your prescriptions electronically sent to that pharmacy. Not all pharmacies can accept this yet.

E-Prescribing offers patients of High Ridge Family Practice a more convenient method of sending their prescriptions to the pharmacy by reducing wait time, creating a more efficient method of obtaining refills and providing early awareness of the need of prescription authorizations. This is done through direct electronic communication between the provider and the participating pharmacies.

Name(s): _____ Date of Birth: _____

Primary Pharmacy: _____

Location: _____

Phone Number: _____

Fax Number: _____

Secondary Pharmacy: _____

Location: _____

Phone Number: _____

Fax Number: _____

Mail-Order Pharmacy: _____

Location: _____

Phone Number: _____

Fax Number: _____

OFFICE USE ONLY

_____	_____	_____
Configuration Updated	Date	Office Staff Initials

High Ridge Family Practice in order to continue to provide it's patients with the best technology and access to one of the top Patient Centered Medical Homes in the country , has a required annual Technology Access Fee that all Patients must pay to be part of and remain part of High Ridge Family Practice's patient population.

The Technology Access Fee will be assessed, collected or billed with the first Office Visit of each year for all existing Patients. It will be assessed, collected or billed with the second Office Visit of each year for a New Patient to the practice.

These fees allow High Ridge Family Practice to continue to function and have the technology required to provide you the best of access and medical care. As well as develop and bring you new and valuable services.

The Fees are not covered by Insurance or Medicare and are solely the patient's responsibility and are requirements for all patients of High Ridge Family Practice.

The Fees are: $ 50 / person Annually or $ 100 / Family.

The fees are due and payable at those visits, otherwise you will be billed.

These Fees then provide you access to Webview and Instant Medical History.

USE INSTANT MEDICAL HISTORY TO ENHANCE YOUR OFFICE VISITS AND ADD TO YOUR MEDICAL CARE

(FOR ESTABLISHED PATIENTS ONLY)

INSTRUCTIONS:

GO TO HIGH RIDGE FAMILY PRACTICE WEBSITE

WWW.HRFP.NET

ON HOME PAGE ON LEFT HAND SIDE OF PAGE GO TO

INSTANT MEDICAL HISTORY (CLICK HERE)

INSTANT MEDICAL HISTORY PASSWORD: IMHATHRFP

FOLLOW ON SCREEN INSTRUCTIONS

ENTER REASON FOR OFFICE VISIT, MEDICAL ISSUE, ETC

(SHORTER 1 OR 2 WORDS PREFERABLE)

THIS WILL TRIGGER QUESTIONS, ANSWER QUESTIONS UNTIL

THE END OF THE SERIES OF QUESTIONS

USE WEBVIEW TO ACCESS YOUR MEDICAL RECORDS SECURELY FROM ANYWHERE THERE IS INTERNET ACCESS (FOR ESTABLISHED PATIENTS ONLY)

USE TO VIEW YOUR MEDICAL RECORD

VIEW YOUR LABS AND TESTS

MESSAGE YOUR PHYSICIAN FROM WITHIN YOUR CHART

Patient Acknowledgement that information has been read, understood & accepted:

_____

Patient Name

_____

Patient Signature

_____

Date

You must sign and accept this agreement to be a patient at High Ridge Family Practice

V2020.1

Notice of Privacy Practices

HIGH RIDGE FAMILY PRACTICE

30 BUXTON FARMS ROAD, SUITE 210, STAMFORD, CT 06905

203-322-7070

Effective Date: April 3, 2003
Reviewed and updated: January 1, 2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy, and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide, and may receive such records from others. We use these records to provide or enable other health care providers to provide qualify medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of out legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact out Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

The law permits us to use or disclose your health information for the following purposes:

Treatment
We may use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services, which we do not provide. We may also share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

Payment
We may use and disclose medical information about you to obtain payment for the services we provide. For example, we may give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations
We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information to request that your health plan authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your information with other health care providers, a health care clearing house or health plans that have a relationship with you when they request this information, to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of compliance, qualifications and performance of health care professionals, their training programs, their accreditation, certifications or licensing activities, or their health care fraud and abuse detection and compliance efforts.

Business Associates
We may share your medical information with our "business associates", such as our billing service that performs administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information.

Appointment Reminders
We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information with the person answering the phone or on your answering machine.

Sign in Sheet
We may ask you to sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and Communication with Family
We may disclose your health information to a family member or a close friend or other person you identify where relevant to that person's involvement in your care or payment for your care. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communicating with your family and others.

Marketing
We may contact you to give you information about product or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not use of disclose your medical information for marketing purposes without your written authorization.

Required by Law
As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public Health
We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Health Oversight Activities
We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings.

Judicial and Administrative Proceedings
We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law Enforcement
We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners
We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

Organ or Tissue Donation
We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

To Avert a Serious Threat to Health or Safety
We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized Government Functions
We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Worker's Compensation
We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Change of Ownership
In the event that this medical practice is sold or merged with another organization, your health information/record may be transferred the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Research
We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review-Board or privacy board, in compliance with governing law.

Directories
Unless you object, we will include your name, the location at which you are receiving care, your condition (in general terms) and your religious affiliation in our facility directory. Members of the clergy will be told your religious affiliation. The other information will be disclosed to people who ask for you by name.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information, which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization.

C. Your Health Information Rights

Right to Request Special Privacy Protections
You have the right to request restrictions on certain uses and disclosures of your health information, by submitting a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications
You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy
You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Connecticut law. We may deny your request under limited circumstances.

Right to Amend or Supplement
You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is.

Right to an Accounting of Disclosures
You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (Treatment), 2 (Payment), 3 (Health Care Operations), 7 (Notification and Communication with Family) and 17 (Certain Government Functions) of Section A of this Notice of Privacy Practices or disclosures of data which exclude direct patient identifiers for purposes of research or public health or disclosures which are incident to a use or disclosure otherwise permitted or authorized by raw, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or law enforcement official that providing this accounting would be reasonably likely to impede their activities and certain other disclosures.

Right to Receive a Notice of Privacy Practices
You have a right to receive a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Special Rules Regarding Disclosure of Psychiatric, Substance Abuse and HIV-Related Information

Under Connecticut or federal law, additional restrictions may apply to disclosures of health information that relates to care for psychiatric conditions, substance abuse or HIV-related testing and treatment. This information may not be disclosed without your specific written permission, except as may be specifically required or permitted by Connecticut or federal law. The following are examples of disclosures that may be made without your specific written permission:

- **Psychiatric information**
  We may disclose psychiatric information to a mental health program if needed for your diagnosis or treatment. We may also disclose very limited psychiatric information for payment purposes.

- **HIV-related information**
  We may disclose HIV-related information for purposes of treatment or payment.
- **Substance abuse treatment**
  We may disclose information obtained from a substance abuse program in an emergency.

E. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and provide you with a copy upon request.

F. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

You may also submit a complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Signature on File Form for Authorization of Access to Medical Records, Assignments of Benefits and authorization to contact patient regarding confirmation of appointments and test results

I, _____ (print your name) provide this signature as authorization for payment of all my medical services to High Ridge Family Practice, LLC (for any of the Family Practice associated providers: Alan T. Falkoff, M.D. and/or David M. Berkun, M.D., and/or any other authorized A.P.R.N. or P.A. also called "the providers" herein). I understand that any services not covered by my insurance will become solely my (the patient's) responsibility. I authorize the providers as well as the office staff for High Ridge Family Practice, LLC to permit the release of medical or other information necessary to process insurance claims. I also request payment of government benefits directly to High Ridge Family Practice, LLC (as noted above for any/or all of the providers), at the above address for all medical services rendered. I provide this signature as authorization for payment of all my medical services to High Ridge Family Practice, LLC for services rendered by the providers and the office staff of High Ridge Family Practice, LLC at the following address:

High Ridge Family Practice, LLC
30 Buxton Farms Road, Suite 210
Stamford, CT 06905

Additionally, in accordance with new federal and state government regulations under HIPPA (began 10/2002) I authorize the providers as well as the office staff for High Ridge Family Practice, LLC to contact me to confirm appointments and advise me of the results of any of my medical tests or procedures. They **[ ] may or [ ] may not** leave a message with an answering machine of persons taking messages at the phone number(s) I provide on my registration form.

I provide this signature as acknowledgement that I have been presented with and have read and understood the Office Policies & Procedures information provided to me by High Ridge Family Practice, LLC. This includes but is not limited to the Patient Registration Form (2 pages), the Office Policies regarding Non-Covered Services, the Patient Responsibility List and the High Ridge Family Practice Responsibility to Patient's List.

_____ _____

Signature of Patient or Legal Representative

Date

This form is valid until indicated by the above signee in writing of other arrangements

Signature on File Form for Prior Authorization of Release of Medical Records & Discussion of Care

I, _____ (print your name) authorize High Ridge Family Practice, LLC (the providers at HRFP either/or any of the providers: Drs. Falkoff / Berkun , and/or any other authorized A.P.R.N. or P.A.) as well as the office staff for High Ridge Family Practice, LLC to [ ] discuss my care and/or [ ] release my medical records including but not limited to progress notes, consults, hospital reports, immunizations, communications and the results of any of my medical tests or procedures to the below individual(s):

_____

_____

_____

_____

_____

_____ _____

Signature of Patient or Legal Representative

Date

This form is valid for a period of one (1) year from the date indicated by the above signee

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIGH RIDGE FAMILY PRACTICE
30 BUXTON FARMS ROAD, SUITE 210, STAMFORD, CT.

ALAN T FALKOFF, MD, SENIOR MEDICAL PARTNER, OFFICE MANAGER, SECURITY OFFICER
203-322-7070

Name of Patient:_____

I hereby acknowledge that I have reviewed a copy of this medical practice's Notice of Privacy Practices. I understand that I may request a copy of this notice and any amended Notice of Privacy Practices in the future.

Signed:_____Date:_____

Print Name:_____Telephone:_____

If not signed by the patient, please indicate your relationship to the patient:_____

_____

For Office Use Only:

Signed form received by:_____

Acknowledgement refused:_____

Efforts to obtain:_____

Reasons for refusal:_____

RECORDS RELEASE

To _____
(Doctor/Hospital Requesting Records From)

Address_____

City_____State_____Zip_____

Phone _____ Fax_____

I hereby authorize the release of my medical records or copies of such and request that they are transferred to:

HIGH RIDGE FAMILY PRACTICE
Alan Falkoff, M.D., David Berkun, M.D.,
Melissa Montaruli A.P.R.N. Lindsay A Green A.P.R.N,
Soohyun Nam A.P.R.N., Eileen Madsen A.P.R.N.,
Lynda G Royce A.P.R.N

30 BUXTON FARMS ROAD, SUITE 210
STAMFORD, CT 06905
Telephone: 203-322-7070
Fax: 203-322-2389

Records requested: **ALL** ☐ _____
Other Reports:
Consult☐ **Discharge Summary**☐ **EKG**☐ **Immunization**☐
Lab Report☐ **Physical**☐ **Pathology**☐ **Progress Notes**☐
Radiology☐

_____
Print Name of Patient Date of Birth

From: **To:**
Date of Records

_____
Patient's Signature Date

2020.1