Annandale Family Practice, LLC

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56 Payne Road, Suite 21, Lebanon, NJ 08833 Phone: (908)238-0100 Fax: (908)238-0951

**PRE-VISIT GUIDELINE**

* Arrive 15 minutes early so paperwork can be put into the system and you can be roomed in a timely fashion.
* Notify your insurance of your new primary care provider(PCP). Please bring your insurance card to each visit as it must be scanned every time.
* Copay is due at time of both nurse and doctor visits. Checks should be made out to Annandale Family Practice. We accept Discover, Visa, Mastercard, and Diners Club International cards.
* Bring immunization records and or general records from prior doctor.
* Minimum Processing times:

o Prescription & Refill requests: **72 hrs** o Insurance referrals: **48-72 hours** o All forms dropped off at office: **5 days min.**

PLEASE REVIEW THE FOLLOWING OFFICE POLICY.

Annandale Family Practice, LLC

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56 Payne Road, Suite 21, Lebanon, NJ 08833 Phone: (908)238-0100 Fax: (908)238-0951

Dear valued patient,

As of January 1st, 2020, our office policies will be changing to better serve you. These policies are designed to ensure timely access to your healthcare provider.

There will be new fees associated with same day cancellation and no-show for appointments. The following are the changes:

* First no-show/ same day cancellation- $25.00
* Second no-show/ same day cancellation - $50.00
* Third no-show/ same day cancellation (within a year)- $75.00 and discharged from the practice
* No-show/ same day cancellation for physicals- $100.00

The office will be calling you 48 hours prior to confirm your appointment. If we do not receive verbal confirmation from you, the patient, **within 24 hours** of your appointment, we reserve the right to cancel and reschedule your appointment. Please ensure that we have your most up to date contact information.

* **WE DO NOT ACCEPT WALK-IN VISITS.** Please call in advance for a same day visit. A voicemail can be left after business hours for a same day appointment the following day.

**Medication Requests:**

Please contact your pharmacy directly for medication refills and they will contact the office. Please allow **72 hours** for the doctor to complete your request. A staff member will contact you if we have any questions regarding your request. If you do not hear from the pharmacy or our office after 72 hours, please contact our office.

**Document requests:**

As a courtesy to you, we do not charge a form fee. In order to continue this courtesy please allow **5-7 business days** for the completion of forms after they have been dropped off. If you require a form be filled out same day, you will incur a fee.

Please allow **24-48 hours** for insurance referrals to be processed.

The goal of these changes is to improve your experience. We appreciate you choosing us for all of your healthcare needs, and we value any feedback that you may have.

Annandale Family Practice, LLC

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56 Payne Road, Suite 21 Lebanon, NJ 08833 Phone: (908)238-0100 Fax: (908)238-0951

**Patient Registration Form**

Name (last, first): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsibility Party Information** (if different from above):

Name (last, first): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_**

Annandale Family Practice – Pediatric Medical History Form

In order to ensure that we are aware of your complete medical history and to better assess your individual risk factors, please take a few minutes to answer these questions.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse/Significant Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Household Members**: (Name, age, and relation)

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

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

**Birth History:** (Circle all that apply)

Infertility Y/N

Preterm: Infertility/Gestational Diabetes/Pre-eclampsia/Preterm labor/Hyperemesis gravidarum/High Blood Pressure

Intrapartum: Vaginal delivery/c-section/forceps/vacuum/meconium aspiration/placenta previa/episiotomy

Postpartum: Maternal fever/neonatal fever/hypoglycemia/jaundice/hypothermia

**Previous Surgeries or Hospitalizations**: (please state year)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccination Record:**

Up to date\_\_\_\_\_, Missing\_\_\_\_\_, Refused Vaccines\_\_\_\_\_\_\_, Adverse Reaction\_\_\_\_\_\_\_\_\_

**Medications**: (include over the counters, herbals, supplements, and vitamins)

|  |  |  |
| --- | --- | --- |
| **Name of Medication**  | **Dose**  | **Directions**  |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

**Preferred Pharmacy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**: (medication, food, and environmental)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Annandale Family Practice – Pediatric Medical History Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**:

Smokers in the home Y/N, Smoke Outside Y/N, Pets in Home Y/N, Guns in home Y/N, Lead paint in home Y/N, relationship with siblings Y/N, Caretaker \_\_\_\_\_\_\_, Daycare\_\_\_\_\_\_\_,

School\_\_\_\_\_\_\_\_,Grade\_\_\_\_\_, Gets along with other children Y/N, Gets along with teachers Y/N

Parents relationship: Single/married/domestic partnership/divorced/separated/estranged

**Family History**: (relation, age at diagnosis; if deceased, age at time of death)

Heart Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Failure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Cholesterol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Aneurysm: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Poor Circulation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amputation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emphysema: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asthma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COPD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chronic Bronchitis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer (type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Oxygen used at home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Liver Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kidney Failure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dementia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Arthritis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Review of Symptoms**: (circle all the symptoms that you have been experiencing)

**Cardiac:** chest pain, palpitations, pressure in the chest, heaviness in the chest, heart murmur

**Lungs:** shortness of breath, chronic cough, coughing up blood, wheezing

**GI**: nausea, vomiting, diarrhea, chronic constipation, hemorrhoids, blood in the bowels, black tarry stools, abdominal pain, pelvic pain, heart burn, indigestion, acid reflux

**GU**: difficulty urinating, blood in urine, pain with urination, urinary incontinence, frequent urination, waking at night to urinate, circumcision, bedwetting, daytime wetting

**Reproductive:** vaginal discharge, vaginal itching, heavy/painful/irregular periods, penile discharge, Age of first period \_\_\_\_\_\_\_ Last menstrual period \_\_\_\_\_\_\_

**MS:** Swelling in legs, chronic joint pain (If yes, which joint \_\_\_\_\_\_\_\_\_\_), back pain (chronic, recurrent), muscle aches, muscle deformity

**Derm:** lumps, bumps, moles of concern, rash, sores/lesions, tattoo, piercing

**Neuro:** numbness/tingling/tremor/seizure/convulsions/headaches(migraine/tension/cluster/ sinus)

**Eyes:** vision loss, blurred vision, double vision, blindness; Wears: Glasses /Contacts (read/drive)

**Ears:** hearing loss, vertigo, ringing in the ears, hearing aid (R/L/B), failed hearing screening

**Nose:** bloody nose, obstruction, deviated septum, snoring, post nasal drip

**Throat:** sore throat, lump in throat, change in voice, difficulty swallowing

**Psych:** depressed, moody, anxiety, panic attacks, hallucinations, tearfulness, lack of motivation

**Gen:** fever, chills, weight loss, weight gain, fatigue, lack of energy, change in appetite, change in sleep

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Annandale Family Practice, LLC

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56 Payne Road, Suite 21 Lebanon, NJ 08833

Phone: (908)238-0100 Fax: (908)238-0951

**Authorization for Disclosure of Protected Health Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to disclose information from the records of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( \_\_/\_\_\_/\_\_)

 Patient Name Date of Birth

The information is to be:

|  |  |  |
| --- | --- | --- |
| Released from: **Annandale Family Practice**  To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |     OR  | Released to :  **Annandale Family Practice**  From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

|  |  |
| --- | --- |
| Purpose for request:\_\_\_\_ For personal use only  | \_\_\_Transferring care to another local practice  |
|  \_\_\_\_ Relocation out of area  |   |
|  \_\_\_\_ Insurance change related  | \_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**The following information is to be released: (please check one)**

\_\_\_\_\_**Entire Medical Record**. Records specifically protected under State and Federal Confidentiality Statutes.

I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of substance abuse , AIDS/HIV related, genetic, venereal disease, or tuberculosis information, which are protected under State and Federal law prohibits and further disclosure without written consent of the persons to whom it pertains or otherwise protected by law.

\_\_\_\_**Only specific portions of the medical record**. Itemize portions of record and time period of records

to be released and indicate specific records that may not be released\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Having read the above information , I release Annandale Family Practice, LLC, its employees, staff, and agents from all legal responsibility or liability that may arise from the disclosure of information set forth above relating to my protected information. I understand that this authorization will remain in effect for 180 days or until I provide a written notice of revocation to Annandale Family Practice, LLC at the address listed above. The revocation will be effective immediately upon Annandale Family Practice’s receipt of the written notice. I understand that revocation may not be made if the action has already been acted upon based on prior authorization.

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |   |   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Date   |   |   | Patient’s Signature  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |   |   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Date  |   |   | Witness’s Signature  |

**Annandale Family Practice, LLC**

**Patient Communication Form**

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Family and Friends. It is the office policy of **Annandale Family** **Practice, LLC** not to release confidential medical information regarding your treatment to family members or friends, (i) except for parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the box next to “consent declined”. By signing below, you authorize the following people to receive information regarding your treatment or care.

|  |  |  |
| --- | --- | --- |
|  Name  |   | Relationship to self/patient  |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

 **CONSENT DECLINED**

1. If we are not able to speak with you directly by phone, is it ok to leave a detailed message that may or may not contain personal medical information?

**Okay to leave detailed voicemail?**

□ Yes **(Please specify phone number)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No Thank you

**Okay to send text message?**

□ Yes **(Please specify phone number)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No Thank You

By my signature, I acknowledge that I have received the Notice of Privacy Practices of Annandale Family Practice, LLC.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY**

Signature of staff updating in chart

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Annandale Family Practice, LLC

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56 Payne Road, Suite 21 Lebanon, NJ 08833 Phone: (908)238-0100 Fax: (908)238-0951

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

**FORM**

**By your signature below, you indicate that you have accessed and read the document entitled “Annandale Family Practice, LLC Notice of Privacy Practices.”**

|  |  |  |  |
| --- | --- | --- | --- |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |  |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **Patient Name**  |  |  | **Date of Birth**  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |  |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **Patient Signature (over 18 yrs old)**  |  |  | **Date**  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |  |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **Parent or Guardian Signature** **(under 18 yrs old)**  |  |  | **Date**  |

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