PATIENT INFORMATION

Today's Date ________________

Name of Patient:____ Male ________ Female ______

Birthdate(mm/dd/yyyy)__________ Insured's email address:______________________________

Address:____

City_________________________ State_________________ Zip____________________

Home Phone: (_________)_______________________________ Cell phone: (______)___________

Physician Requesting Visit: _________________________ Town____________ Phone: (_____)__________

Primary Care Physician:___________________________ Town____________ Phone: (_____)__________

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Parent/Guardian: ___________________________ Birthdate:___________________SSN#:__________

Parent/Guardian: ___________________________ Birthdate:___________________SSN#:__________

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Primary Insured's Name:____

Address:(if other than above)____

City:____________________ State______________ Zip_______ Phone(______)______________

Insurance Company:____

Group#:__________________________ ID#______________________ Birthdate:______________

Employer' Name:____

Address:____

City:____________________ State_____________ Zip_______ Phone(______)________________

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Secondary Insured's Name:____

Address:(if other than above)____

City:_____________________ State_____________ Zip_______ Phone(______)______________

Insurance Company:____

Group#:__________________________ ID#______________________ Birthdate:______________

Employer' Name:____

Address:____

City:_____________________ State____________Zip___________ Phone(______)____________

Does patient have any allergies to medications:

____ Yes Is so, please list: _____

_____

____ No

_____

_____

_____

I authorize the release of any medical or other information necessary to process this claim. I authorize the release of medical records to any physicians regarding the treatment of this patient and to anyone listed below. I also authorize payment of medical benefits to:

ALPERT, ZALES AND CASTRO PEDIATRIC CARDIOLOGY, P. A.
MITCHEL B. ALPERT, M. D.
VINCENT R. ZALES, M. D.
ELSA I. CASTRO, M. D.
MARIA ANGELA T. UMALI, M.D.
STEPHANIE E. CHIN, M.D

_____

_____

_____

_____
Signature

_____
Print Name

Alpert, Zales and Castro
Pediatric Cardiology, P.A.
Board Certified Pediatric Cardiologists
Mitchel B. Alpert, M.D., F.A.C.C., F.A.A.P.
Vincent R. Zales, M.D., F.A.C.C., F.A.A.P.
Elsa I. Castro, M.D., F.A.C.C., F.A.A.P.
M. Angela T. Umali, M.D., F.A.C.C., F.A.A.P.
Stephanie E. Chin, M.D., F.A.C.C., F.A.A.P.
PO Box 1719
1623 Route 88 West
Brick, NJ 08724
732-458-9666
Fax: 732-458-0840
2 Apple Farm Road
Red Bank, NJ 07701
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ALPERT, ZALES & CASTRO PEDIATRIC CARDIOLOGY, P.A.

1623 Route 88 West
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(732) 458-9666

2 Apple Farm Road
Red Bank, New Jersey 07701
(732) 671-5659

NOTICE OF PRIVACY PRACTICE

To our patients. THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AS A PATIENT OF THIS PRACTICE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy.

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collection information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required, to do so by law enforcement officials.
4. When necessary to reduce or prevent a serious threat to your health and safety or the heath and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To Federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.
9. To other health care providers when necessary for your treatment.
10. To obtain payment for services that we provide to you, such as disclosures to claim and obtain payment from insurance companies and other payors.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our office and you must pay the cost of copying.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request.
5. You have a right to request an accounting of disclosures of your confidential health information.
6. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of this Notice at any time. We also reserve the right to change our Privacy Practices at any time. To obtain a copy of this notice, contact our front desk receptionist.
7. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you choose to authorize a use or disclosure, you can later revoke it by notifying us in writing.

This notice is effective April 14, 2003 and was updated on May 9, 2012. If you have any questions regarding this notice or our health information privacy policies, please don't hesitate to ask any member of our staff or contact Susan Lesser, our privacy officer, at the Brick address and telephone number listed on this notice.

I hereby acknowledge that I have been presented with a copy of Alpert, Zales & Castro Pediatric Cardiology, P.A., Privacy Practice Notice.

Signature _____ Date _____

PRINTED NAME OF PATIENT _____