

Patient Registration Information

New Beginnings, OB/GYN
 Jose J. Pinto, D.O.
 193 Mountain Avenue
 Springfield, NJ 07081

New Beginnings, OB/GYN
 Sarah E. Little, D.O.
 193 Mountain Avenue
 Springfield, NJ 07081

Patient's Personal Information

Name: (Last, First)		Social Security	Birth date	Home Phone	Cell Phone
Address		City	State	Zip code	Marital Status
Employer	Employer Address:	City	State	Zip code	Employer Phone

Responsible Party

Name (Last, First):	Social Security	Birth date	Sex	Relationship to Patient
Address	City	State	Zip code	Cell Phone
Employer	City	State	Zip code	Work Phone

Insurance Information

Primary Insurance	Policy Number	Group Number	Copay
Subscriber's Name	Birth date	Social Security	Relationship
Secondary Insurance	Policy Number	Group Number	Copay
Subscriber's Name	Birth date	Social Security	Relationship

Primary Care Provider

Primary Doctor's Name	Address	Phone Number	Fax Number
-----------------------	---------	--------------	------------

Pharmacy Information

Pharmacy Name	Address	Phone Number
---------------	---------	--------------

Emergency Contact

Name	Relationship	Primary Phone	Secondary Phone
------	--------------	---------------	-----------------

Financial Agreement

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies, for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I further agree that a photo copy of this agreement shall be as valid as the original.

Signature _____

Date _____

NEW BEGINNINGS, OB/GYN
Jose J. Pinto, D.O. and Sarah E. Little, D.O.
193 Mountain Avenue
Springfield, NJ 07081

FINANCIAL AGREEMENT

Fees for professional services are payable in full by the undersigned upon completion of treatment. If you have insurance, Dr. Pinto/Dr. Little will process your claim to help obtain maximum insurance benefits. Should your insurance carrier fail or refuse to pay your entire bill within 60 days or should you not have any insurance coverage, you will be obligated to pay said bill in full upon receipt of our request for payment. Should you fail or refuse to pay our bill, you agree to pay all costs and an attorney fee of 50% of unpaid balance due if your bill is referred to an attorney for collection.

Signature:

Name:

Date:

**New Beginnings, Ob/Gyn
Jose J. Pinto, D.O.
Sarah E. Little, D.O.
193 Mountain Avenue
Springfield, NJ 07081**

We are dedicated to providing you with the best possible care, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. In addition to cash, we accept Visa, Mastercard, American Express and Discover.
2. Keep in mind that your insurance policy represents a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to be paid directly to the doctor. If your insurance company does not pay our doctors within 3 months, we will look to you for payment.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to:

Pay Your Co-Payment At The Time Of Your Visit

4. If you are insured by a plan that we do not have prior arrangements with, we will prepare and send the claim to you on an unassigned basis. This means the insurer will send the payment directly to you. In this situation, our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the practice's financial policy, and I agree to be bound by its Terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or responsible party, if a minor)

Date

Please Print Name of Patient

Jose J. Pinto, D.O.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning you IIHI. By federal and state law, we must follow the terms of the notice of privacy that we have in effect at the time.

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

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

New Beginnings, OB/GYN
Jose J. Pinto, D.O.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others, who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purpose related to your treatment.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

New Beginnings, Ob/Gyn

Jose J. Pinto, D.O., F.A.C.O.G.

Sarah E. Little, D.O.

193 Mountain Avenue

Springfield, NJ 07081

(973) 218-1579

***Receipt of Notice of Privacy Practices
Written Acknowledgment Form***

I, _____ have received a copy of
(Patient's Name)

Notice of Privacy Practices from the office

of Dr. Pinto and Dr. Little.

Signature of Patient

Date