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	E-Mail

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 _____

TO THE PREGNANT PATIENTS OF DR. JOSE PINTO:

At the prenatal visits, you have the choice of listening to your baby's heartbeat, or seeing the baby grow and develop on ultrasound. These ultrasounds are to look at the heartbeat ONLY, as well as for the pleasure you will have watching the wonders of fetal development.

You will have an ultrasound done outside the office to look for fetal anomalies.

You will read and understand the above statement:

I wish to have ultrasound to see the heartbeat. Please initial: _____

I wish to have Doppler to hear the heartbeat. Please initial: _____

Please Sign Here: _____

Date: _____

TO OUR PREGNANT PATIENTS
(No Insurance)

Your initial pre-natal visit with Dr. Pinto/Dr. Little will cost $275. If you plan on staying with us throughout your pregnancy and subsequent delivery, the fee is $4500. Payments of no less than $750 must be made at each visit, starting with your 2nd visit.

You may pay in larger installments, if you wish, paying off the total balance earlier in your pregnancy.

Thank you for your cooperation.

Patient Name: _____

Date: _____

Patient Signature: _____

Witness: _____

TO NON-INSURED PATIENTS

The bill you will pay for seeing Dr. Pinto today is for his services only. It includes the cost of the physical exam.

The cost of the lab work is NOT included in our fee. You will get a bill from a lab for the analysis of your specimen(s).

Thank you.

_____

Patient's Name

PACIENTES SIN SEGURO

Los cargos de esta visita son para el servicio de el Dr. Pinto. Es solo para el examen fisico.

La cuenta de laboratorio no esta includia en el precio de nosotros. Ustede recibira una cuenta separada.

_____

Nombre de paciente

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 COMITMENT 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

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 you IIHI in order to write a prescription for you, or we might disclose you 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 assists 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 your 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

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(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