

DasMD Clinic

TODAY'S DATE (MM/DD/YYYY): _____

VISIT REASON _____

PATIENT'S NAME (LAST, FIRST, MIDDLE): _____

DOB (MM/YY/YYYY): _____ SSN#: _____

PHONE NUMBER (PREFERRED): _____ E-MAIL: _____

MARITAL STATUS: _____ SEX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

OCCUPATION: _____ EMPLOYER: _____

WHO IS RESPONSIBLE FOR THE BILL: _____

RELATIONSHIP: _____ DOB: _____

NAME OF INSURANCE CARRIER: _____

INSURANCE CARRIER ID#: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____

SECONDARY INSURANCE (IF APPLICABLE) _____

SECONDARY ID# _____

**I authorize DasMD Clinic to release any laboratory or test results & discuss my medical condition with: (please list names below with the relationship). Please leave blank if you do not want to disclose any health information with friend/family.*

Name(s) 1. _____ 2. _____ 3. _____

Relationship to patient 1. _____ 2. _____ 3. _____

**I HEREBY AUTHORIZE DASMD CLINIC TO RELEASE TO MY INSURANCE CARRIER ANY MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF MY MEDICAL CLAIM. I UNDERSTAND THAT THIS MAY INCLUDE COPIES OF MY MEDICAL RECORDS OR LAB RESULTS.*

SIGNATURE: _____ DATE: _____

DasMD Clinic

MEDICATION LOG

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Allergies to medications

Other allergies

Medication	Dose	Frequency

Do you take any supplements? _____

DasMD Clinic

FAMILY HISTORY: (Please check all that apply)

High Blood Pressure: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
High Cholesterol: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Heart Disease: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Cancer: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Diabetes: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

MEDICAL HISTORY: _____

SURGICAL HISTORY: _____

SOCIAL HISTORY:

☐ Cigarette Smoking
☐ Never smoked
☐ Quit/former smoker
☐ Vape

Alcohol Intake:

☐ None
☐ Less than 1 drink per day
☐ 1 to 2 Drinks per day
☐ 3 or more drinks per day

I HEREBY AUTHORIZE DASMD CLINIC TO RELEASE TO MY INSURANCE CARRIER ANY MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF MY MEDICAL CLAIM. I UNDERSTAND THAT THIS MAY INCLUDE COPIES OF MY MEDICAL RECORDS OR LAB RESULTS.

SIGNATURE _____ DATE: _____

DasMD Clinic

SUMMARY OF PRIVACY PRACTICES

This notice describes how much medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples.

- For medical treatment.
- To obtain payment for our services.
- To run our practice more efficiently & ensure all our patients receive quality care.
- To avert a serious threat to health or safety
- For appointment and patient recall reminders

If you believe your privacy rights have been violated, you may file a complaint with the Practice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions

For more information about these rights please do not hesitate to ask us.

I _____, have been given the opportunity to read and or receive DasMD's notice of privacy practices.

Signature of patient

Date

DasMD Clinic

PAYMENT POLICIES

1. You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
2. \$50 No Show Fee for any Missed Appointment that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.
3. \$35 NSF charge for any returned check from the bank.
4. If you are a private patient without insurance, all charges are due at the time of the visit. We do not send a statement to private pay patients.

EXTERNAL PRESCRIPTION HISTORY

I authorize DasMD Clinic and its affiliated providers to access and view my external prescription history. I understand that a prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by the providers and staff of DasMD Clinic and may include past prescriptions from several years ago.

CONTROLLED SUBSTANCE POLICY

1. No refills of controlled substances will be given on the first visit.
2. There must be a separate visit to assess the need for the chronic controlled substances.
3. We will ask you to obtain prior notes and testing supporting the diagnosis which requires a chronic controlled substance.
4. A referral to the appropriate specialist may be made after the evaluation, who will then be the only physician who can prescribe the controlled medication.
5. You may receive an alternate medication to help control your chronic medical problem.
6. After hours and on weekends, the doctor on call WILL NOT call in any additional prescriptions or refill medications over the phone.
7. You are responsible for your prescriptions. Stolen or lost refills will not be replaced.
8. NO early refills will be given.
9. You must only use one designated pharmacy- NO EXCEPTIONS.
10. You must inform us of any prescription drugs you are obtaining through other physicians. Failure to do so may result in discharge from our practice.
11. It is illegal to share prescription drugs and to alter or forge prescriptions. We reserve the right to discharge patients engaging in such activities.
12. We reserve the right to obtain random drug testing. There is zero-tolerance policy for illegal substance use.
13. We reserve the right to discharge patients engaging in activities considered “drug-seeking”, such as persistent medication uses past the period indicated by the physician; repeated visits to emergency rooms with pain complaints; use of illegal substances; and other activities in this category at the discretion of our physicians.

Patient Signature

Date

Printed Name

Out-of-network Policy

On behalf of **DasMD Clinic** (hereinafter “health service provider” or **DasMD Clinic**), kindly accept this disclosure in accordance with P.L. 2018 c. 32, (“Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act”) as it applies to health care providers and physicians. Pursuant to this new legislation, notice is required to be provided by all physicians, including those at **DasMD Clinic** as follows:

Pursuant to the above captioned legislation, health care professionals are required to inform patients whether or not they participate in a certain health insurance plan. Please note, in accordance with this requirement, accept notice that **DasMD Clinic** does not currently participate in some insurance plan and is not considered an “in-network” Provider. **DasMD Clinic** which includes **DasMD Clinic** treating physicians, are considered “Out-of-Network” Providers.

Pursuant to the above captioned legislation, please take notice that, upon request prior to the scheduling of non-emergency procedure(s), you may receive, in writing, the amount, or estimated amount that will be billed by **DasMD Clinic** for the medical treatment and/or health care service you received from **DasMD Clinic**. This disclosure will include the associated Current Procedural Terminology (CPT) Codes associated with the service or procedure.

Pursuant to the above captioned legislation, please take notice that you may be financially responsible for service provided that are deemed “out-of-network” by your health insurance carrier, including costs in excess of, but not limited to, co-pay, deductible, and/or coinsurance (if applicable). **DasMD Clinic** reserves the right to seek additional reimbursement from you for procedures or services in excess of those benefits provided by your health insurance benefits plan and/or rates of reimbursement allowed by your health benefits plan for “out-of-network” providers, in excess of, and in addition to, co-pay, deductible, or co-insurance (if applicable). Please take notice that it is advised that you contact your health benefits plan with any questions and for further consultation on costs. Please also take notice that a physician, including those physicians at **DasMD Clinic** is required to provide you with the name, practice name, mailing address and telephone number (if that information is known or available) for a health care provider providing services in conjunction with those provided by **DasMD Clinic** to the extent applicable, when that health care provider is providing the Neurology service.

Please take notice that if the status of a health care professional changes with respect to the health care professional network status, including those physicians here at **DasMD Clinic**, between the time of the disclosure and the provision of the procedure, the health care professional shall notify you of the change.

Please note that by signing this document, you acknowledge that you have reviewed this document and have received all the required disclosures listed above and that you hereby waive any challenge to the notice requirements contained within P.L. 2018, c.32, also known as “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act”.

UNDERSTOOD AND AGREED:

Patient Name: _____

Patient Signature: _____

Date: _____

DasMD Clinic
35 South Washington Avenue, Bergenfield, NJ 07621