

OCEAN OTOLARYNGOLOGY LLC

Dr. Bruce Peters
54 Bey Lea Road
Toms River, NJ 08753

Dr. Stephen Kupferberg

Rajat Sood, MSN, APN-C

Samantha Turano PA-C

1707 Atlantic Ave
Manasquan, NJ 08736

(p) 732-281-0100

(fax) 732-281-0400

PATIENT DEMOGRAPHIC FORM

First Name: _____ Last Name: _____ M.I. _____

Date of Birth: _____ Sex: _____ SSN: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Allow text confirmations? _____

Work: _____ X _____

E-mail address: _____ Do not wish to share e-mail Do not have e-mail

DO YOU HAVE A LIVING WILL ? YES/NO

Race: American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander

Black or African American Caucasian/White Hispanic Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Language: _____

Responsible Party: Self Other: _____

INSURANCED SUBSCRIBER NAME: _____ D.O.B. _____

Emergency Contact: _____ Relation: _____

Phone: _____ Address: _____

Primary Care Physician: _____ Referring Physician: _____

Address: _____ Address: _____

Pharmacy: _____ Address: _____ Phone: _____

How did you hear about us? Primary Care Physician Other Healthcare Physician Family/Friend

Office Website Newspaper/Ocean County Women Facebook Internet Emergency Dept.

Insurance Company Other: _____

I authorize the release of any information related to claims on behalf of myself. I acknowledge that my signature authorizes this office to submit claims for services rendered, and serves as an assignment of benefits to my physician. I further understand that even though the physician's office will submit to my insurance company, the bill is ultimately my responsibility, and I agree to payment in a timely manner. For participating insurance companies, the proper referral or precertification must be presented for complete coverage.

FAILURE TO OBTAIN A REFERRAL OR PREAUTHORIZATION PRIOR TO THE VISIT WILL RESULT IN PATIENT BEING FINANCIALLY RESPONSIBLE FOR THE VISIT.

I AGREE TO ALLOW THIS HEALTHCARE PROVIDER TO FILE AN APPEAL ON MY BEHALF WITH MY HEALTH PLAN IF THERE IS A QUESTION ABOUT COVERAGE FOR ALL OR ANY SERVICE RENDERED.

Signature: _____

Date: _____

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NOTICE OF PRIVACY ACTS

This is to certify that I _____ allow my medical information to be released to:

Family members (include relation): _____

Medical Doctors : _____

OR

I do not wish to have any of my health related information released to anyone other than myself.

PLEASE CHOOSE ONE:

I give permission to leave a message in regards to blood work results, outside testing, appointments, etc. either on my answering machine or with a family member who answers my home telephone.

OR

If I am unable to be reached by phone, no messages pertaining to myself are to be left on my home answering machine or with a family member except for appointment reminders.

*Any changes of patient release information must be given in writing.
Verbal requests for changes will not be honored.*

Print Name: _____

Initial: _____

PATIENT FOLLOW-UP PLEDGE

I, _____ (print name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of the doctors should be expected.

Signature: _____

Date: _____

CONSENT FOR HEALTH INFORMATION EXCHANGE (HIE)

This Consent form allows Ocean Otolaryngology to view and access your health information through a computerized health information system. HIE allows all providers access to your healthcare records

_____ I GIVE CONSENT _____ I DENY CONSENT

Patient Name (Print) _____

Patient Signature _____

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement about our Financial Policy which we request you read and sign prior to any treatment.

REGARDING INSURANCE:

All copayments are due at time of service. If we are a participating provider with your insurance company, we will be happy to submit your claim. We accept usual and customary rates from the insurance companies; however you will be responsible for any co-pays, co-insurance, or deductibles due to us. If your insurance plan requires you to obtain a referral from your Primary Care Doctor, and if that referral is not given to the office at the time of service, you may be financially responsible for that office visit. In the event that your insurance coverage changes to a plan where we are not participating providers, you will be responsible for the balance at the time of your visit. Regarding Medicare, we do accept assignment. However, if you do not have a supplemental insurance, the 20% co-insurance is your responsibility and due at the time of service. We do not accept Cobra, Workman's Comp., or Auto/Accident Insurance. **As an ears, nose, and throat specialty office, it may be required for the physician to use diagnostic instruments to achieve a treatment plan. You're insurance company may categorize this as a surgical procedure. Based on your insurance and the type of plan you have, this may require us to bill you for this procedure.**

ELECTRONICAL AI MEDICAL RECORDS

At Ocean ENT this office uses the help of AI to generate your electronical medical records. To ensure accuracy, your conversation with the doctor is recorded and intergraded into your visit notes. These recordings are deleted after seven days and are not used in anyway outside of your personal medical record.

CANCELLATION POLICY

We reserve the right to charge a patient **\$50.00** if they do not show for their scheduled appointment, or if a patient cancels less than 24 hours prior to their appointment.

ASSIGNMENT OF BENEFITS:

I hereby authorize assignment and payment of all my medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans, directly to Ocean Otolaryngology Associates. I have read the Financial Policy. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature of Responsible Party: _____ Date: _____

Patient Name (print): _____