Shawn Tepper-Levine, D.O.

New Patient Registration

20 Heathcote Road Kingston, NJ 08528

Personal Information (Please Print) **Today's Date:** _____/____/_____

Patient Name: _____ **Date of Birth:** _____-_____-_____

Address: _____ **Age:** _____

City, State, Zip: _____

PHONE Cell: _____**Home:** _____ **Work:** _____

It is OK to leave messages at: ☐Cell ☐Home ☐Work **Sex:** ☐Male ☐Female

Email Address: _____

Relationship Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Domestic Partner

Pharmacy Name and Number:_____

Employer Name: _____ **Occupation:** _____

Emergency Contact: _____ **Emerg. Phone #:**_____

Relationship to Patient: _____

Is this the result of a:

Motor Vehicle Accident? ☐Yes ☐No

Work Accident or Injury? ☐Yes ☐No

Other Accident? ☐Yes ☐No

Is there a lawsuit pending regarding your medical condition? ☐Yes ☐No Are you on disability? ☐Yes ☐No

Referred By/How Did You Hear About Us?: _____

For Pediatric Patients: (complete only items different from patient's information above.)

Mother: _____

Address: _____

City, State, ZIP: _____

Home Phone: _____

Work Phone: _____

Employer: _____

Occupation: _____

Father: _____

Address: _____

City, State, ZIP: _____

Home Phone: _____

Work Phone: _____

Employer: _____

Occupation: _____

Who is responsible for medical bills? _____

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Insurance Company: _____ **Policy Number:** _____

Name on Policy: _____ **Group Number:** _____

Policy Holder SS#: _____-_____-_____ **Date of Birth:** _____-_____-_____

Secondary Insurance: _____ **Policy Number:** _____

Name on Policy: _____ **Group Number:** _____

Policy Holder SS#:_____-_____-_____ **Date of Birth:** ____-____-_____

From Whom Are You Currently Receiving Medical Care?

Primary Physician: _____

Address: _____ **City, State, ZIP**: _____

Phone Number: _____

Physician	Condition you are being treated for	Medications

Surgeon	Date	Surgical procedure and reason performed

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OFFICE POLICIES & GUIDELINES

Welcome:

To help you get acquainted with the office, we have prepared a few words about our policies and fee schedules. Please read and initial to ensure that you understand and agree to the guidelines.

Your Appointment:

Your appointment is time set aside for you to see the Doctor. We have a twenty-four (24) hour cancellation policy. A message may be left on our answering machine at any time to cancel your appointment. The earlier you can inform us of a change in your plans, the more efficient use we can make of our time. We also respect your time and make every effort to be punctual for your appointment.

____ **I understand if I miss or cancel an appointment less than 24 hours prior to its scheduled time, I am responsible for paying the full visit fee.**

Fragrances:

Some of our patients are allergic to environmental pollutants such as perfumes and hair sprays:

____ I agree to refrain from wearing fragrances to the office.

Fees & Payment:

Regardless of insurance, we require payment for services at the time they are provided. We supply a standard itemized receipt that you may submit to your insurance company in case you qualify for reimbursement. We regret we are unable to accept assignments from your insurance carrier.

In the case of minors, the parent or guardian who brings the minor in is responsible for the bill. If the parents are divorced or separated and one is responsible for the medical bills, we require payment from the minor or person accompanying him or her at the time of the visit.

_____ I understand that Dr. Tepper-Levine does not participate in any insurance plans and agrees to making payments at each visit.

_____ I understand If a check is returned from the bank, a $30.00 “return check” fee will be charged to your account.

_____ I understand that it is my responsibility to know my insurance plan benefits. Dr. Tepper-Levine will not respond to any requests on my behalf in relation to paying, collecting, or negotiating my insurance claim(s).

Thank you for taking the time to read this policy sheet. If you have any questions about our policy, please let us know.

I have read and understand the above office policies and agree with them.

Name (please print): _____

Signature: _____ Date: ____/_____/_____

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CONSENT TO SERVICES

I understand that Dr. Shawn Tepper-Levine is board certified in neuromusculoskeletal medicine and osteopathic manipulative medicine (OMM) and the care that I receive from her may also include integrative medicine, complementary, or alternative medicine (ACM or CAM). These services may be nontraditional or non-conventional and may not be recognized as standard medical practice, generally accepted by the medical community, or approved by the Food and Drug Administration or other regulatory agencies. While many of these approaches have long been practiced, they may still be considered investigational or experimental. I am seeking care from Dr. Tepper-Levine in order to benefit from her special training and years of clinical experience in integrative/alternative medicine.

As part of a treatment plan, I understand that Dr. Tepper-Levine may recommend lifestyle changes, dietary recommendations and/or prescribe supplements, herbal or botanical products. Many products are generally available over-the-counter and considered safe based upon their long history of use but have not been widely tested. I understand that Dr. Tepper-Levine recommends certain brands because of their safety and efficacy profile. However, there is some risk that these products could prove harmful, particularly if I am allergic to them, which in rare circumstances could lead to serious consequences. I understand that interactions between herbs, vitamins and/or drugs, are not yet well known. I will let Dr. Tepper-Levine and other physicians know what herbs, vitamins and medications I am taking. I agree to notify Dr. Tepper-Levine if I experience any interactions or adverse experiences or reactions. If there is a serious reaction, I agree to seek emergency care immediately.

I have read and understand the nature of the services provided by Dr. Tepper-Levine. I agree to take an active and responsible role in improving my own health. I acknowledge that if I do not follow the treatment plan as provided or choose brands other than those researched by Dr. Tepper-Levine, I may not receive the full benefit of the treatment proposed by Dr. Tepper-Levine and I accept responsibility for less than satisfactory results.

I have read and understand the above, and consent to treatment by Dr. Tepper-Levine.

Name (please print): _____

Signature: _____ Date: ____/_____/_____

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NOTICE THAT SERVICES ARE NOT PRIMARY CARE

I understand that Dr. Shawn Tepper-Levine is not acting as my primary care physician. Even though she may address issues affecting my general health, this is a complementary approach to medicine. It is in my best interest to also have a primary care physician to ensure that I am fully informed about all available conventional means to address any medical conditions I may have.

I understand that Dr. Shawn Tepper-Levine does not provide emergency, on-call assistance. Should Dr. Tepper-Levine provide treatment for an urgent condition, I understand this assistance does not mean she is taking primary responsibility for managing that condition, but is complementing the care I receive from my primary care physician. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists.

When appropriate, Dr. Tepper-Levine will be in communication with your other health care providers. Please provide us with the name and contact information of your primary care physician and sign the records release consent form so Dr. Tepper-Levine can legally discuss your care.

Dr. Tepper-Levine will make available copies of all lab results at scheduled office visits only. I understand that it is my responsibility to keep copies of all my results. Future requests for copies of medical records will be supplied for a fee determined by the New Jersey Department of Health's annually published schedule.

I understand that Dr. Tepper-Levine does not assist patients in filing disability or SSI claims. Any patients wishing to file for disability must have their primary care physician provide such services.

Name (please print): _____

Signature: _____ Date: ____/_____/_____

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PERMISSION TO RELEASE INFORMATION TO INSURANCE CARRIERS

We must have your authorization in order to respond to any correspondence from your insurance carrier. At times we receive EOBs (Explanation of Benefits forms) from insurance carriers. They may have used incorrect codes or they may classify codes incorrectly. We have form letters to send to correct these errors in order for you to receive appropriate reimbursement. **Please sign this form so that we may help you obtain reimbursement.**

Patient's Name: _____
Please print clearly

Insured's Name: _____
Please print clearly

I give permission to this office to release medical information to my health insurance company.

Name (please print): _____

Signature: _____ Date: ____/_____/_____

PERMISSION TO SHARE INFORMATION WITH HEALTH PROVIDERS

If you want the doctor to share your medical information with other health providers, so that we may function as a team please give permission:

Name (please print): _____

Signature: _____ Date: ____/_____/_____

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PATIENT PRIVACY POLICY

In order to protect sensitive personal and medical information, we have instituted a number of measures aimed at maintaining your privacy. The National Institutes of Health have a newly developed Health Information Privacy Act (HIPA) that requires every medical provider to make available to patients a privacy policy. This effort is to maintain privacy of patient information in an era of high technology and data-laden medical systems. The end result will be a more streamlined system of medical information with a higher degree of information security in the process. The following is the policy for patients in this office regarding patient privacy and confidentiality of information collected and stored in this office:

1. Payments and Scheduling will be done by Dr. Tepper-Levine and/or the office manager. Patients must remain in the waiting area and NOT at the office manager's desk so that the schedule book and computer screen are NOT visible to them.

2. An information sheet with demographic data, insurance information, consent for treatment and medical disclosure will be completed by every patient as part of her/his record. A copy of this sheet and the insurance card(s) will be released to our office manager for billing records and to help process medical claims. This form will include the patient's preferences for where appointment reminders may be left, (home, work or cell phone.)

3. All superbills for office visits will be shared with the office manager in order to process insurance claims and record business transactions for tax purposes.

4. Any paper trash with patient information will be shredded prior to discarding it.

5. Employees and staff are required to sign a confidentiality agreement regarding any information they are exposed to in the office setting which is not to be discussed or revealed to any person(s)/business(es) outside of the office setting without prior written consent by the patient/legal guardian.

6. Medical release forms are required to be signed by the individual or parent/guardian in order to release any medical information to themselves, medical offices, insurance companies, or to any other desired location. A copying charge may apply for extensive record copying.

7. Only first names will be used when addressing patients in the office.

8. All medical related conversations will occur in private.

9. All papers related to patient care will be stored in cabinets when not in use where only authorized medical staff have access to them.

10. Any breach of confidentiality must be submitted in writing to Dr. Shawn Tepper-Levine, D.O. for proper action to be taken to amend the situation and/or policy.

I have read and understand the above Patient Privacy Policy.

Name (please print): _____

Signature: _____ Date: ____/_____/_____