

# Signature Medicine - New Patient Registration Form

(Please Print)

PATIENT INFORMATION					
Patient's last name:		First name:		Middle name:	
Mailing address:			City:	State:	ZIP code:
Home phone no.: ( ) -		Cell phone no.: ( ) -		Work phone no.: ( ) -	Patient Email:
Patient Date of Birth:		Patient Age:	Patient Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> other	
Social Security no.: - -		Employer Name and Address:			
If patient is a senior with a legal Power of Attorney or a minor, please give POA/guardian/parent names and specify relation to patient:					

IN CASE OF EMERGENCY				
Name of emergency contact person:		Relationship to patient:	Home phone no.: ( ) -	Work phone no.: ( ) -
Mailing address:		City:	State:	ZIP code:

INSURANCE INFORMATION					
Name of primary insurance:		Policy subscriber's name, if not patient:		Policy subscriber's date of birth:	
Policy Number:		Policy Effective Date:			
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other, please specify:					
Name of secondary insurance (if applicable):		Policy subscriber's name, if not patient:		Policy subscriber's date of birth:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other, please specify:					

RESPONSIBLE PARTY (GUARANTOR)					
The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip the next section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.					
Guarantor's last name:		Guarantor's first name:		Guarantor's middle name:	
Guarantor's mailing address, if different from patient:			City:	State:	ZIP code:
Guarantor's phone number: ( ) -		Relationship to patient:	Guarantor's date of birth:	Guarantor's Social Security No.: - -	

OTHER INFORMATION			
Pharmacy name:		Pharmacy location:	Pharmacy phone no.: ( ) -
How did you hear about this office, or who referred you here?			
May we notify you of appt./test results at the e-mail address listed above		<input type="checkbox"/> Yes <input type="checkbox"/> No	
May we leave messages of test results on your answering machine?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
May we leave voicemail messages of appointments on your answering machine?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
May we notify you of appointments at this mailing address?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
May we notify you of test results at this mailing address?		<input type="checkbox"/> Yes <input type="checkbox"/> No	



**PATIENT HISTORY FORM**

**PRINT & COMPLETE: BRING THIS FORM WITH YOU TO YOUR APPOINTMENT**

Name:

Age:

Date of Birth:

Who was your previous primary care provider? Dr.  
What is the reason for requesting this visit?

**PAST MEDICAL HISTORY:** Please list any medical conditions from which you have suffered in the past or currently:

**PAST HOSPITALIZATIONS - SURGERIES:** Please list any surgeries, or hospitalizations, reason & date:

**ALLERGIES:** *List any allergic reactions or adverse side effects you've had to any drugs or other*

Drug/Food/Item	Type of Reaction

**CURRENT MEDICATIONS INCLUDING BIRTH CONTROL:**

Prescription medications	Dose	How often taken

**NON-PRESCRIPTION:** *List all over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.*

Over-the-counter medications	Dose	How often taken

**HERBAL PREPARATIONS:** *List all*

Herbal preparation	Dose	How often taken

**FOR WOMEN ONLY:**

Age onset of menses?	
When was your last menstrual period?	
Number of Pregnancies:	
Number of Births:	



Patient History Form

**Home situation** Single Married (how long\_\_\_\_) Divorced (how long\_\_\_\_) Widowed (how long\_\_\_\_)  
Domestic partnership (how long\_\_\_\_)

**Employment:** Status: full-time\_\_\_\_ part-time\_\_\_\_ retired\_\_\_\_ disabled\_\_\_\_ homemaker\_\_\_\_

**Occupation/ Highest Degree Achieved:** \_\_\_\_\_

**Habits:**

Do you smoke or chew tobacco? No\_\_\_\_ Yes\_\_\_\_ If yes, how many packs per day? \_\_\_\_\_  
Are you a former smoker No\_\_\_\_ Yes\_\_\_\_ How many years did you smoke? \_\_\_\_\_  
If you have quit, how long ago \_\_\_\_\_  
Do you use alcohol? No\_\_\_\_ Yes\_\_\_\_ If yes, how often do you drink? \_\_\_\_\_  
If you have quit, how long ago? \_\_\_\_\_  
Do family or friends worry about your alcohol intake? Y / N  
Do you exercise regularly? No\_\_\_\_ Yes\_\_\_\_  
How often? \_\_\_\_/week What activity? \_\_\_\_\_ Minutes per session\_\_\_\_ Gym membership? \_\_\_\_\_  
Do you have any exercise equipment at home? \_\_\_\_\_  
Number of times a week do you eat at a restaurant (out of 21 average weekly meals)? \_\_\_\_\_  
Do you/have you used illicit drugs? No Yes  
Do you have smoke detectors? No Yes  
Do you use seatbelts? No Yes

**Immunizations:**

if YES, give approximate year given  
Pneumococcal No\_\_\_\_ Yes\_\_\_\_  
H. influenza No\_\_\_\_ Yes\_\_\_\_  
Shingles Vax No\_\_\_\_ Yes\_\_\_\_  
Hepatitis B (series of 3) No\_\_\_\_ Yes\_\_\_\_  
Tetanus booster No\_\_\_\_ Yes\_\_\_\_

**Transfusions:** Have you ever received a blood transfusion? No\_\_\_\_ Yes\_\_\_\_ When? \_\_\_\_\_

**FAMILY HISTORY:** (Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives)

	Maternal Grandparent	Paternal Grandparent	Father	Mother	Brother	Sister	Son	Dtr	Other
Colon or rectal cancer									
Breast or other cancer									
Explain									
Stroke/Heart Attack before age 65									
Diabetes									
High blood pressure									
High cholesterol									
Alzheimer's Disease									
Alcohol/drug abuse									
Depression									
Bipolar Disorder									
Genetic disorder									
Other (Prostate ca, Ovarian Ca, Melanoma, Bleeding problems, Blood clots)									

**Age of Parents:** \_\_\_\_ **Mother** Alive Deceased \_\_\_\_ **Father** Alive Deceased  
**Number & Age of Children:** \_\_\_\_ **Healthy:** Yes No

- Are you experiencing an unusually stressful situation? Explain \_\_\_\_\_
- Are there any specific personal issues you would like to bring up at the time of your visit?



Patient History Form

**SYMPTOM REVIEW**

**General**

- change in weight: \_\_\_\_\_ lbs during last 6 months
- poor sleep
- fevers
- feeling depressed
- feeling forgetful
- night sweats or chills

**Head, Eyes, ears, nose, throat**

- headaches or migraines
- light headedness or dizziness
- bleeding gums
- blurred vision
- other change in vision
- dry eyes
- history of glaucoma or cataracts
- loss of hearing
- ringing in ears
- sinus problems
- hoarseness or voice changes
- dentures: type \_\_\_\_\_

**Cardiovascular**

- chest pain
- palpitations or rapid heart beat
- history of angina or heart attack
- history of high blood pressure
- history of irregular beat or murmur
- history of poor circulation
- Date/Result of last EKG \_\_\_\_\_
- Result of any other cardiac tests \_\_\_\_\_

**Pulmonary/lungs**

- shortness of breath
- difficulty breathing
- difficulty breathing lying down
- persistent cough
- sputum
- coughing up blood
- history of asthma or wheezing

**Gastrointestinal**

- poor appetite
- abdominal pain or cramps
- bloating after meals
- indigestion
- difficulty swallowing
- diarrhea
- constipation
- recent change in bowel habits
- nausea or vomiting
- vomiting blood
- rectal bleeding or blood in stools
- history of jaundice, liver disease or abnormal liver tests
- history of hemorrhoids
- history of colitis
- history of Hepatitis
- Date & result of last colonoscopy \_\_\_\_\_

**Genitourinary**

- Urinary urgency
- Frequent urination
- hesitancy during urination
- inability to hold urine
- burning or painful urination
- blood in urine
- urinating at night: \_\_\_\_\_times/per night
- Hx of recurrent urinary tract infections
- Hx of kidney stones
- Hx of STDs (eg: Syphilis, Gonorrhea, Herpes, HIV)

**Muscle/joint/bone**

- swelling of ankles
- muscle aches
- joint pains or swelling
- Hx of chronic fatigue or tiredness
- Hx of osteoporosis
- Have you ever fallen in last 2 years

**Neurologic/Psychiatric**

- history of stroke
- loss of consciousness
- numbness or tingling in fingers OR hands, OR feet
- leg cramps when walking
- restless legs at night
- Hx of seizures
- Do you ever feel depressed or anxious or out of control
- History of suicide attempt

**Skin**

- Itching: where \_\_\_\_\_
- easy bruising
- new or change in moles
- eczema
- rashes
- new lumps or bumps

**Endocrine**

- change in tolerance to hot or cold weather
- excessive thirst
- excessive urination

**Women only**

- History of abnormal Pap smear
- History of bleeding between periods
- vaginal discharge
- breast discharge or lumps
- date of last mammogram \_\_\_\_\_
- date of last pap smear \_\_\_\_\_

**Men only**

- penile discharge
- impotence
- date of last PSA
- date of last prostate exam



**MEDICAL RECORDS REQUEST FORM**

Patient Name: \_\_\_\_\_  
Patient's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I request and authorize my previous doctor or specialists to release healthcare information of the patient named above to:

Name: ASHISH SITAPARA M.D. P.C.  
Address: 770 NEWTOWN YARDLEY RD, SUITE 220A  
NEWTOWN, PA 18940

Specific description of the information that may be used or disclosed (including date(s)):

ALL NOTES, LABS, XRAY, COLONOSCOPY, MAMMOGRAM, EKG, IMMUNIZATION RECORDS AND CONSULT REPORTS

Specific description of how the information will be used:

CONTINUED MEDICAL TREATMENT

- 1) I understand that this authorization will expire on \_\_\_\_ / \_\_\_\_ / \_\_\_\_.
- 2) I understand that I am responsible for any charges associated with obtaining my medical records (some practices may charge for copying, etc)
- 3) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Signature Medicine in writing.
- 4) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits if applicable.
- 5) I may inspect or copy any information used or disclosed under this agreement.
- 6) I understand that if person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

\_\_\_\_\_  
Patient's Signature or Patient's Representative \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative Relationship to Patient



**AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION FORM**

Patient Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Your health information is personal and private. There are times when you may want us to be able to share your health information with someone such as a child or spouse or parent. Please complete this form

I request and authorize Signature Medicine to be able to discuss my personal health information to the following list of authorized people:

Name _____	Relationship _____	Phone Number _____
Name _____	Relationship _____	Phone Number _____
Name _____	Relationship _____	Phone Number _____
Name _____	Relationship _____	Phone Number _____
Name _____	Relationship _____	Phone Number _____

OTHERS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

All medical records/health information may be discussed except:

Please specify

\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*IF THEY ARE NOT ON THIS LIST, WE WILL NOT BE ABLE TO SPEAK TO THEM ABOUT YOUR PERSONAL HEALTH INFORMATION UNLESS THEY ARE YOUR MEDICAL POWER OF ATTORNEY.

\*\*\*\*IF YOU WISH TO ADD OR SUBTRACT PEOPLE FROM THIS LIST, YOU MUST NOTIFY US EITHER IN WRITING OR IN PERSON

X \_\_\_\_\_  
PATIENT SIGNATURE DATE



**Acknowledgment of Receipt of Notice of Privacy Practices & Authorization/Consent to use & disclose health information**

I hereby acknowledge that the Practice has provided me its Notice of Privacy Practices (the "Notice"). The Notice defines the terms "treatment", "payment" and "health care operations" and the types of uses and/or disclosures that the Practice can make if I execute this Consent. I have had the opportunity to review the Notice. I understand that the Practice may change the terms of the Notice from time to time, and that I may contact the Practice, at the address listed below, to obtain a revised version of the Notice at any time.

I also hereby authorize and consent to the use and/or disclosure of my protected health information so that Ashish Sitapara, M.D., P.C., d/b/a "Signature Medicine" (the "Practice") can carry out treatment, payment and health care operations. I understand that this authorization/consent includes granting my authorization to view my prescription history from external sources. I also understand and authorize the Practice to use 3<sup>rd</sup> party providers such as an outside medical billing company, a medical transcription company, and a clinical health data management organization in their efforts to provide care for me. I also allow for and authorize the Practice to disclose my protected health information to Signature Practice Management, LLC, a company with which the Practice works to help carry out Practice administrative and related functions. For purposes of this document, protected health information means any and all information relating to health care services provided to me by the Practice including, but not limited to, information relating to services provided to me prior to this date.

I understand that I may submit a written request to the Practice asking that the Practice restrict how my protected health information is used or disclosed to carry out treatment, payment or health care operations. I understand that the Practice is not required to agree to my requested restriction.

I also understand that this authorization/consent will remain in effect until I provide a written notice of revocation to the Practice. The revocation will be effective immediately upon the Practice's receipt of my written notice, although the revocation will not affect any actions the Practice took before it received my notice of revocation.

The address of the Practice is:                      Signature Medicine  
770 Newtown Yardley Road, Suite 220  
Newtown, PA 18940  
(215) 968-4804 (phone)  
(215) 968-4759 (fax)

\_\_\_\_\_  
Signature of Patient or Personal Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Personal Representative  
and relationship to patient



**ASHISH SITAPARA, M.D., P.C.**  
dba Signature Medicine

## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY SIGNATURE MEDICINE AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. REVIEW THIS DOCUMENT CAREFULLY.

Ashish Sitapara, M.D., P.C., dba "Signature Medicine" is required by law to maintain the privacy of your Protected Health Information ("PHI"). Signature Medicine is further required to provide you with notice of Signature Medicine's legal duties and privacy practices with respect to PHI. PHI includes all individually identifiable health information concerning you which is either maintained by Signature Medicine or transmitted by Signature Medicine to others, whether in oral, written or electronic form.

Please be assured that Signature Medicine considers the maintenance of your privacy to be integral to its mission, and that Signature Medicine has taken steps to guard against any improper use or disclosure of your PHI.

The uses and disclosures of PHI are generally regulated by a federal law called the Health Insurance Portability and Accountability Act of 1996 (referred to as "HIPAA") and the regulations which were promulgated to enforce HIPAA. In instances where state laws relating to the privacy of PHI differ from HIPAA and a state law is either more protective of your PHI or provides you with greater access to your PHI, the state law overrides HIPAA.

### **Part I: Uses and Disclosures of PHI**

#### **1. Carrying Out Treatment, Payment and Health Care Operations**

Except in an emergency or other special circumstance, before providing treatment to you, we will ask you to read and sign a written consent to allow us to use and disclose PHI for purposes of treatment provided to you, obtaining payment for services provided to you and for Signature Medicine's health care operations (e.g., internal administration, quality improvement, and customer service), as detailed below. The consent will also authorize Signature Medicine to disclose your PHI to Signature Practice Management, LLC, a company Signature Medicine works with, to help carry out Signature Medicine administrative and related functions. The consent will also authorize Signature Medicine to work with additional organizations such as a medical billing, medical transcription, and medical data review organizations in an order to facilitate your care.

"Treatment" is the providing, coordinating or managing of your health care and related services. It includes consultations and referrals between one or more of your health care providers, such as doctors, nurses, therapists and technicians. Uses and disclosures of PHI for treatment purposes might include disclosures within Signature Medicine or between Signature Medicine and other providers. For example, a Signature Medicine physician may refer you for care to another provider, including a specialist, in order to better assure continuity of care. Signature Medicine may also use your PHI to contact you to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

"Payment" includes billing, collection and related services relating to seeking and obtaining payment from third parties (e.g., commercial insurance carriers and government payers like Medicare), and may involve communications relating to such activities as coverage determinations, claims processing, subrogation, reviews for medical necessity or appropriateness of care, and utilization review. Uses and disclosures of PHI for payment purposes may include communications with other health care providers if PHI is needed by the other providers to enable them to obtain payment for medical services provided to you.

"Health care operations" include quality assessment and quality improvement activities, licensure and credentialing activities, and training of health care and non-health care professionals.

#### **2. Other Uses and Disclosures of PHI** Signature Medicine may also use or disclose your PHI in the following circumstances:

(1) **Disclosures to Relatives and Close Friends Involved in Your Care.** Signature Medicine may disclose PHI to a family member or friend involved with your care or with handling your bills if (a) you are present (or reasonably available to us) prior to the disclosure and you agree to the disclosure, or (b) we have provided you with an opportunity to object to the disclosure and you did not object, or (c) we may reasonably infer that you do not object to the disclosure (e.g., if family or friends are present while treatment is being provided and they are participating in discussions regarding treatment). If you are not present or available, and the opportunity for you to agree or object to a use or disclosure cannot practically be provided, Signature Medicine may exercise professional judgment to determine whether a disclosure would be in your best interests. If information is disclosed to a family member or close friend, only that information which is relevant to that person's involvement with your treatment will be disclosed.

(2) **Public Health Activities.** Signature Medicine may disclose PHI for the following public health activities and purposes: (a) to report health information to appropriate public health authorities for the purpose of preventing or controlling disease, injury or





disability; (b) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (c) to report information about products under the jurisdiction of the U.S. Food and Drug Administration for quality, safety or effectiveness purposes; (d) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (e) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

(3) Victims of Abuse, Neglect or Domestic Violence. Signature Medicine may disclose PHI to a government authority, including a social service or protective services agency authorized by law to receive such reports, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

(4) Health Oversight Activities. Signature Medicine may disclose PHI to a health oversight agency that oversees the health care system and ensures compliance with the rules of government health programs such as Medicare or Medicaid.

(5) Judicial and Administrative Proceedings. Signature Medicine may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

(6) Law Enforcement Officials. Signature Medicine may disclose PHI to the police or other law enforcement officials as required by law or in compliance with a court order.

(7) Decedents. Signature Medicine may disclose PHI to a coroner or medical examiner as necessary to identify the deceased, determine the cause of death, or as otherwise authorized by law. Signature Medicine may also disclose PHI to a funeral director as necessary to carry out the funeral director's duties, including arrangements after death.

(8) Organ and Tissue Procurement. Signature Medicine may, in a manner consistent with State law, disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

(9) Research. Signature Medicine may disclose PHI without your consent or authorization for research if an Institutional Review Board approves a waiver of authorization for disclosure and authorization is not required by law.

(10) Health or Safety. Signature Medicine may use or disclose PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

(11) Specialized Government Functions. Signature Medicine may disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

(12) Workers' Compensation. Signature Medicine may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

(14) Required by Law. Signature Medicine may disclose PHI when required by federal, state or local laws.

3. Uses and Disclosures of PHI that Require Your Written Authorization Except as described in this Notice or specifically required or permitted by law, Signature Medicine will not use or disclose your PHI without your specific written, signed authorization. Even if you have signed an authorization, the authorization may be revoked by you, in writing, at any time, and once the authorization is revoked, Signature Medicine may no longer use or disclose PHI for the purpose described in the authorization (unless, and to the extent that, Signature Medicine has already taken action based upon the authorization).

## **Part 2. Your Individual Rights**

- a. Right to Request Restrictions on Uses and Disclosures of PHI If you wish, you may request that Signature Medicine restrict its uses and disclosures of your PHI for the carrying out of treatment, payment or health care operations, or you may request that Signature Medicine restrict uses and disclosures of your PHI to family members, relatives, friends or other persons identified by you who are involved in your care or the payment for your care. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Please note, however, that Signature Medicine is not required to agree to your request.
- b. Right to Request Alternate Method of Communication You have the right to reasonably request that Signature Medicine communicate with you in specific ways or at specific locations, including in order to better ensure your privacy. Requests to receive communications by specific or alternative means or at specific or alternative locations should be made to the Signature Medicine Privacy Officer at Signature Medicine, 780 Newtown Yardley Road, Suite 314a, Newtown, PA 18940, (215) 968-4804.
- c. Right to Inspect and Copy PHI You also have a right to inspect and obtain a copy of your PHI to the extent that it is contained in a "designated record set." A "designated record set" includes: medical records and billing records, and other information used by or for Signature Medicine to make decisions about your treatment. If you want access to your PHI, you will be required to complete a form and to submit the form to the Signature Medicine Privacy Officer at Signature Medicine, 780 Newtown Yardley Road, Suite 314a, Newtown, PA 18940, (215) 968-4804. Under some circumstances, Signature Medicine may deny a request to inspect or obtain a copy of some information in a record. If access is denied, you will be provided with a written denial setting forth the basis for the denial and a description of how you may exercise review rights with respect to the denial.



- d. **Right to Amend PHI** You have the right to request that Signature Medicine amend your PHI or a record about you. If you desire such an amendment, you will be required to complete a request form, including a statement explaining the reason for the requested amendment, and to submit the request to the Signature Medicine Privacy Officer at Signature Medicine, 780 Newtown Yardley Road, Suite 314a, Newtown, PA 18940, (215) 968-4804. If the request is denied in whole or part, Signature Medicine will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosure of your PHI. Signature Medicine may include a rebuttal statement with your PHI addressing your statement of disagreement.
- e. **The Right to Receive an Accounting of PHI Disclosures** At your request, Signature Medicine will also provide you with an accounting of disclosures of your PHI by Signature Medicine during the period covered by your request (which may be a period of up to six years prior to the date of your request). This accounting will not include PHI disclosures made: pursuant to your authorization; to you about your own PHI; to carry out treatment, payment or health care operations; incident to a use or disclosure which was otherwise permitted or required by law; for national security or intelligence purposes; to correctional or law enforcement officials; or prior to April 14, 2003. If you request more than one accounting within a 12-month period, Signature Medicine will charge a reasonable, cost-based fee for each subsequent accounting.
- f. **The Right to Receive a Paper Copy of This Notice Upon Request** To obtain a paper copy of this Notice of Privacy Practices, you may print it from Signature Medicine's website or contact the following individual: the Signature Medicine Privacy Officer at Signature Medicine, 780 Newtown Yardley Road, Suite 314a, Newtown, PA 18940, (215) 968-4804.
- g. **The Right to Receive Further Information or to Complain.** If you would like to receive further information about your privacy rights, are concerned that Signature Medicine may have violated your privacy rights, or disagree with a decision that Signature Medicine has made about access to your PHI, you may contact the Signature Medicine Privacy Officer at Signature Medicine, 780 Newtown Yardley Road, Suite 314a, Newtown, PA 18940, (215) 968-4804. You may also file a written complaint with the Director, Office of Civil Rights, U.S. Department of Health and Human Services. Upon request, Signature Medicine will provide you with the correct address for the Director. Signature Medicine will not retaliate against you if you file a complaint with us or with the Director.

### **Part 3. Effective Date and Duration of this Notice of Privacy Practices**

- a. **Effective Date.** This Notice of Privacy Practices is effective on July 1<sup>st</sup>, 2007.
- b. **Right to Change Terms of this Notice.** Signature Medicine may change the terms of this Notice of Privacy Practices at any time. If Signature Medicine changes the terms of this Notice, we will make the new Notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new Notice. If Signature Medicine changes this Notice of Privacy Practices, we will post the new Notice in our office waiting room and on our internet site at [www.signaturemedicineMD.com](http://www.signaturemedicineMD.com). The new Notice may also be obtained by contacting the Signature Medicine Privacy Officer.

### **Part 4. Contact Information of the Signature Medicine Privacy Office:**

You may contact the Signature Medicine Privacy Officer at:

Attn: Privacy Officer  
Signature Medicine  
770 Newtown Yardley Road  
Suite 220  
Newtown, PA 18940  
Tele: 215-968-4804



IMPORTANT INFORMATION ABOUT PROVIDER/PATIENT EMAIL

As a patient of our practice, Signature Medicine, you have the right to request we communicate with you by electronic mail (email). It is also your right to be informed in sufficient detail about the risks of communicating via email with your health care provider or office, and how we will use and disclose provider/patient email.

PLEASE READ THIS INFORMATION CAREFULLY

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be **hours or days apart**. This means that there could be a delay in receiving treatment for an acute condition.

***If you have an urgent or an emergency situation, you should not rely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient e-mail is not available to you - and seek assistance by means consistent with your needs.***

Email messages on your computer, your laptop, and/or your PDA have inherent privacy risks -especially when your email access is provided through your employer or when access to your email messages is not password protected.

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the post office.

Email messages may be inadvertently missed. To minimize this risk, the practice requires you respond appropriately to a test email message before we will allow health information about you to be communicated with you via email. You can also help minimize this risk by using only the email address that you are provided at the successful conclusion of the testing period to communicate with our office.

You agree to hold harmless the practice for information sent through email that may be lost due to technical failures.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur.

In order to forward or to process and respond to your email, individuals at our practice other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider.

Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted.

At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

X \_\_\_\_\_

**(Patient name)**



PATIENT REQUEST FOR EMAIL COMMUNICATION

**Communications over the Internet and/or using the email system are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicated this way.** Nevertheless, you may request that we communicate with you via email. To do so, you must complete this form and return it to our office.

Please be advised that:

- 1) Your Request will not be effective until you receive and respond appropriately to a test email message from our practice. Please select the test question you want to use below and provide us with your answer.
- 2) Email Restrictions: Email is not checked in a regular manner hence anything you may say will not be conveyed to the care provider in an appropriate manner. Any & all medical questions or concerns are best dealt with & should be dealt with via a telephone call or in-person visit. If you are experiencing any medical symptoms, please dial 911.
- 3) Email access is a privilege and a service convenience. The practice holds the full right to discontinue email communication with any patient at any time without any reason or advance notice.

Please provide the following information:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please specify the email address to which communications should be addressed:

Please select the question you want to use (by checking one of the boxes below) for your test email and provide your answer:

- My date of birth is : \_\_\_\_\_
- My mother's maiden name: \_\_\_\_\_
- The street number of my address: \_\_\_\_\_

Please initial each blank and sign below:

- \_\_\_\_ I certify the email address provided on this Request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.
- \_\_\_\_ I have received a copy of the IMPORTANT INFORMATION ABOUT PROVIDER/PATIENT EMAIL form, and I have read and understand it.
- \_\_\_\_ I understand and acknowledge that communications over the Internet and/or using the email system are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.
- \_\_\_\_ I understand that all email communications, in which I engage, may be forwarded to other providers, including providers not associated with this practice, for purposes of providing treatment to me.
- \_\_\_\_ I agree to hold the practice and individuals associated with it harmless from any and all claims and liabilities arising from or related to this Request to communicate via email.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of patient or personal representative Date

\_\_\_\_\_  
If personal representative, authority to act on behalf of patient



**Financial Policies & Assignment Information**

I authorize Ashish Sitapara, M.D. P.C., dba Signature Medicine (the "Practice") to release any information acquired in the course my treatment which is necessary to complete and file medical claims to my insurance company, Medicare or other responsible party on my behalf. I hereby acknowledge financial responsibility for the costs of services rendered for me or for the person for whose account I am acting as guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to the Practice or its or their assignees. I understand that I am responsible to pay for services and supplies that are not covered by my insurance plan, as well as for applicable co-payments, deductibles and coinsurance amounts. I understand that this office does not participate in Pennsylvania's Worker's Compensation or No Fault Insurance programs and that I will be responsible for payment if this visit results from a work-related injury or a car accident and is not covered by an insurance plan that is accepted by the Practice. I agree to pay attorneys fees and/or collection costs if my account is referred to an outside collection agency. This acceptance and assignment will be in force for all future services by practitioners from this office.

**PRACTICE RELATED FEES & POLICIES**

**Test Results Policy:** In accordance with good medical care, do not assume that "no news is good news" regarding test results. If you do not hear from our office within 1 week regarding any test results, you should contact the office to obtain the results.

**Broken Appointment Fee:** We understand emergencies occur and patients may need to reschedule appointments. If you need to cancel, you must notify the office via phone at least 24 hours before your appointment time. If not, or if you miss your appointment time, you will be charged a "NO SHOW" Broken Appointment Fee of \$50. If circumstances force you to run late, please advise the office via phone as soon as possible so we can plan accordingly. Exemptions may be given on a case by case basis.

**Medical Record Copy Fee:** At your request, Signature Medicine provides you with one free electronic only copy of your medical record and any physician you designate. There is a nominal charge for additional copies or for copies sent to insurance companies or attorneys or other parties. That charge, in accordance with Pennsylvania State guidelines, is \$1.48 per page for pages 1-20, \$1.10 per page for pages 21-60, and 37 cents per page for pages 61 and up in 2017. Rate is updated periodically per state regulations so above may be out of date.

**Form Completion Fee:** The practice has a policy for completion of forms & letters when requested outside of an office visit such as life insurance forms, legal forms such as Family and Medical Leave Act eligibility, disability paperwork, forms for schools, sports, or camp etc. These forms do take time to be properly completed and as such the practice charges a small nominal fee of \$10.

**Returned Check Fee:** Checks returned for insufficient funds will be charged a \$50 processing fee. We will be unable to accept any personal checks until account balance and associated services fees are paid in full. If this is a repeated occurrence, we will only be able to accept cash or credit card as method of payment.

**Prior Authorizations:** If your insurance company requires a prior authorization for a drug that is prescribed, you agree to provide the office with the appropriate form or website link where our staff can download them. Due to significant hold times with insurance companies, pharmacy benefit management companies, & mail order pharmacies, our staff cannot obtain them for you.

By my signature, I verify that I have read and fully understand the above policies and fees. Policies may be updated time to time and can be found on our website for reference. *Thank You.*

X \_\_\_\_\_  
Signature of Patient or Patient's guardian/representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of person signing above



## **Financial Notice Update**

### Annuals & Co-pays

To clarify recent insurance regulations, we are reminding patients about the annual physical financial policy, between a "free" annual and when you get a co-pay. During a physical, you may ask questions about something that bothers you or provider may review a chronic condition like high blood pressure, osteoporosis, obesity or the provider may need to dive deeper into a specific concern raised by the physical. If that occurs during a visit, you are financially responsible for any co-pay and out of pocket costs as contracted by your insurance company. Insurance companies may not allow you to schedule separate visit to return to cover the chronic conditions. And due to limited appointment times, we also cannot accommodate any requests to do so.

### TYPES OF PATIENT PAYMENTS

- 1. Co-payments** - We are contractually required by insurance carriers to collect co-payments at the time of services are rendered. The patient's appointment may be rescheduled if he/she is not prepared to make this payment.
- 2. Deductibles** - Some insurance plans require patients to pay a predetermined amount before services will be covered.
- 3. Co-insurance** - Some insurance plans require that patients pay a predetermined percentage (e.g. 20%) of the allowed charge amount. If amount can be determined at time of service, amount will be collected up front.
- 4. Non-Covered** - "Non-covered" means that a service will not be paid under a patient's insurance contract. If a patient is unsure whether a service is covered by his/her plan, it is ultimately the patient's responsibility to call his/her insurance carrier to determine what the schedule of benefits allows. If non-covered services are provided, the patient will be expected to pay for the services at the time of service. Appeal procedures are generally available and billing staff will assist patients in attempting to resolve adverse determinations. Under no circumstances will billing staff falsify or change a diagnosis or symptom in order to convince an insurer to pay for care that is not covered.



**signaturemedicine**  
Center for Wellness & Healthy Aging

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CREDIT CARD PAYMENT FORM

As a medical practice, our goal is to provide you with the best, most current medical care available in a positive and supportive environment. Today's insurance plans are becoming more complicated in how they determine what the medical practice can collect and what the patient actually owes. Insurance plans now have different co-payments and deductibles that are often confusing to their clients and can even elude the smartest medical practice office manager. What a patient actually owes once insurance pays its portion is a function of the individual's co-payments, deductible, maximum out-of-pocket expenses and where the patient falls within this continuum.

In an effort to streamline this system and make it more cost effective for everybody, we are asking every patient to provide us with a credit card at the time of service. This system is exactly like that found in all hotels, rental car agencies, gasoline stations, Amazon.com, and mail order pharmacies. Nothing will be charged to your credit card or checking account until the Explanation of Benefits (EOB) returns from your insurance company and we can enter the contractual write-offs and amount paid by your insurance company into our system. *The only amount charged to your credit card will be the PATIENT RESPONSIBILITY portion as defined by your insurance company's EOB (similar to an invoice), and/or missed co-pay, returned checks, missed appointment fees, uncovered by insurance tests performed, etc* You will receive a courtesy Email notification or mailed statement if the amount owed to us and charged to your credit card is greater than \$100.00. Thank you for your cooperation and understanding.

I authorize Signature Medicine to charge my credit card with the balance due (patient responsibility) portion of my insurance explanation of benefits (EOB), and any balance not paid for by insurance. I understand that I can dispute the charge at any time with my credit card company; however, the actual amount of the charge can only be disputed with my insurance company. If I feel the "patient responsibility" portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company. Any change in the EOB by the insurance company will be reflected as a credit or additional charge on my credit card.

I assign my insurance benefits to the provider listed above. I understand that this authorization is valid for duration of the patient-practice relationship with Signature Medicine unless I cancel through written notice.

Type of credit card:  Visa  MasterCard

Name as it appears on the card \_\_\_\_\_

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Billing Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Patient or Responsible Party Signature \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*\*\*This will not be used to balance bill. It will only be used to collect outstanding amounts owed to the practice by the patient and deemed in full compliance with all state, and federal regulatory agencies, including Medicare.*