PATIENT REGISTRATION FORM for CLIFFORD A. TAYLOR, M.D.

Name of Patient: **Date:**

Patient Address - Street:

City: **State:** **Zip code:**

Age: **Date of Birth:** **Birthplace:** **Adopted?:**

Home Phone: **Work Phone:** **Cell Phone:**

Designated phone number where a secure detailed message can be left about clinical information, billing, payment, and insurance information:

Patient Social Security:

Employer/School/Training Program: **Current year or Duration:**

Referred by?:

Name of spouse/significant other: **May we contact in case of an emergency?**
(or closest relative) **Phone Number:**

Citizenship: **Immigration status:** **Native Language:**

Racial/cultural/ethic background: **Gender Identification:**

Occupation: **Yearly Income(optional)** **Retired?** **If so when?**

Own home? **Rent?** **Receive alimony?** **Pay alimony?**

Marital or Family Status: **How long?** **Number of children?**

Number adopted? **Number step children?** **Number foster children?** **Number deceased?**

Religious or Spritiual Preference (optional): **Political affiliation?(optional)**
Military Status?

Disabilities?

Currently designated as medically or psychiatrically disabled?

Currently on disability leave ? **Receiving Disability Income?**

Family doctor's name: **Phone:**

Allergies? **Pharmacy:**
Pharmacy ID#: **Phone:**

Current Medications Name: **Dose:** **Prescribed by whom?**

Bill to (if other than patient) Name: **Relationship to patient:**

Date of Birth: **Social Security #:**

Address:

City: **State:** **Zip code:**

Please note: PAYMENT IS DUE AT THE TIME OF VISIT. PAYMENT OPTIONS ARE CHECK, CREDIT/DEBIT CARD, CASH, THE PARTY RESPONSIBLE FOR PAYMENT AGREES TO PAY REASONABLE ATTORNEY FEES, COURT COSTS AND COLLECTION COSTS IN THE EVENT THAT INSTITUTION OF LEGAL PROCESSING IS NECESSARY TO COMPEL PAYMENT OF A DELINQUENT ACCOUNT

_____

SIGNATURE OF PARTY RESPONSIBLE FOR PAYMENT

CONFIDENTIAL PATIENT HISTORY

The following information will help to expedite your evaluation/consultation and will remain confidential. Please indicate a positive history or concern by noting the appropriate topics with a check mark. Please feel free to give this directly to the doctor. If you have any questions please discuss them directly with Dr. Taylor.

	Anxiety		Dyslexia		Emotional Disability Illness
	Panic		Attention Deficit Disorder		Physical Disability Status
	Performance Anxiety		Learning Disabilities		Death of Child/Children
	Depression		Hyperactivity		Death of Spouse
	Post Partum Depression		Memory Deficits		Death of Friend
	Stress Overload Feelings		Developmental Delays		Death of Sibling (s)
	Excessive Anger		Amnesia		Death of Significant Other
	Mania		Stuttering/Stammering		Death of Parent
	Suicidal Ideation		Abnormal Movements		
	Homicidal Ideation		Narcolepsy		
	Sexual Misconduct		Alcohol Use		Ongoing care of medically or
	Sexual Disorder		Alcohol Abuse		Emotionally ill relative or spouse
	Phobia		Tobacco Use		Significant other
	Obsessions		Caffeine Use		
	Compulsions		Other Substance Abuse		Relationship problems
	Hallucinations		Performance Enhancing Drugs		Extramarital relations
	Delusions		Over the counter medications		Recent unemployment
	Paranoia		Vitamins/Supplements Use		Stressful recent relocation
	Confusion		Poor Job Performance		
	Stealing		Fired from job		Regular exercise
	Vandalism		Poor school performance		Meditation/Relaxation exercises
	Physical Abuse Victim		School Truancy		High School Graduation
	Torture Victim		School suspension/expulsion		Trade School/Vocational School
	Sexual Abuse Victim		Assaultive behavior		College Graduation
	Rape Victim		DWI/DUI		Adult Education Classes
	Kidnap/Abduction Victim		License suspended/revoked		Graduate School
	Natural Disaster Victim		Conviction of felony		
	Man Made Disaster Victim		Imprisonments/Incarceration		OTHER (explain)
	War Experience Victim		Recent Severe Injury		
	Political Exile Victim				
	Violent Crime Victim		Recent severe mental illness		
	Divorce		Recent major surgery		
	Separation		Currently Pregnant		
	Head Injury		Miscarriage		
	Seizures		Termination of pregnancy		
	Meningitis		Use of Birth Control pills		
	Encephalitis		Other contraception		
	Hypochondriasis		Infertility		
	Stroke		PMS		
	Toxic Exposures		Menopause		
	Birth Injury		Perimenopause		
			Sexually Transmitted Illness		

_____ _____

Patient Signature Date

Clifford A. Taylor, M.D.
261 James Street, Suite 2ER
Morristown, NJ 07960

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN REQUEST ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We reserve the right to make changes to these policies consistent with federal law.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment: Providing, coordinating, or managing health care and related services by one or more health care providers. We may also communicate with your pharmacy for medication prescriptions.
- Payment: Such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operations: The business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions and customer service.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to confirm or change appointments or regarding your treatment or other health related benefits or services that may be of interest to you.

We may use and disclose your personal health information to the extent permitted or required by law and in a manner which is limited to relevant requirements of such law. Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practice* containing a more complete description of the uses and disclosures of my heath information. I understand that this organization has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I have attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Clifford A. Taylor, M.D.
Office Policies

In order to manage our office efficiently and provide optimal care to you, the following office policies are detailed for you.

Appointments & Cancellations

- When scheduling an appointment, please inform the receptionist of amount of time needed for your appointment.
- Telephone sessions are available if you are not within reasonable traveling distance or in case of emergency or illness; however, telephone sessions are not regular substitutes for office sessions.
- 24-hour notice is required for cancellations with the receptionist during business hours (Mon-Fri).
- If less than 24-hour notice is given to our office you will be billed for the amount of time reserved for your session. Exceptions include personal illness, and extreme weather conditions. Please do not leave cancellation messages on weekends.
- If you fail to keep an appointment, you will be billed for the amount of time reserved for your session. Missed appointments cannot be billed to insurance carriers.
- It is not our responsibility to remind you of your appointments however, efforts will be made to inform you if you have missed an appointment.
- Patients taking prescription medications must be evaluated at least twice yearly.

Prescription Refills

- 2 days notice is required for prescription refills. This allows time for the prescription to be reviewed and evaluated by the doctor. Please do not wait until you are out of medication to contact our office or your pharmacy.
- No non-emergency prescriptions will be filled on Friday's after 2:00 p.m., so please make sure you have enough medication for the weekend.
- The patient must call in for refills, we do not accept refill requests from pharmacies.

- Requests for renewal of certain controlled substance medications can only be refilled by Dr. Taylor and must be picked up in person in the office.

Insurance

- We do not participate in Medicare or Medicaid.
- We do not participate in any commercial insurance plans, but we will submit to your insurance company as a courtesy for reimbursement to you. Insurers do not determine our customary and usual charges.
- It is your responsibility, not our office, to follow up with the insurance company regarding payment of claims.
- It is your responsibility to keep your insurance information current with the office.
- Remember to notify the office of any change of address, or telephone number.

Payment **Initials_____**

Payment is due at the time of the office visit, and not contingent upon payment by the insurance.

- Any other payment arrangements must be pre-approved with Dr. Taylor.
- There may be a charge for time required to complete lengthy reports.
- There may be a charge for extended telephone discussions about treatment issues.
- Payment options are check , cash, MasterCard or Visa.
- There will be a monthly late fee of $25.00 imposed on accounts outstanding for over 90 days.
- The party responsible for payment agrees to pay reasonable attorney fees, court costs and collection costs in the event that Institutions of legal proceedings is necessary to compel payment of a delinquent account.

Signature:_____Date:_____

PRIMARY INSURANCE INFORMATION

Patient Name: _____ Relationship to Insured;___ _____

Insured Name:_____ Insured Date of Birth:_____

Insured Address:_____

_____

Name of Insurance Co:_____

Address of Insurance Company:_____

_____Phone Number: _____

Insurance ID#_____ Group #:_____

SECONDARY INSURANCE INFORMATION

Patient Name: _____ Relationship to Insured;___ _____

Insured Name:_____ Insured Date of Birth:_____

Insured Address:_____

_____

Name of Insurance Co:_____

Address of Insurance Company:_____

_____Phone Number: _____

Insurance ID#_____ Group #:_____

Clifford A. Taylor, MD
261 James Street
Suite 2ER
Morristown, NJ 07960
(973)540-1656

CREDIT CARD INFO TO KEEP ON FILE

DATE:_____

PATIENT NAME:_____

CARD HOLDER NAME:_____

CARD #:_____ EXP DATE:_____

VCODE:_____

NUMERIC PORTION OF BILLING ADDRESS:_____

BILLING ZIP CODE:_____

PLEASE KEEP THIS CARD ON FILE AND USE FOR ALL VISIT CHARGES UNTIL I ADVISE YOU IN WRITING TO DISCONTINUE.

CARD HOLDER SIGNATURE