RONALD W. LI, M.D. – EAR, NOSE AND THROAT

PRINCETON, NJ ♦ 609-921-1000 www.DrLiMD.com CRANBURY, NJ ♦ 609-655-3000
800 Bunn Drive, Suite 305 2650 US Highway 130 and Dey Road, Suite B

PATIENT REGISTRATION FORM – Date: _____

Name _____ _____ _____ _____ _____ _____ ____
Title Last First Middle Birthdate Sex

Home _____ _____ ____ _____
Address Street City State Zip

Phone _____ _____ _____
Numbers Home # Cell # Work #

_____ _____ _____
Social Security # E-mail Fax #

_____ _____
Pharmacy Name/Address and Zip code Primary Care Physician Name/Address

_____ _____ _____
Marital status Employment status Occupation Primary language spoken at home

Race: ❑ Asian ❑ Black ❑ Hispanic ❑ White **And** ***Ethnicity:*** ❑ Latino ❑ Not Latino ❑ patient refused

Please, tell us how you learned about our office. Circle **all** that apply: Doctor, Family, Friend, Yellow pages, Insurance, Internet, or provide the specific source(s): _____

INSURANCE INFORMATION

_____ _____
Primary Plan Secondary Plan

_____ _____
Policy Holder Name & Social Security # Policy Holder Name & Social Security #

_____ _____
Policy # Policy #

_____ _____ _____ _____ _____ _____
Group# Co-Pay Yearly Deductible Group# Co-Pay Yearly Deductible

SEND MY BILLS AFTER INSURANCE TO:

_____ _____
Title Last name: First Name Relationship to Patient

_____ _____
Street Address City/State/Zip code

_____ _____ _____
Home Phone Cell Phone Work Phone

PARENT/ SPOUSE OR EMERGENCY CONTACT

_____ _____
Title Last Name First Name Street Address

_____ _____ _____
Relationship to Patient Phone City/State/Zip

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INFORMATION CONCERNING FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we would like to help you receive you maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy.

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Mastercard, Visa and Discover cards. We only bill insurance carriers with whom we participate (have signed an agreement with).

Regarding Managed Care Insurance with which we participate: You are responsible to supply our staff with ALL your insurance cards at each visit and to notify us of any changes to your insurance coverage. If your insurance company requires a referral from your primary doctor, you **must** have a valid referral before being seen, as we cannot bill your insurance without it. If you do not obtain a referral you will be required to pay for your visit in full at the time of service. If your insurance requires a co-pay, it must be paid at the time of the appointment. You will also be responsible for the payment of your yearly deductible. Please remember that our relationship is with you, not your insurance company. We may need your help in resolving a billing issue with your insurance company.

We do participate with Medicare. This means that we will submit your claim to Medicare. The 20% difference between what Medicare "allows" and what it "pays" will be sent to your secondary insurance if you have one. If not, the remainder of the bill will be sent to you.

Regarding Non-Participating Insurances: If we do not participate with your insurance, the bill is your responsibility and is due at the time of service.

Return Check Fee: $35.00. Our bank charges us a fee for any check that is returned for "insufficient funds" and this will be added to the patient's bill if this occurs.

Collections Policy: Any outstanding balance for which the patient is responsible is due within 30 days of billing. There will be an interest charge of 1% per month that will accrue on any balance over 30 days old. Any account that has gone 60 days without payment is subject to immediate collection process. Accounts that go to collection will be subject to a $50.00 charge.

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns please feel free to ask.

I have read the above financial policy of the office of Ronald W. Li , M.D.. I understand and agree with its terms. I certify that I have provided this office with all of my medical insurance cards. The office does not accept liability regarding insurances that are not provided at time of service.

_____ _____ _____

Signature of Patient, Parent or Guardian **Date**

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CONSENT TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

I,_____OF _____
PATIENT NAME PATIENT ADDRESS

GIVE RONALD W. LI, M.D. MY CONSENT TO USE AND DISCLOSE ANY AND ALL PROTECTED HEALTH INFORMATION CREATED BY THE OFFICE OF DR RONALD LI, M.D. AND/OR MAINTAINED IN MY "MEDICAL RECORD" (DEFINED TO INCLUDE ALL MEDICAL REPORTS, DIAGNOSIS, CLINICAL ABSTRACTS, CASE HISTORIES, PROPOSED TREATMENT PLANS AND PROGNOSIS, X-RAY REPORTS, INSURANCE INFORMATION AND/OR ANY OTHER INFORMATION) AS NECESSARY TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

I UNDERSTAND THAT A COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES THAT MAY BE MADE OF MY HEALTH INFORMATION ARE SET FORTH IN OUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW THE NOTICES OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. I UNDERSTAND THAT THIS GROUP WILL PROVIDE ME WITH A REVISED COPY.

I UNDERSTAND THAT THE GROUP MAY REFUSE TO PROVIDE TREATMENT TO ME IF I DO NOT EXECUTE THIS CONSENT. I FURTHER UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST THE GROUP RESTRICT HOW MY MEDICAL RECORD IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. HOWEVER THE GROUP IS NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS. IF THE GROUP DOES AGREE WITH MY REQUESTED RESTRICTIONS, SUCH RESTRICTIONS WILL BE BINDING ON THE GROUP.

I UNDERSTAND THAT THE SPECIFIC INFORMATION RELEASED MAY CONTAIN INFORMATION IN REFERENCE TO ALCOHOL/DRUG, SEXUALLY TRANSMITTED DISEASES, HIV/AIDS INFECTION AND/OR PSYCHIATRIC CONDITIONS AND THE TREATMENT OF THESE DISORDERS. HOWEVER, I UNDERSTAND THAT AN ADDITIONAL AUTHORIZATION WILL BE REQUIRED IN MOST CASES BEFORE THE GROUP MAY USE OR DISCLOSE ANY PSYCHOTHERAPY NOTES.

I UNDERSTAND THE TERMS OF THIS CONSENT ARE GOVERNED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AND ITS IMPLEMENTING REGULATIONS ("HIPPA"). I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS CONSENT, AT ANY TIME, EXCEPT TO THE EXTENT THAT THE GROUP HAS TAKEN ACTION RELIANT THEREON. I UNDERSTAND THAT ANY REVOCATION MUST INCLUDE MY NAME, ADDRESS, TELEPHONE NUMBER, DATE OF THIS CONSENT AND MY SIGNATURE AND THAT I SHOULD SEND IT TO:

RONALD LI, M.D.
2650 US 130 AND DEY ROAD
SUITE B
CRANBURY, NJ 08512

_____ _____
SIGNATURE **DATE OF CONSENT**

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CONTACTING YOU

As part of the Federal Guidelines governed by the Health Insurance Portability And Accountability Act of 1996, and it's implementing regulations ("HIPPA"), please check each space below, thereby allowing our office to contact you in the following manner:

____ Your home phone number

____ Leaving a VOICEMAIL message to any answering device

____ Your work phone number

____ Your cell phone number

____ Any family member or next of kin at any phone number you have provided

____ By Fax

____ By E-Mail which you have provided

____ Via US Mail

BE SURE TO CHECK EACH ONE THAT APPLIES

_____	_____	_____
Print Name	**Sign Name**	**Date**