ISLAND MEDICAL
PROFESSIONAL ASSOCIATION

1812 Long Beach Boulevard Ship Bottom, NJ 08008

HARRY L. LARKIN, M.D.
DIPLOMATE OF THE AMERICAN BOARD OF FAMILY MEDICINE

JAMES N. SUDDETH, M.D.
FELLOW OF THE AMERICAN BOARD OF FAMILY MEDICINE
DIPLOMATE OF THE AMERICAN BOARD OF GERIATRICS

PAUL W. PROSPERI, D.O.
DIPLOMATE OF THE AMERICAN BOARD OF FAMILY MEDICINE

Name:_____
First Middle Last Maiden

I prefer to be called: _____ **Date of birth:**_____ **Social Security #:**_____

Home Phone #:_____ **Cell Phone #:**_____ **Work #:**_____ **(circle preferred #)**

Home Address:_____
Street City State Zip Code

Employer:_____ **Occupation:**_____

Employer Address:_____
Street City State Zip Code

Marital status: _____ **Male**____ **Female**_____ **Email:**_____

Pharmacy name:_____ **Pharmacy phone #:** _____

Pharmacy Address:_____ **Zip Code:** _____

Person responsible for account:_____ **Consent to receive text/email appt. alerts? Yes**____ **No**____

PARENT/GUARDIAN (IF PATIENT IS A MINOR)

Name:_____
First Middle Last Maiden

Relationship to patient:_____ **Social Security #:**_____

Home Phone #:_____ **Cell Phone #:**_____ **Work #:**_____ **(circle preferred #)**

Home Address:_____
Street City State Zip Code

Employer:_____ **Occupation:**_____

Employer Address:_____
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EMERGENCY CONTACT INFO:

Name: _____ **Relationship:** _____

Home Phone #: _____ **Cell Phone #:** _____ **Work #:** _____

INSURANCE CARRIER

Name: _____ **Date of birth:** _____
First Middle Last

Home Address: _____ **Social Security #:** _____
Street City State Zip Code

Home Phone #: _____ **Work #:** _____ **Relationship to patient:** _____

Employer Name/Address: _____
Street City State Zip Code

Please list your **CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS:**

NAME	DOSAGE(e.g., MG)	HOW TAKEN (e.g.,1 tablet daily

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Please list any ALLERGIES to medications/foods:

Allergy	Type of Reaction (e.g., rash, nausea)

Please provide your **IMMUNIZATION HISTORY:** **Immunization Preference (circle one):** Traditional None

	Yes	No	Date		Yes	No	Date
Tetanus-Diphtheria Booster				Hepatitis A Vaccine			
Influenza Vaccine (Flu Shot)				Hepatitis B Vaccine			
Pneumococcal Vaccine				Human Papilloma Virus (HPV)			
Tuberculosis (TB) Skin Test				Varicella Vaccine			

Please provide your **PAST MEDICAL HISTORY**:

____ Allergies	____ Blood Clots	____ Hepatitis C	____ Osteoporosis
____ Anemia	____ Cancer,type _____	____ High Cholesterol	____ Peptic Ulcer Disease
____ Angina (chest pain)	____ CVA	____ High blood pressure	____ Renal Disease
____ Anxiety	____ COPD(emplysema)	____ Irritable bowel disease	____ Seizure Disorder
____ Arthritis	____ CAD(Heart Disease)	____ Liver Disease	____ Ulcerative Colitis
____ Asthma	____ Depression	____ Migraine headaches	____ Thyroid Disease
____ Atrial Fibrillation	____ Diabetes	____ MI(Heart Attack)	Other: _____
____ BPH(enlarged prostate)	____ GERD(reflux)	____ Osteoarthritis	

PAST OPERATIONS: What operations have you had?

Type of Operation	When it happed	Doctor or Hospital

PATIENT SIGNATURE: _____ **DATE:** _____

Medical Information Release Form

HIPAA Release Form

Name:_____ Date of Birth:_____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Name_____ Relationship: Telephone#_____

[ ] Name_____ Relationship: Telephone#_____

[ ] Name_____ Relationship: Telephone #_____

[ ] Information is "Not" to be released to anyone.

The release of information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] Other_____

The best time to reach me is (day)_____ between (time) _____

Signature:_____ Date: _____/_____/_____

Witness:_____ Date:_____/_____/_____

PRINT NAME:_____ **Date of Birth:**____/_____/_____

PRACTICE POLICIES

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. Insurance: We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

2. Patient payment: All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract
with your insurance company.

3. Medical Records: There is a $1 fee per page for Medical Records. Upon receipt of request records will be processed within 30 days. This fee must be paid before the forms are mailed or picked up

4. Registration: All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

5. Claims: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

6. Uninsured/Non-Participating patients: Please be advised that the charges are paid at the time of service. If a balance remains, you will receive a statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action. Note: For Non-Participating insurances IMPA will not be able to obtain any authorization or referrals on your behalf.

7. Medication Policy: It is important to your health that you follow the directions carefully on all medications that we prescribe. In addition, we must be informed of all other medications, prescription, over-the-counter and supplements that you are taking. If there is an unavoidable reason that you cannot make an appointment, **we require a 3-day notice for a medication refill.**

8. Missed appointments: We require 24 hours notice if you intend to cancel your appointment. Should you cancel, reschedule or no-show for an appointment, we reserve the right to charge a no-show fee of $25.00. These charges will be your responsibility and billed directly to you. **Please help us serve you better by keeping your regularly scheduled appointment.**

9. Authorization to Release Information and Assignment of Benefits:
I hereby assign all medical benefits to which I am entitled, including Medicare, Blue Cross Blue Shield and commercial insurance to Island Medical Professional Association. I understand that I am fully responsible for all charges whether or not they are covered by said insurance. I hereby authorize assignee to release any information necessary to secure payment on my behalf.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We are committed to providing the best possible treatment and ask your cooperation in following our policies.

I have read and understand the financial policy and agree to abide by its guidelines.

X _____ **Date** _____

SIGNATURE