Patient Name: _____ DOB: _____

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I,_____, have received a copy of Lifeline Medical
Patient Name
Associates, LLC's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Patient Name: _____ DOB: _____

PATIENT INFORMATION		
NAME (LAST, FIRST)		
SSN#	DOB	SEX
STREET ADDRESS		
CITY	STATE	ZIP CODE
CELL PHONE	EMAIL	
PRIMARY CARE PROVIDER (PCP)	PCP OFFICE PHONE	

PRIMARY INSURANCE		
NAME OF INSURANCE		
POLICY NUMBER		
GROUP NUMBER		
P.O. BOX ADDRESS (Check back of card)		
NAME OF POLICY HOLDER	DOB	RELATIONSHIP TO PATIENT
CELL PHONE		

SECONDARY INSURANCE (IF APPLICABLE)		
NAME OF INSURANCE		
POLICY NUMBER		
GROUP NUMBER		
P.O. BOX ADDRESS (Usually on back of card)		
NAME OF POLICY HOLDER	DOB	RELATIONSHIP TO PATIENT
CELL PHONE		

I authorize the release of medical information to process the claims for medical benefits and any payment of medical benefits to LMA, LLC.

I agree to pay all costs of collection and attorney's fees associated with collection due to services rendered and performed. I am financially responsible to LMA and its successors and assign any individual it may designate for any balance not covered by insurance.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

Patient Name: _____ DOB: _____

PROSPECT OBGYN

Maria R. KeanChong, M.D. Melissa Prior, APN

Jonathan Jimenez, D.O. Jessica Androsiglio, APN

Gabriela Ross, M.D. Yvonne Matthews, APN

20 Prospect Avenue, Suite 705, Telephone: (201) 880-4949

Hackensack, NJ 07601 Fax: (973) 852-1747

HIPAA Authorization for Verbal Release of Protected Health Information

I, _____ give permission to: Prospect OBGYN and its employees. To Release the information regarding appointments dates/times and protected health information, including; but not limited to, insurance, address, phone numbers, test results, health care information, and treatment to the following:

If you do not wish to include anyone on your HIPAA form please mark the line(s) with an "X" and sign the bottom of the page.

Name of Person: _____ Relationship to Patient: _____

I understand that:

I may revoke this authorization at any time, in writing. My revocation may not apply to the information already retained, used or disclosed in response to this authorization.
Unless the purpose of this authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon the signing of this Authorization.
Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
The information Authorized for release may include information which may indicate the presence of a communicable disease or non-communicable disease.
The information authorized for verbal release may also include protected health information related to mental health.
It is my responsibility to update the above contact names and numbers, in case they should change. I must do so by contacting Prospect OBGYN and its' employees requesting a new form to be filled via:

- **Mail:** 20 Prospect Avenue, Suite 705, Hackensack, NJ 07601
- **Fax:** 973-852-1747

_____ _____

Patient Signature Date