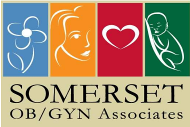

PATIENT REGISTRATION FORM

(Please Print)

Patient #____________________

Patient's Name	**Maiden Name/Other Names**
Street Address	**Home Phone** ____________ **Cell Phone** ____________
City **State** **Zip**	**CAN WE LEAVE CONFIDENTIAL MESSAGE?** ☐ **YES** ☐ **NO** ☐ **HOME** ☐ **CELL** ☐ **WORK**

Marital Status S M W D Sep	**Date of Birth**	**Age**	**Social Security #**

Primary Care Physician: **Referred By:**

Employed by	**Occupation**
Street Address	
City	**Business Phone**
Subscriber or Policyholder **Social Security #**	**Date of Birth**
Employed by	**Occupation**
Address	**Business Phone**

PLEASE READ: Payment is due at the time of service, unless we agree otherwise in advance. You are responsible for all fees regardless of insurance coverage If your insurance requires a second opinion, or precertification, it is your responsibility to make the necessary arrangements before surgery is scheduled. Please be aware that ancillary services may not be covered in this office. A copy of your insurance card(s) is required to verify the carrier information.

Primary Insurance	**Secondary Insurance**
Insurance Company:	**Insurance Company**
Address	**Address**
City **State** **Zip**	**City** **State** **Zip**
Policy Holder (Company if group)	**Policy Holder (Company if group)**
Group #	**Group #**
Policy # or ID #	**Policy # or ID #**
Effective Date **Verification Telephone #**	**Effective Date** **Verification Telephone #**

I hereby authorize Somerset OB/GYN Associates to furnish information to insurance carriers concerning my illness (including mental disorders, drug or alcohol abuse and sexually transmitted diseases) and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself.

I understand I am financially responsible for charges not covered by insurance plans in which Somerset OB/GYN participates and any applicable copays and deductibles. Some insurance plans do not cover ancillary services in our office.

____________________ ____________________

Signature Date

(A) Notifier(s):
(B) Patient Name: **(C) Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***(D)***_____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ***(D)***_____________ below.

(D)_______________	***(E)*** **Reason Medicare May Not Pay:**	***(F)*** **Estimated Cost:**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ***(D)***_____________listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) **OPTIONS:** **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the ***(D)***__________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the ***(D)***__________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

❑ **OPTION 3.** I don't want the ***(D)***__________listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) **Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) **Signature:**	***(J)*** **Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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Ayanna R. Woltz, MD, FACOG
Matilda Miranda, MD, FACOG
Carmine P. Errico, MD, FACOG
Sambra Bernstein, MD

Michelle Liddy, CNM
Jody A. Darwick, WHNP
Christine J. Kurnath, APN

OBSTETRICS • GYNECOLOGY

Mammography • Ultrasound • Dexa Scan

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date ______________________

To Whom It May Concern:

I, ____________________ of ______________________________ __________,
(patient's name) (patient's address) (patient's date of birth)

do hereby authorize,____ to release the medical records in your possession. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose(s) and may include the following items (unless crossed out by me).

- drug and alcohol abuse
- information regarding human immunodeficiency virus (HIV), including laboratory results
- diagnosis of AIDS, if applicable
- history and physical examination
- consultations
- genetic testing and counseling, if applicable
- diagnostic testing, excluding HIV testing
- discharge summary
- psychosocial history
- treatment recommendations
- other (specify) ____

From ________________________________ to ____________________________
date date

☐ I will pick up **OR** The information may be sent to: ______________________________

____
(ADDRESS)

According to the New Jersey Administrative Code, Title 8 Department of Health and Senior Services, Chapter 43G, Hospital Licensing standards subchapter 15. Medical Records:

The fee for copying records shall not exceed $1.00 per page or $100 per record for the first 100 pages. For records which contain more than 100 pages, a copying fee of no more than $0.25 per page may be charged for pages in excess of the first 100 pages up to a maximum of $200 for the entire record.

Sincerely,

Signed ______________________________

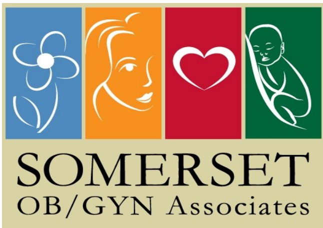
____
Patient's Phone Number

Witness ______________________________

P.O. Box 6130
Bridgewater, NJ 08807
908-725-5068

215 Union Avenue
Bridgewater, NJ 08807
908-722-2900

1 New Amwell Road
Hillsborough, NJ 08844
908-874-5900



OBSTETRICS • GYNECOLOGY

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Dear Patient:

We are providers for many plans and it is impossible for us to know the details and restrictions of every plan. It is essential that you know the services covered by your insurance plan. For example, some insurers do not reimburse for annual preventive examinations and any labwork associated with the visit. Also, referral requirements vary from plan to plan. It is important for you to state the reason for your visit to both your health care provider and the check-out receptionist.

The State of New Jersey has passed a law which makes it impossible for us to bill you, and in some cases, your insurance company for most laboratory services. When possible, we will draw blood and you will be billed by the laboratory. In some cases, we will give you a prescription to take to the laboratory who will perform the venipuncture. Be aware that if laboratory work is denied by insurance, it will become your responsibility and you will be billed by the laboratory.

During the course of your evaluation and treatment, labwork including but not limited to paps, bloodwork and ultrasound examinations may be ordered. Occasionally, these tests may need to be repeated because the information obtained, through no fault of yours or ours, is incomplete. Although this may be inconvenient, it is unavoidable. The usual copayment will be assessed if a return visit is needed.

Should we provide you with services that are not covered by your insurance, and payment is denied by your insurance, we will bill you and expect payment from you for these services. Please sign below with today's date, to indicate that you agree to assume responsibility for payment for non-covered services.

Sincerely,
Somerset OB/GYN Associates

Patient's signature	Date	Insurance Company	Pt. Initials	Date

Patient's signature	Date	Insurance Company	Pt. Initials	Date

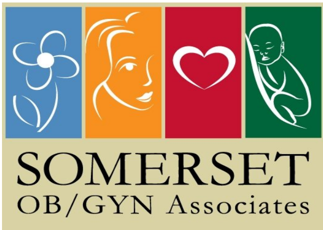
Patient's signature	Date	Insurance Company	Pt. Initials	Date

Accredited by American College of Radiology

MAILING ADDRESS
P.O. Box 6130
Bridgewater, NJ 08807

TEMPORARARY LOCATION
250 Bridgewater Plaza-Route 28 West
Bridgewater, NJ 08807
908-722-2900
908-722-1856 (Fax)

OFFICE LOCATION 2
1 New Amwell Road
Hillsborough, NJ 08844
908-874-5900
908-874-8626 (Fax)



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OBSTETRICS ● GYNECOLOGY

Mammography ● Ultrasound ● Dexa Scan

Dear Patient:

Many patients have a form of managed care insurance. Under the same managed care insurance, plans have variations depending on the employer who contracted with the insurer. We are providers for many plans and it is impossible for us to know the details and restrictions of every plan.

It is essential that you know the services covered by your insurance. For example, some insurers do not reimburse for annual preventive examinations and any labwork associated with the visit. Also, referral requirements vary from plan to plan. It is important for you to state the reason for your visit to both your health care provider and the check-out receptionist.

The State of New Jersey has passed a law which makes it impossible for us to bill you, and in some cases, your insurance company for most laboratory services. When possible, we will draw blood and you will be billed by the laboratory. In some cases, we will give you a prescription to take to the laboratory who will perform the venipuncture. Be aware that if laboratory work is denied by insurance, it will become your responsibility and you will be billed by the laboratory.

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Should we provide you with services that are not covered by your insurance, and payment is denied by your insurance, we will bill you and expect payment from you for these services. Please sign below with today's date, to indicate that you agree to assume responsibility for payment for non-covered services.

Sincerely,
Somerset OB/GYN Associates

Patient's signature	Date	Insurance Company	Pt. Initials	Date

Patient's signature	Date	Insurance Company	Pt. Initials	Date

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SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Somerset OB/GYN Associates

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP), which is attached. If you have any questions about this notice, please contact Practice Manager, Somerset OB/GYN Associates Privacy Official at (908) 722-2900.

WHO WILL FOLLOW THIS NOTICE:

- Somerset OB/GYN Associates

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

- **Appointment Reminders**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from Practice Manager, Somerset OB/GYN Associates at (908) 722-2900.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Practice Manager, Somerset OB/GYN Associates Privacy Official. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

HIPAA NOTICE OF PRIVACY PRACTICES

Somerset OB/GYN Associates

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact Practice Manager, Somerset OB/GYN Associates at (908) 722-2900.

WHO WILL FOLLOW THIS NOTICE:

- Somerset OB/GYN Associates

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;

- give you this notice of our legal duties and privacy practices with respect to health information about you; and

- follow the terms of the notice that is currently in effect.

The following categories describe different ways that we use and disclose health information.
For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctors' office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take X-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, if a dentist is treating you and you are pregnant and need X-rays, they call our office to get our approval. Another situation would be a doctor might need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

As Required By Law. We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify person or organization required to receive information on FDA-regulated products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release health information if asked to do so by a law enforcement official:

- in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person:
    - Name and Address
    - Date of birth or birth place;
    - Social security number;
    - Blood type or Rh factor;
    - Type of injury
    - Date and time of treatment and/or death, if applicable; and

- about the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at our facility; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors. We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Practice Manager, Somerset OB/GYN Associates Privacy Official. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request.). State law permits us to charge $1.00 per page up to $100 maximum for paper copies. We assess this charge when providing copies to patients other physicians, insurance companies, attorneys courts, other. Payment shall be demanded before copies are provided.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the

information. To request an amendment, your request must be made in writing, submitted to Practice Manager, Somerset OB/GYN Associates Privacy Official, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures. You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing to Practice Manager, Somerset OB/GYN Associates Privacy Official. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for
the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Practice Manager, Somerset OB/GYN Associates Privacy Official. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing to Practice Manager, Somerset OB/GYN Associates Privacy Official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this notice at any time. However, at the time of first service rendered after April 14, 2003, it is required that you receive a paper copy. To obtain a copy, please request it from Practice Manager, Somerset OB/GYN Associates Privacy Official.

CHANGES TO THIS NOTICE.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Practice Manager, Somerset OB/GYN Associates Privacy Official. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, date. This acknowledgement will be filed with your records.

****

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________________, have received the Notice of Privacy Practices from Somerset OB/GYN Associates.

Signature: ____________________________________

Date: ___________________

In lieu of patient signature, I, ____, a staff member of Somerset OB/GYN Associates, state that

____ has been given our current Notice of Privacy Practices.

Signature: ____

Date: __________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I, ___________________________________, have received the Notice of Privacy Practices from Somerset OB/GYN Associates.

Signature: ___________________________________

Date: _______________________________________

In lieu of patient signature, I, ____, a staff member of Somerset OB/GYN Associates, state that ______________________________ has been given our current Notice of Privacy Practices.

Signature: ___________________________________

Date: _______________________________________