MARO GROUP
INTERNAL MEDICINE

ROBERT J. MARO, M.D., P.A.

701 Cooper Road, Suite #16, Voorhees, Nj 08043
856-429-224 fax 856-429-1926

WELCOME TO OUR PRACTICE

Patient Bill of Right

- As a patient you have the right to be treated fairly and honestly
- You have the right to be treated on an emergent basis when warranted

As A Provider We Reserve The Right To:

- Discharge you for not adhering to practice policies after a 30-day written notice.
- For abusive treatment of our staff
- For routinely missing appointments and not calling to cancel
- For activities that can be considered potentially fraudulent or abusive by your carrier or the government
- To inform you if a procedure may not be covered by your insurance, a signed ABN will be required

As A Patient You Are Required To:

- Pay Co-payment and/or Deductible
- Present for all appointments 15 minutes prior to the schedule time for paperwork and financial agreements
- Present your insurance information/changes to our practice at each visit
- Clear all prior balances before receiving additional treatment

As A Patient You Are Required To:

- Pay co-payments
- Pay deductible amounts

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New Patient Intake Form

Patient Data

Name _____ Date_____ Email _____

*Email will not be shared and will only be used for occasional office announcements and appointment reminders

Address_____ City_____ State_____ Zip Code_____

Cell Phone_____ Home Phone_____ Work Phone _____

Sex ☐ M ☐ F Birth Date_____ Age_____ Social Security_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Number of Children _____

Occupation _____ Employer_____

Spouse's Name _____ Spouse's Occupation _____ Spouse's Employer_____

Emergency Contact _____ Phone _____

How did you hear about this clinic? _____ Name of person who referred you _____

Current Complaints

Nature of the injury: ☐ Automobile ☐ Work ☐ Other

Please Describe _____

_____

What caused the problem? _____

Date of injury _____ Date symptoms appeared _____

Did your pain come on: ☐ Suddenly ☐ Gradually Is the pain: ☐ Mild ☐ Moderate ☐ Severe

Do you experience pain every day? ☐ Yes ☐ No

Do changes in weather affect your symptoms? ☐ Yes ☐ No

Do your symptoms interfere with daily life? ☐ Yes ☐ No

Do you wear orthotics? ☐ Yes ☐ No

Does the pain wake you up at night? _____

Do you take vitamins or supplements? _____

Are your symptoms worse at certain times of the day?

Payment Information

Name of party responsible for payment_____ Phone_____

Do you have health insurance? ☐ Yes ☐ No Name of insurance company _____

***If auto accident, please provide:**

Insurance company name _____ Contact person _____

Phone_____ Claim number _____

Patient Signature _____ Doctor Signature _____

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Medical History

Have you been treated for any conditions in the last year? ☐ Yes ☐ No

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? ☐ Yes ☐ No

What medications are you taking and for what conditions? Please list dosage and amounts

_____

What vitamins minerals or herbs do you currently take? Please list for what conditions, dosage, and frequency

_____

Are you allergic to any medication? _____

Have you ever:		If yes, please explain:
Broken bones	☐ Yes ☐ No	_____
Been Hospitalized	☐ Yes ☐ No	_____
Been in an auto accident	☐ Yes ☐ No	_____
Had sprains/strains	☐ Yes ☐ No	_____
Been Struck unconscious	☐ Yes ☐ No	_____
Had surgery	☐ Yes ☐ No	_____
Have a pacemaker	☐ Yes ☐ No	_____
Have a defibrillator	☐ Yes ☐ No	_____

Habits	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweet	☐	☐	☐	☐

Women Only

Can you become pregnant? ☐ Yes ☐ No If not, why? _____

Date of last period _____ Normal? ☐ Yes ☐ No If not, why? _____

Are you now or could be pregnant?

Approximate date of last Mammogram: _____ Approximate date of last pap smear: _____

Patient Signature _____ Doctor Signature _____

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Please mark any condition that you now have or have had in the past:

- ☐ Severe headaches
- ☐ Hypertension
- ☐ Stroke
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Dizziness/Fainting
- ☐ Anemia
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Gout
- ☐ Ears ring
- ☐ Chest pain/angina
- ☐ Heart Palpitations
- ☐ Heart murmur
- ☐ Arrhythmia
- ☐ Congenital heart disease
- ☐ Rheumatic or Scarlet
- ☐ Gall stones
- ☐ Pancreatitis
- ☐ Liver disease
- ☐ Arthritis
- ☐ Allergies
- ☐ Kidney Stones
- ☐ Renal Disease
- ☐ Diabetes
- ☐ Endocrine Disease
- ☐ Urinary or genital problems
- ☐ Prostate problems
- ☐ Sexual dysfunction
- ☐ Ovarian cysts
- ☐ Digestive problems
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Claudication
- ☐ Ulcer
- ☐ Venereal disease
- ☐ Mental illness
- ☐ Alcohol/Drug problems
- ☐ Lower back pain
- ☐ Shoulder pain
- ☐ Neck pain
- ☐ Knee pain
- ☐ Numbness/tingling in arm
- ☐ Numbness/tingling in legs

Previous Treatment

Please indicate therapies previously used to treat your condition, where given, and the amount of relief obtained:

	Procedure / Therapy	**Performed by / description of therapy**	**Relief Obtained**
☐	Physical Therapy		
☐	Chiropractic Manipulation		
☐	Biofeedback		
☐	Massage Therapy		
☐	Acupuncture		
☐	Herbal or Homeopathic		
☐	TENS Unit		
☐	Home Traction Unit		
☐	Surgery / Nerve Blocks		
☐	Counseling for pain / depression		

Family History

Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had the following:

	Conditions	**Who**		**Conditions**	**Who**
☐	Heart Disease		☐	Epilepsy	
☐	Hypertension		☐	Glaucoma	
☐	Stroke		☐	Bleeding Disorders	
☐	Cancer		☐	Kidney Stones	
☐	Diabetes		☐	Thyroid Disease	

Patient Signature _____ Doctor Signature _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, ***Robert J. Maro, M.D., P.A***. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to ***Robert J. Maro, M.D., P.A***. Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review your Notice of Privacy Practices prior to signing this consent. ***Robert J. Maro, M.D., P.A***. Privacy Practices may be obtained by forwarding a written request to our privacy Officer at 701 Cooper Road Suite 16 Voorhees NJ 08043.

With my consent, Staff of ***Robert J. Maro, M.D., P.A.*** may call my home or office and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care, including laboratory results among others.

With my consent, Staff of ***Robert J. Maro, M.D., P.A.*** may mail to my _____ home or _____ office any items that assist the practice in carrying TPO such as appointment reminder cards and patient statements.

I have the right to request that ***Robert J. Maro, M.D., P.A.*** restrict how The Staff uses or discloses my PHI to carry out TPO. However, ***Robert J. Maro, M.D., P.A.*** is not required to agree to my requested restrictions, but if ***Robert J. Maro, M.D., P.A.*** does, they are bound by our agreement.

By signing this form, I am consenting to ***Robert J. Maro, M.D., P.A.*** use and disclosure of my PHI to carry out TPO. This consent may be revoked in writing except to the extent that ***Robert J. Maro, M.D., P.A.*** has already mad disclosures in reliance upon my prior consent. If I decline to sign this consent, ***Robert J. Maro, M.D., P.A.*** may decline to provide treatment to me.

Signature of Patient of Legal Guardian	**Print Patient Name**
Print Name of Patient or Legal Guardian	**Print Patient Name**

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MEDICATION REFILL POLICY

Part of good care is monitoring the effects of medications. Medications are best managed during an appointment. **To avoid running out of medication, please make an appointment within the timeframe your clinician recommends.**

Occasionally, appointments must be made for a later date. If this happens, plan ahead to make sure you have enough medication. These are our medication refill policies:

1. To ask for a refill, please call us directly at 856-429-2224 or submit an RX Renewal request through your local pharmacy. Please do not rely on your pharmacy to ask for a refill for you.

2. We work on refills during normal office hours only.

3. Allow at least **2 business days** (48 hours) to get a refill. Call your pharmacy directly to find out if the refill is ready.

4. Some medications need a prior authorization from the Insurance company. (A prior authorization is also called a "P.A".) If you need a prior authorization, please call us at 858-429-2224. This process can take **several days**.

5. For safety reasons, medications are only given to patients who regularly come to appointments. If there is a **pattern of missed or rescheduled appointments**, we may not be able to refill a medication. Your clinician may require an office visit before giving more medication.

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Narcotic Policy

Narcotic Medications are State and Federal Government regulated medications.

I understand that certain pain and pain syndromes can sometimes be too complex to treat. As a result, medication and narcotic medications require strict guidelines for administration in alleviating pain.

Narcotic medications have the potential to cause harmful effects if used inappropriately. Consequently, narcotic medication needs to be monitored carefully by your treating physician. Narcotic medications are very habit forming and may become addictive requiring higher doses, which may cause additional side effects or difficulties.

The following policies have been instituted and bound by the physician for pain management:

1. Narcotic medications are to be used as directed. If the patient takes more than the recommended dosage, they will not receive more medication. If this causes the patient to go into withdrawal, it is the patient's responsibility to report to the emergency room and have themselves admitted for drug rehabilitation.

2. Narcotic medication will not be and cannot be called by telephone also it is not necessarily an emergency if you are out of medication.

3. There will be no early refills of medication. Federal law prohibits us from writing for more than a certain amount of medication in each period of time.

4. There will be no replacement of lost, stolen, or misplaced medications or prescriptions.

5. Your concern and questions regarding your medications should be directed to your treating physician. Any adjustments in directions or medications require an appointment with the treating physician.

6. Any patient on narcotic medications may be required to obtain blood work and urine screening to test for liver and kidney function and for quantative analysis (amount of medication) on a period basis.

7. Any patient taking narcotic medications for more than six months may need to be treated by a support therapist or referred to another physician for evaluation.

8. If the patient alters the prescription, takes medication more frequently than prescribed, shares medication, or takes narcotic medication from another physician or person, without notifying the office they may be discharged.

9. If patients do not keep their appointments for office visits, therapy, or other prescribed treatments, the patient will not be maintained on narcotic medications and may be discharged.

I have read, understand, and agree to abide by the rules set forth in this policy. My breech of the above terms could result in my discharge.

_____ _____

Patient Signature **Date**

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Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I authorize the release of the following protected health information:

☐ Office Notes/Name of Physician _____

☐ Pathology Reports ☐ Radiology Reports ☐ Laboratory Reports Date(s):

☐ Other:_____ ☐ Paper Copy ☐ Electronic Copy

The purpose for this request to release medical information is:

☐ Medical Care / Treatment ☐ Insurance ☐ Other (specify) _____

Send my medical information to: Name: _____

Address: _____

City, State, Zip: _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be redisclosed by the recipient and may no longer be protected by federal or state law. Columbia University Medical Center shall not be held liable for any consequences resulting from re0disclosure.
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical information for will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be release.
- A copy of this signed form will be provided to me.
- CUMC may charge an administrative fee to cover the cost of labor, copying, and postage. The Physician's office will inform me of any charges and arrange for payment.
- This Authorization expires on ___/___/___ {if date not completed / one year after signed}

_____ _____

Patient Signature **Date**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following.

_____ _____

Print Name **Relationship to patient**

Retain this form in the patient's medical record and provide a copy to the patient.

An additional authorization (NYS DOH-2557_ is required for disclosures when your medical records contain information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.

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TO ALL PATIENTS: FROM THE OFFICE OF ROBERT J. MARO, M.D

REGARDING ALL FORMS

PLEASE BE ADVISED IF A FORM NEEDS TO BE FILLED OUT AND SIGNED BY THE DOCTOR REGARDING YOUR MEDICAL CONDITION OR THE MEDICAL CONDITION OF A FAMILY MEMBER IF YOU ARE THE CARETAKER AND REQUIRE FAMILY LEAVE YOU WILL BE REQUIRED TO SCHEDULE AN APPOITNMETN FOR AN OFFICE VISIT SO THAT THE DOCTOR CAN ACCURATELY FILL IN THE PROPER INFORMATION THAT IS NEEDED TO COMPLETE YOUR FORM. THERE IS A $25.00 ADMINISTRATIVE FEE ADDITIONAL TO YOUR VISIT THAT IS REQUIRED TO BE PAID AT THAT TIME. AT NO TIME WILL ANY FORMS BE ACCEPTED UNLESS AN APPOINTMENT IS MADE. THANK YOU FOR YOUR COOPERATION.

I HAVE READ AN ACKNOWLEDE THE POLICY REGARDING ALL FORMS.

PATIENT SIGNATURE: _____

DATE: _____

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MEDICARE PATIENTS

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does not apply to you, please check NO.

Yes	No	
____	____	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
____	____	Are you covered by HMO/PPO which makes Medicare secondary?
____	____	Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
____	____	Do you or your spouse work and have coverage through the insurance at your jobs?
____	____	Are you eligible for any benefits under the Federal Black Lung Program?
____	____	Are you coming to this office for an illness, accident, or injury that is the result of an automobile accident?
____	____	Are you coming to this office due to Medicare disability coverage?
____	____	Are you covered by the Federal End Stage Renal Disease Program?
____	____	Are you presently receiving Worker's Compensation?
____	____	Is the illness or injury you are coming to this office for the result of work-related causes?
____	____	Do you have medical assistance through welfare or state-aid?

If you answered YES to ANY of the above questions: _____

Plolicy Number: _____ Group #: _____

Name of Policy Holder (insured): _____ ☐ **Male** ☐ **Female**

Date of Birth: ____ /_____/_____ Signature: _____

Payment Policy

MEDICARE: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying 20% copayment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patient will be balanced billed.

Note: If you have recently joined (or changed) to a Medicare HMP, please let our staff know so we can update your records and advise if we are participating providers.

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Robert J. Maro M.D., P.A. "The Maro Group"

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practice. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT
We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. In certain cases, it may be necessary to disclose information about you when referring you to another doctor or clinic for other health care or services, or in the event that we may need copies of your health information from another professional that you may have seen before us. These are only examples of uses and disclosures of medical information for treatment purposed that may or may not be necessary in your case.

PAYMENT
We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims. Management and collection purposed, both in our office and through a billing agency. In the event that we need to collect unpaid dues, you information may be used in preparing and sending bills through our office as well as through a collection agency or attorney.

HEALTHCARE
Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administration functions. We may also use the information in our information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION
There are certain circumstances under which may use or disclose your health information without first obtaining your Acknowledgment or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning communicable diseases, sexually transmitted diseases, or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law-enforcement officials' information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time via phone or mail to provide appointment reminders or to schedule a missed appointment, or about information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should also be aware that we utilize an "open treatment area" in which several people may be treated at the same time and in close proximity. Complete privacy may not be possible in this setting. If you would prefer to be seen in a private room or have a question or concern that you wish to be addressed in private, it is your responsibility to let us know and we will do our best to accommodate your wishes.

COMMUNICATIION
We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgement, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat

you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in automobile accident, or educational authorities, without your written authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
- You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
- All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addresses to the Privacy Officer at our address. We will respond to your request in a timely fashion.
- You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosure required for treatment, payment and health care operations, disclosures that require an Authorization; disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
- If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if your wish.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the rights to chance this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have, as well as such information that we may generate in the future. If we change our Notice of Privacy Practice, we will make it known to you and have copies of the new notice available to you in our office.

COMPLAINTS

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. If you wish to complain to our office, please send or fax a written complaint to the information provided at the beginning of this notice. If you wish to file a complaint in person or over the phone, please make it known to the office manager and set up a scheduled appointment to address your concerns.

FOR MORE INFORMATION

If you would like more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this notice.