Medication/Allergy Form

Current Medications- Please list any medications that apply to this visit. If you are not currently taking any medications, please write "none" on the first line.

Main Reason for today's visit _____

Name of Medication	Dosage	Frequency

MEDICATION/ALLERGY SENSITIVITY

List all Medications allergic to: If no allergies please write "none" under medication.

Medication	Nature of Allergy

_____

Patient Signature Date

_____

Patient Representative Signature Relationship Date

LYNNE B. KOSSOW, M.D.
BARBARA A. BROWN, M.D.
FRANCIS E. REHOR, M.D.
EMILY K. SANDBERG, M.D.

731 Alexander Road, Suite 201
Princeton, NJ 08540

609-655-3800

PATIENT INFORMATION

Patient Name: _____ Sex: _____
(Last) (First)

Date of Birth: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Work: _____ Cell: _____

Email: _____ Referred by: _____

Preferred Pharmacy _____ Phone _____

Do Drs. Kossow, Brown, Rehor, and Sandberg have permission to leave clinical info on your voicemail at?: (circle all that apply)

Home: Yes/No Work: Yes/No Cell: Yes/No

INSURANCE INFORMATION

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

IN CASE OF AN EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

NEAREST RELATIVE OUTSIDE OF HOUSEHOLD:

Name: _____ Relationship: _____ Phone: _____

I authorize any holder of medical or other information about me to be released to Social Security and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

PATIENT SIGNATURE: _____ DATE: _____

LYNNE B. KOSSOW, M.D.
BARBARA A. BROWN, M.D.
FRANCIS E. REHOR, M.D.
EMILY K. SANDBERG, M.D.
731 ALEXANDER ROAD, SUITE 201
PRINCETON, NJ 08540
(Phone) 609-655-3800
(Fax) 866-912-7741

The Department of Health and Human Services has recently enacted the HIPAA (Health Insurance Portability and Accountability Act) privacy rule to protect patient privacy. The rule requires physicians and hospitals to take necessary precautions to limit how much protected health information about a patient can be disclosed and to whom. It also requires an enactment of a privacy policy and notification of the policy to each patient.

We are required by law to obtain your signature indicating that we have informed you of our HIPAA Privacy Policy.

Specific Consent for Drs. Kossow, Brown, Rehor, and Sandberg

I hereby authorized any agent of Drs. Kossow, Brown, Rehor and Sandberg to make appointments at their office or with consultants to whom they may make referral or from whom they may make referral or from whom they may request consultation for me or for the patient for whom I am the responsible or authorized party. Furthermore, I authorize any agent of Drs. Kossow, Brown, Rehor and Sandberg to examine, diagnose and treat, to perform laboratory tests or diagnostic tests, to administer medications and immunizations, to write, fax, telephone or electronically transmit prescriptions, and to disclose information as necessary to me, my designate and medical, educational, or ancillary medical consultants on behalf of the patient(s) named herein, when Drs. Kossow, Brown, Rehor and Sandberg believe such action is in the best interest of the patient.

I have been given the opportunity to review the Privacy Policy Statement of Drs. Kossow, Brown, Rehor and Sandberg. I understand that I may revoke or amend this authorization at any time or request to restrict the disclosure of the personal health or financial information as set forth herein.

This authorization will expire when the patient is no longer under the active care of Drs. Kossow, Brown, Rehor and Sandberg or the patient's association with said doctors has been explicitly terminated.

Please initial below all which apply:

I give Drs. Kossow, Brown, Rehor and Sandberg permission to leave clinical information on the following answering devices. Please initial on which device we can leave clinical information:
_____Home _____Cell _____Work

I give Drs. Kossow, Brown, Rehor and Sandberg permission to discuss clinical information about myself (or the patient for whom I am the responsible party) with the following people (family members or close friends):

_____

_____

_____

_____

_____ _____

Patient's Printed Name Authorized Signature

LYNNE B. KOSSOW, M.D.
BARBARA A. BROWN, M.D.
FRANCIS E. REHOR, M.D.
EMILY K. SANDBERG, M.D.
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PRINCETON, NJ 08540
(Phone) 609-655-3800
(Fax) 866-912-7741

To Our Patients:

We would like to remind our patients of our office policy on missed appointments, form fees, and records charges.

There will be a $50.00 charge for a routine office visit and a $100.00 charge for physical exams and new patient appointments that are missed without at least 24 hour notice of cancellation. Emergency same day appointments will also be subject to these fees if missed or cancelled.

There is a $25.00 form fee for any form(s) that the doctor is asked to fill out for a patient.

There is a $1.00 per page fee for records that need to be copied and faxed to a new doctor when a patient is leaving the practice.

Thank you.

_____ _____

Signature Name

_____

Date

MEDCIAL RECORD RELEASE FORM

Lynne B. Kossow, M.D.
Barbara A. Brown, M.D.
Francis E. Rehor, M.D.
Emily S. Sandberg, M.D.

Patient Name: _____

DOB: _____

Address: _____

Home Phone: _____

TO: _____FAX: _____

I hereby authorize and request you to send or fax my medical records to:

Dr. _____at 731 Alexander Road, Suite 201, Princeton, NJ 08540.
Phone: 609-655-3800 Fax: 866-912-7741.

TYPE OF RECORDS REQUESTED:

_____ Complete Medical Record

_____ Immunization Record

_____ Records checked below from the past _____years

_____ Doctor's Notes/H&P's

_____ Labs

_____ Colonoscopy/Endoscopy

_____ Xray (Mammo, U/S, MRI, CT, etc)

_____ Medication List

_____ EKG/Stress Test/Echo

_____ Hospital Discharge Summaries

_____ _____

Patient Signature or Legal Guardian Date