

Welcome To



HACKETSTOWN MEDICAL P.C.
PRIMARY CARE PARTNERS AFFILIATE

5 Hastings Square
Hackettstown, NJ 07840
908.979.0050
Fax 908.979.0044

Primary Care Partners' physicians provide high quality healthcare with a personal, caring touch that focuses on the health, safety, and well-being of our patients and their families. We are dedicated to providing excellent healthcare throughout your lifetime.

Keri Ingrassia-Squiers, DO

Billing Inquiries:

Central Billing Office:	888.793.1929
Email:	InquiryPCP@challc.net

To reach us after hours, please call our main number and follow the voice mail prompts.



PRACTICE PHILOSOPHY

Welcome to Primary Care Partners. We are honored that you have chosen us as your health care provider, and together we will work diligently to keep you and your family safe and healthy.

1. Our philosophy is to provide high quality care; to treat our patients with courtesy and respect; to provide our patients with the information needed to make informed decisions; and to answer all questions to the best of our ability.
2. As an informed healthcare consumer, we encourage you to ask questions regarding diagnosis or treatment. You have the right to obtain from your physician complete, current information concerning your diagnosis, treatment and prognosis.
3. It is important that you follow through on our recommendations. This includes scheduling follow-up appointments as requested; administering the medications we prescribe according to our instructions; following up on laboratory or x-ray studies that we order; and scheduling referral appointments with specialists as instructed.
4. We make every effort to ensure that you receive the results of any laboratory or x-ray studies ordered. However, you should always call if you do not receive results in a timely manner.
5. We respect your time and make every effort to minimize waiting time in our office. However, we ask that you understand that there may be occasions when one of our patients needs more of our time than anticipated (such as emergencies and complicated health issues). While this may prolong your wait, please be assured that you would receive the same consideration should the need arise.
6. We ask that you treat our staff with courtesy and respect, be on time for your appointment, and provide advance notice if you are unable to keep an appointment.

Thank you for selecting our office to partner with you in providing high quality health care!



PAYMENT POLICY

- Insurance.** We participate with most major insurance plans, including Medicare. Knowing what benefits your insurance plan provides for you is your responsibility. Please contact your insurance company with any questions. **IF WE PARTICIPATE WITH YOUR INSURANCE CARRIER** all services provided in our office (unless otherwise indicated) will be submitted to your insurance. All co-payments are due at time of service. Deductibles and coinsurance are your responsibility and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse. The doctor's fees may be higher than what the insurance carrier reimburses or it may not be a covered service. Therefore, any balances not covered by insurance become the responsibility of the patient.
IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE CARRIER OR IF YOU DO NOT HAVE HEALTH INSURANCE, payment in full is expected from you at the time of your visit.
- Proof of Insurance.** All patients must complete our patient registration form before seeing the doctor. Photo identification and a current valid insurance card are required at every visit to provide proof of insurance. It is your responsibility to verify that the office staff has the most current and correct information regarding your health insurance policy. Failure to provide current information may result in non-coverage for services provided, and the resulting charges will be your responsibility.
- Co-payments and Deductibles.** In accordance with your insurance plan and services provided, you are responsible for any and all co-payments, deductibles, and coinsurances at the time of service.
- Referrals.** In accordance with your insurance carrier it is your responsibility to know if a written referral is required to see a specialist, or for a certain procedure. When a referral is not presented at the time of service to the provider, the patient may be responsible for payment in full at the time of service.
- Claims Submission.** Submission of claims is a courtesy extended to our patients. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. Your insurance coverage is a contract between you and your insurance carrier; we are not party to that contract.
- Non-covered Services.** Certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", "cosmetic" or simply "non-covered" by your insurance carrier. You are responsible for payment of these services. In the event your care exceeds a plan limitation; the balance becomes your responsibility.
- Non-payment of patient balances.** Should your account become delinquent, the patient or guarantor agrees to pay all costs associated with collecting the balance due including, but not limited to, attorney, collection, and contingent fees.
- Non-sufficient funds (NSF)/ Returned Checks.** A fee of \$25.00 will be charged for all returned checks.
- Missed Appointments** or failure to cancel your appointment within 24 hours of your scheduled visit may result in a fee of \$50.00.



GLOSSARY OF INSURANCE TERMS

Advanced Beneficiary Notice (ABN) – If Medicare will not pay for a procedure or service, the physician or hospital will request you to review and sign an Advanced Beneficiary Notice. This notice will assist you in determining whether you wish to have the procedure or service performed and how you prefer to pay for it.

Benefit – The amount your plan will pay a physician, group or hospital, as stated in your policy, toward the cost of the service or procedure to be performed by the physician.

Claim -The form that the physician files with a health insurance company that details the services and procedures performed by the physician, on your behalf, and other pertinent data that is required by the health insurance company to receive payment.

Co-Payment or “co-pay” – The part of your medical bill you must pay each time you visit the doctor. This is a pre-set fee determined by your health insurance policy.

Co-Insurance – The part of your bill, in addition to the co-pay, that you must pay. Co-insurance is usually a percentage of the total medical bill – for example, 20 percent.

Deductible -The amount you must pay for medical treatment before your health insurance company starts to pay - for example, \$500 per individual or \$1,500 per family. In most cases, a new deductible must be satisfied each calendar year.

In-Network -The physician has contracted a payment schedule with the health insurance company to provide you with medical care. The physician will submit your medical bill directly to the health insurance company for payment. However, you may be responsible for a co-payment, deductible and/or co-insurance according to your health insurance company benefit plan.

Non-Covered Charges – Costs for medical treatment that your health insurance company does not pay. You may wish to determine if your treatment is covered by your health insurance policy before you are billed for these charges by the doctor’s office.

Out-of-Network – The physician is not contracted with the health insurance company to provide you with medical treatment. You are responsible for the payment of the medical care. The physician may agree to submit your medical bill directly to the payer for payment. However, you may be responsible for an increased co-payment, deductible, co-insurance and/or additional charges according to your insurance company benefit plan.

Primary Health Insurance Company – The health insurance company that is responsible to pay your benefits first when you have more than one health insurance plan.

Secondary Health Insurance Company – The secondary health insurance company is not the first payer of your claims. The remaining claim balance will be sent to a secondary health insurance company, if provided, after payment is received by the primary health insurance company.

GUIDE TO UNDERSTANDING YOUR PRIMARY CARE PARTNERS STATEMENT

Numbered Areas Point Out Where Important Information Can Be Found On Our Statement

1. Office name
2. Fill out if paying with a credit card
3. Patient's account number
4. Date statement was printed
5. Total guarantor portion due with statement
6. Area to write amount you are paying
7. Responsible party for account (guarantor)
8. Remit to address
9. Box to check if incorrect address or insurance information
10. Invoice number
11. Date services were provided and financial transactions posted
12. Description of services provided
13. Description of financial transactions such as payments and adjustments

14. Contact information
15. Message box
16. Back of statement - please use this section to inform us of changes or corrections to your personal and/or insurance information

Has any of the following changed since your last statement...	
About You	About Your Insurance
Name	Primary Insurance Info
Address	Primary Policy Numbers
Telephone	
Employer's Name	Secondary Insurance Info
Employer's Address	Secondary Policy Numbers

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PRIMARY CARE PARTNERS
PO BOX 2403
VOORHEES, NJ 08043-0598

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW			
Check Card Using For Payment			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MasterCard	Discover	Visa	American Express
Card Number		Signature Code	
Print Cardholder Name		Exp. Date	
Signature			
Patient Name JOHN Q. PATIENT			
Account Number	Statement Date	Payment Due	
98765	11/15/10	Upon Receipt	
Pay This Amount	5 30.00	Show Amount Paid Here	6 \$

7

JOHN Q. PATIENT
202 MAIN STREET
ANYTOWN, USA 12345-0000

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PRIMARY CARE PARTNERS
PO BOX 2403
VOORHEES, NJ 08043-0598

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Check box if above address is incorrect and indicate change(s) on reverse side

STATEMENT

Please detach and return this portion with your payment

Invoice Number	Date	CPT Code	Description	Amount
12345	10/25/10	99213	INVOICE BALANCE: 30.00	139.00
	11/09/10		OFFICE VISIT EXISTING PATIENT	-75.00
	11/09/10		INSURANCE PAYMENT	-34.00
			INSURANCE CONTRACTUAL ADJUSTMENT	
Thank you for choosing Primary Care Partners for your healthcare needs.				
AMOUNT DUE FROM PATIENT:				30.00

Contact Information

Thank you for choosing our organization for your healthcare needs. Please pay the account shown above.

Message

Any questions please call 888-793-1929 from 8:00 am to 4:00pm, Monday-Friday. Or you may email us at InquiryPCP@challc.net Thank you.



HACKETTSTOWN MEDICAL P.C.
PRIMARY CARE PARTNERS AFFILIATE

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how medical information about you (as a patient of this care center) may be used and disclosed, and how you can get access to this information. Please review this notice carefully.

A. Our commitment to your privacy

Our care center is dedicated to maintaining the privacy of your protected health information (PHI). "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy care centers that we maintain in our care center concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy care centers that we have in effect at the time. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our care center has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our care center will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. We may use and disclose your protected health information (PHI) in the following ways –

The following are examples of the types of uses and disclosures of how Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who is involved in your care and treatment for the purpose of providing health care services to you.

- 1. Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your PHI to other physicians who may be treating you or whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.
- 2. Payment:** Our care center may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members or to other health care providers and entities to assist in their billing and collection efforts.
- 3. Health Care Operations:** Our care center may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our care center may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our care center. We may disclose your PHI to other health care providers and entities to assist in their health care operations. We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

C. Other permitted and required uses and disclosures - *We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. The use or disclosure will be made in compliance with federal, state or local law and will be limited to the relevant requirements of the law. These situations include:*

1. **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information for the purpose of: (1) Maintaining vital records, such as births and deaths, (2) Reporting child abuse, neglect or domestic violence (3) Preventing or controlling disease, injury or disability, (4) Notifying a person regarding potential exposure to a communicable disease, (5) Notifying a person regarding a potential risk for spreading or contracting a disease or condition, (6) Reporting reactions to drugs or problems with products or devices, (7) Notifying individuals if a product or device they may be using has been recalled; notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information, (8) Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight:** We may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include: investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.
4. **Law Enforcement/ Criminal Activity:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes, (2) pertaining to victims of a crime, (3) in the event that a crime occurs on the premises of our practice, and (4) medical emergency (not on our practice's premises) and it is likely that a crime has occurred, (5) Concerning a death we believe has resulted from criminal conduct, (6) In response to a warrant, summons, court order, subpoena or similar legal process, (7) To identify/locate a suspect, material witness, fugitive or missing person, (8) In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator), (9) for law enforcement authorities to identify or apprehend an individual.
5. **Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
6. **Research:** Research is defined as a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. In the course of conducting research our care center is permitted to use and disclose protected health information for research with individual authorization, or without individual authorization under limited circumstances set forth in the Privacy Rule.
7. **Military Activity and National Security:** If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authority we may use or disclose protected health information of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
8. **Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

9. **Inmates:** We may use or disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
10. **Others Involved in Your Health Care or Payment for your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
11. **Childhood immunizations:** We may disclose immunizations list to schools required to obtain proof of immunization prior to admitting the student so long as the physicians have and document the patient or patient's legal representative's "informal agreement" to the disclosure.
12. **Decedents:** We may make relevant disclosures to the deceased's family and friends under essentially the same circumstances such disclosures were permitted when the patient was alive; that is, when these individuals were involved in providing care or payment for care and the physician is unaware of any expressed preference to the contrary.

D. Your rights – You have the following rights regarding the PHI we maintain about you:

1. **Inspect and copy:** This means you may inspect and obtain a copy of your record that contains medical and billing records and any other records that your physician and the practice use for making medical decisions about you for so long as we maintain your protected health information. Medical record copies remain available via hardcopy and/or electronic copy where available. As permitted by federal or state law, we may charge you a reasonable fee for the cost of copying, mailing, labor and supplies associated with your records request. However, under federal law you may not inspect or copy the following records without the proper written authorization: (1) Psychotherapy notes; (2) Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and (3) Information of CLIA (laboratory results) to the extent the provision of access would be prohibited by law.
2. **Request a Restriction:** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. At the patient's request, physicians may not disclose information about care the patient has paid for out-of-pocket to health plans, unless for treatment purposes or in the rare event the disclosure is required by law. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your written request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. With this in mind, please discuss any restriction you wish to request with your physician.
3. **Confidential Communications:** You have the right to request that our care center communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work.
4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our care center. You must provide us with a reason that supports your request for amendment. Our care center will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the care center; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our care center, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures:** All of our patients have the right to request an "accounting of disclosures" (a list of certain non-routine disclosures our care center has made of your PHI for non-TPO purposes). Use of your PHI as part of the routine patient care in our care center is not required to be documented; for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim.

6. **Breach of PHI:** Our care center will notify individuals following a breach of their PHI. A breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted and/or compromises the security or privacy of the protected health information.
7. **Marketing, Fundraising & Sales:** We will obtain patient authorization if the care center wants to use PHI for certain non-TPO purposes, including, but not limited, to: (1) Marketing [any communication about a product or service that encourages recipients of the communication to purchase or use that particular product or service] treatment options for financial remuneration in exchange for making the communication; except when the communication is face-face with the patient or if it involves the provision of services of nominal value. (2) Fundraising [intention of contacting individuals to raise funds for the entity], at the time of collection the care center must also inform the individual that he or she has the right to opt out of receiving such communications. (3) Our care center does not participate in the "Sale" of PHI, nor shall it enter into a relationship with an entity that result in such without written authorization of the individual.
8. **Revoke this Authorization:** You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

If you have any questions about this notice, would like to file a complaint, create a disclosure or revoke this authorization with our care center please contact our Privacy Officer, Keri Ingrassia-Squiers, DO, 5 Hastings Square, Hackettstown, NJ 07840, (908) 979-0050.