NJ Heart Registration Form

Patient Information

Name: ____

S.S.#: ____ DOB: ____

Address: ____ City, State, Zip: _______________________________________

Home Tel#: ____ Cell: ____

Emergency Contact: (not living with you): ____

Who is your next of kin? (Include Name, address & tel#): ____

Do you have an Advanced Directive? YES or NO Advanced Directive attached? YES or NO

Pharmacy Info: **(Name, full address, tel#)**____

Family History

Is there any history of medical problems in your biological relatives? If so, what type of medical problem and whom? **(mother, father, brother, sister and children)**

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Social History

What kind of work do you do? _________________________ Marital Status: _______________________________________

How many children do you have? **(provide age and sex)**

1. ____ 3. ____

2. ____ 4. ____

Have you ever used any illegal drugs? If so, when was the last time used? ____

Are you a smoker? YES or NO **(If so, how many per day?______________________)**

Do you drink alcohol? YES or NO **(If so, how much daily?______________________)**

Medical History

Referring Doctor: __________________________________ Reason for visit: _____________________________________

List all your medical problems and surgeries with dates:

1. ____ 3. ____

2. ____ 4. ____

List all your medications: **(Include name, dosage and how often taken)**

1. ____ 4. ____

2. ____ 5. ____

3. ____ 6. ____

Any known allergies to medications or food? ____

****Doctors Notes / Comments****

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NJ Heart

Notice of Privacy Practices Acknowledgemnt

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

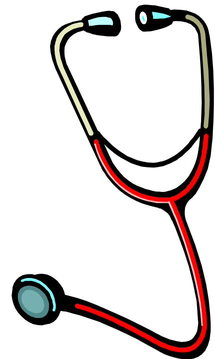
- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Upon your request, a chaperone can be provided by NJ Heart to be present during your examination by the physicians. If so, please inform the front desk or the physician so that we can fulfill your request.

☐ **Please check box for chaperone (only if needed)**



Patient Name: ____

Signature: ____

Power of Attorney: ____

Date: ____

OFFICE USE ONLY:

I attempted to obtain patient's signature in acknowledgement on this ***Notice of Privacy Practice Acknowledgement,*** but was unable to do so as documented below:

Date:	Initials:	Reason:

NJ Heart

Billing Process

To help our patients fully understand our billing process, we ask that you read and sign our financial policy statement.

As a courtesy to you, NJ Heart will submit a copy to your insurance carrier. Depending upon your individual policy, your coverage, your deductible and/or co-payment requirements, you may be billed for the balance.

Although we at NJ Heart participate with most insurance carriers, it is your responsibility at the time of service to veify with your insurance company if the particular physician you are seeing is registered as a participating physician with your plan.

For claims not submitted as courtesy or insurance plan that do not allow such admissions, NJ Heart accepts credit cards, cash, checks and money orders as methods of payment due at the time of services.

When our doctor participates fully in your insurance plan, you are still responsible for paying any co-payments and co-insurance deductibles as indicated by your carrier as well as non-covered services under their contract.

Although NJ Heart may on occasion, as a courtesy to you, file private insurance claims, we will not become involved in disputes between you and your insurance carriers regarding covered charges, secondary insurance issues or usually and customary charges other than supply factual information as request by the insurance carrier.

Responsible Party Signature: ____ Date: ________________________

****Please read carefully and make sure that you fully understand before signing****

You are responsible for bringing all the necessary referrals to the office on the day of your appointment. If you do not have the required forms on the day of your visit and agree to be seen by the physician without the referral, you must sign the waiver accepting full responsibility for complete payment of the office visit.

Patient Signature: ____ Date: ________________________

Thank you for taking the time to review the NJ Heart financial policy statement.

Please let us know if you have any questions, comments or special concerns.

NJ Heart

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get acces to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you, the patient, penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes:

- ✓ **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- ✓ **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- ✓ **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer:

- ✓ The right to request restrictions, certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- ✓ The right to reasonable requests to receive confidential communications of protected health information from us by alternative locations.
- ✓ The right to inspect and copy your protected health information.
- ✓ The right to amend your protected health information.
- ✓ The right to receive an accounting of disclosures of protected health information.
- ✓ The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The notice is effective as of **April 14, 2003** and we are required to abide by the terms of the Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights

200 Independence Ave, S.W.

Washington, DC 202001 1-202-619-0257 Toll Free#: 1-877-696-6775

NJ HEART / NJ MEDCARE

ATTN: HMO PATIENTS

It is a requirement for all HMO patients to bring in a referral for all doctor's visits.

In the absence of a referral for your visits, we will reserve the rights for the patient to pay upfront before being seen by the physician.

Thank you very much for your cooperation.

______________________________ ______________________________

NJ HEART STAFF **PATIENT**

ATENCION PACIENTES DE SEGURO HMO

Es mandatorio que todo los paciente que tienen un seguro HMO ddeben traer un referido el dia de su cita con el doctor.

Si no tiene un referido para su cita con el medico, nosotros reservamos el derecho de cobrarle la consulta antes de ver al doctor.

Mucha gracias por su atencion.

______________________________ ______________________________

EMPLEADO DE NJ HEART **PACIENTE**

NJ HEART / NJ MEDCARE

***** ATTENTION ALL PATIENTS *****

Effective January 1, 2012, there will be a $20.00 fee applied to NON-CANCELLED appointments for office visits due to scheduling inconvenience caused to office.

Referrals are needed based on insurance policy; we are not responsible for obtaining them and you will be rescheduled. If you insist on seeing the physician without a referral, you will be held responsible for any billing charges.

Co-pays are due before seeing the doctor. In the event that the co-pay cannot be paid at the time of the visit, there will be an additional fee of $5.00 applied to the amount.

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Patient's Signature of Acknowledgement

HEALTH INFORMATION (PHI) USE & DISCLOSURE

Patient Name:	
Patient Address:	
Medical Record #:	
Date of Birth	Social Security #: - -

Please consider this a request for me to exercise my rights under the federal and state laws to request confidential communication of my protected health information

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Please explain below how, specifically, you want the use of your protected health information restricted in **our practice**

A. WHAT information would you like restricted?

B. WHO is RESTRICTED from accessing this information?

C. WHO is ALLOWED access?

Please explain below how, specifically, you want your protected health information restricted from **DISCLOSURE TO OUTSIDE ENTITIES.**

A. WHAT information do you want restricted?

B. WHO is restricted from accessing this information?

I understand that the physician (or provider) to whom I am making this request will make reasonable efforts to accommodate this request. I understand the physician (or provider) is not required to honor this request when information about me is needed for emergency treatment, or in serious circumstances when the information is permitted by law to be released. I further understand that the physician (or provider) may terminate this restriction and I will be informed of the termination. I may choose to terminate this restriction and may do so in writing.

____________________ ______________________________________

DATE: **PATIENT SIGNATURE:**