

Medical Associates of Englewood, PC
Leonia Medical Associates

REGISTRATION FORM

PATIENT INFORMATION				
Date:	Date of Birth:	SSN #:		
Patient Name:		Male	Female	
Address:		Phone #:		
City:	State:	Zip code:	E-mail Address:	
Home phone #:		Cell #:	Are you a part of the Bloodless Program? Yes No	
Can we leave a voice message at your Home number? Yes No Brief or Extended		Can we leave a voice message on your cell phone? Yes No Brief or Extended		
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race ☐ Other Pacific Islander		Ethnicity: ☐ Hispanic or Latin ☐ Non Hispanic or Latin ☐ Refused to Report		
Primary Language: ☐ English ☐ Other ☐ French ☐ Indian ☐ Spanish ☐ Russian ☐ Italian		Do you need a translator? Yes No		
Pharmacy Name:		Pharmacy Phone Number:		
Pharmacy Address:				
EMPLOYMENT INFORMATION				
Employer:		Occupation/Position:		
Employer's Address:				
Work Phone #:	Can we leave a voice message at your business number? Yes No Brief or Extended			
INSURANCE INFORMATION				
Subscriber Name:		Subscriber SSN #:		
Subscriber Date of Birth:		Relationship to Subscriber:		
Subscriber Employer Name:		Telephone #:		
Subscriber Employer Address:				
PRIMARY INSURANCE				
Name:		Policy #:	Group #:	
SECONDARY INSURANCE				
Name:		Policy #:	Group #:	
EMERGENCY CONTACT				
Emergency Contact:		Relationship:	Phone #:	
REFERRING PHYSICIAN INFORMATION				
Referring Physician:		Specialty:		
Address:		Phone #:		
City:	State:	Zip code:		
Reason for Visit:				
ACKNOWLEDGEMENT/AUTHORIZATION				
I CERTIFY THAT ALL INFORMATION I PROVIDED ABOVE IS ACCURATE AND TRUE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR ANY SERVICES FURNISHED TO ME BY THIS PHYSICIAN GROUP. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I AUTHORIZE THE RELEASE OF INFORMATION CONCERNING MY HEALTHCARE TO MY INSURANCE COMPANY FOR THE PURPOSE OF REVIEWING AND PROCESSING MEDICAL CLAIMS FOR PAYMENT. ALSO, I CERTIFY THAT ALL INFORMATION I PROVIDED ABOVE IS ACCURATE AND TRUE.				
Signature:		Relationship to Patient:	Date:	

MD PARTNERS INTAKE FORM

List all allergies and type of reactions (include meds,x-rays, dyes and/or other substances):

ALLERGIES	REACTIONS TYPES

List all medications including dose and frequency, If you do not take any meds, please indicate 'NONE'

NAME OF MEDICATIONS	DOSES	FREQUENCY

Pregnancies (if applicable)	Births	Miscarriages

List all surgeries and hospitalizations you have had. Please indicate 'NONE' if not applicable.

SURGERY/HOSPITALIZATIONS	DATES

LAST COLONOSCOPY (IF APPLICABLE):

DATE :

LAST MAMMOGRAPHY (IF APPLICABLE):

DATE:

LAST BONE DENSITY (IF APPLICABLE):

DATE:

LAST FLU SHOT

DATE:

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)
Registrant Name (Print)	Name (Print)
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant
I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history. I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3. I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above. There is no cost to participate in this program. ☐ Yes, I would like to participate in this program. ☐ No, I do not want to participate in this program.	
Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	
Date	

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number
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- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

Medical Associates of Englewood, PC

Leonia Medical Associates

CONSENT FOR TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

1. CONSENT FOR TREATMENT

The undersigned consents to any x-rays, laboratory or other medical procedures or examination rendered to me under the general and specific instructions of my physician(s). I acknowledge that no guarantees have been made to me as to the result of treatment/examination in the Practice. I also consent to the testing of my blood for Human Immunodeficiency Viruses (HIV) and/or other blood borne pathogens, in the event that any individual at Medical Associates of Englewood/ Englewood Cardiology Consultants is accidentally exposed to my blood or body fluids, or my physician believes such testing is medically indicated. Results of such testing will be reported to me, noted on my medical record and reported to the State Department of Health as required by law.

2. RELEASE OF INFORMATION

The Practice is hereby authorized to release any/all of my medical records to the person(s) liable for my financial obligations resulting from services and to use data from my medical record for quality, epidemiology and education studies to which no identifying information will be made public. I understand that occasionally my care and/or portions of my care may be photographed and/or videotaped for educational purposes within and outside of the Practice. At no time during this process will my identity (or any information linked to my identity) be revealed. The actual film or videotape will remain in the physical possession of the Practice or the physician at all times and will not be released to any other person, agency or institution unless I specifically authorize it. I consent to the use of photography/videography. I reserve the right to withdraw permission for filming/video/publication upon proper notification. Upon receipt of withdrawal of permission, no further images will be taken.

3. ASSIGNMENT OF INSURANCE BENEFITS

In the event the patient is entitled to physician benefits of any type arising out of any policy of insurance coverage from the patient or any other party liable for the patient, said benefits are hereby assigned to the Practice and/or treating physician. In the event the patient's insurer denies medical benefits, coverage, or payment, consent is hereby authorized to allow the Practice and/or treating physician to appeal such decisions on the patient's behalf.

4. MEDICARE BENEFITS (IF APPLICABLE)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I assign the benefits payable for services to Medical Associates of Englewood, PC or the physician furnishing the services and authorize Medical Associates of Englewood, PC or the treating physician to submit a claim to Medicare for payment.

5. MEDICAID

I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for practice services to Medical Associates of Englewood, PC and/or treating physician. I authorize Medical Associates of Englewood, PC or the physician to submit a claim to Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

6. OTHER PHYSICIAN SERVICES (OUTSIDE OF OUR PRACTICE)

In the event the patient is entitled to benefits of any type arising out of any policy of insurance covering the patient, that said benefits are also hereby assigned to any other physicians (outside of our practice) providing services to you at our request. I understand that it is the responsibility of the patient to obtain information from his/her insurance company to determine if the above mentioned physicians are participating in the patient's insurance plan. Participation by Medical Associates of Englewood, PC in any given insurance plan does not indicate participation by the other physicians outside of this Practice. I understand that I am responsible to the other physicians practices for any charges not covered by my insurance plan.

7. FINANCIAL AGREEMENT

The undersigned agreed, whether he/she signs as agent or patient, that in consideration of the services rendered to the patient, he/she hereby individually obligates himself/herself to any the account of the Practice in accordance with the regular rates and terms of the Practice. I understand that I am responsible to the Practice for any charges billed to and not covered by any insurance carrier(s), including any charges denied by insurance carrier for no pre-certification or referral. Should the account be referred for collection after a default, the undersigned agrees to pay costs of collection, including reasonable attorney's fee. All delinquent accounts bear interest at legal rates.

The undersigned certifies that he/she has read and understands the foregoing, receiving a copy thereof and as a patient or the patient's agent, authorize to execute the above, accepts its terms.

Patient Signature/Authorized Agent

Date

Print Name Patient Signature/Authorized Agent

I acknowledge that I have been provided with a copy of Medical Associates of Englewood, PC Privacy Notice

Patient Signature/Authorized Agent

Date

Medical Associates of Englewood, PC

Leonia Medical Associates

NOTICE OF PRIVACY PRACTICES

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

Medical Associates of Englewood, PC is dedicated to protecting your privacy, including the protected health information about you that we generate and maintain. This Notice describes how we may use and share protected health information, our legal obligations related to the use and sharing of this information, and your rights related to the protected health information about you. As required by law, we must maintain the privacy of protected health information, provide you with this Notice of our legal duties and privacy practices with respect to such information, and abide by the terms of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your health information to provide you with treatment and health care services. For example, we may disclose information about you to doctors, nurses, technicians, students, or other personnel involved in your care. We may also share this information about you with other agencies or facilities in order to provide the different things you need, such as prescriptions, lab work, and/or continuing medical care after you leave our facility. Sharing your information for this purpose gives your providers the information they need to provide you with appropriate care.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care, such as an ambulance company. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send an invoice disclosing your health information to your insurance company or to a benefit payer that is responsible for all or part of your medical bill. If federal or state law requires us to obtain a written release from you prior to disclosing health information for payment purposes, we will ask you to sign a release.

Health Care Operations: We may use and disclose your health information for our health care operations. For example, your health information may be used by the members of the medical

staff to evaluate the performance of our health care professionals, assess patients' quality of care and case outcomes, and seek areas of improvement within our facility. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.

Appointment Reminders: We may contact you to remind you of an appointment with a provider.

Treatment Alternatives: We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Research: We may use or disclose your health information for research purposes, subject to the requirements of applicable law. All research projects are subject to a special approval process, which establishes protocols to ensure that your health information will continue to be protected. When required, we will obtain a written authorization from you prior to using your health information for research.

Marketing Activities: We may contact you as part of our marketing activities, as permitted by applicable law.

Required by Law: We may use and disclose your health information as required by law. For example, we may disclose health information for mandated patient registries, communicable disease reporting, and for judicial and administrative proceedings, including disclosures in response to a court order.

Law Enforcement: We may release your health information to assist law enforcement officials with their law enforcement duties. Examples include responding to a court order, subpoena, warrant, summons, or similar process; identifying or locating a suspect, fugitive, or missing person; and reporting criminal conduct on our premises.

To Avert a Serious Threat to Health or Safety: As permitted by applicable law and standards of ethical conduct, we may use and disclose health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Disaster-Relief Efforts: When permitted by law, we may coordinate our uses and disclosures of health information with public or private entities assisting in a disaster-relief effort. If you do not want us to disclose your health information for this purpose, you must communicate this to your caregiver so that we do not disclose this information unless done so in order to properly respond to the emergency.

Organ and Tissue Donation: If you are an organ donor, we may release your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the Armed Forces, domestic or foreign, we may release your health information to military command authorities as authorized or required by law.

Worker's Compensation: We may release your health information for programs that provide benefits for work-related injuries or illnesses.

Public Health Activities: We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report births and deaths;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight Activities: We may disclose health information to federal or state agencies that oversee our activities, including licensing, auditing, and accrediting agencies.

Coroners, Medical Examiners, and Funeral Directors: We may disclose health information to coroners, medical examiners, and funeral directors as necessary for them to carry out their duties.

National Security and Intelligence Activities: We may release your health information to authorized federal officials for intelligence, counterintelligence, or other national security activities that are authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so that they may provide protection to the President or other authorized persons or foreign heads of state or to 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 your health information to the correctional institution or to law enforcement officials so that duties can be carried out under the law.

Other Uses of Your Health Information: Other uses and disclosures of health information not covered by this Notice or by the laws that apply to us will be made only with your permission in a written authorization, including certain marketing activities, sale of health information, and disclosure of psychotherapy notes with some exceptions. You have the right to revoke your

authorization at any time, provided that the revocation is in writing, except to the extent that we have already taken action in reliance on your authorization.

HEALTH INFORMATION EXCHANGE (HIE)

We participate in an electronic health information exchange network (HIE) called "Jersey Health Connect". Generally, an HIE is an organization that health care providers participate in to exchange patient information in order to facilitate health care, to avoid duplication of services (such as lab tests), and to reduce the likelihood that medical errors will occur. Jersey Health Connect allows participating providers to exchange such information through a secure network, thus giving your participating providers immediate electronic access to your pertinent health information that is necessary for treatment, payment, and health care operations.

If you do not wish to have your information included in the Jersey Health Connect HIE, you may opt out. Unless you opt out, your information will be available through the Jersey Health Connect HIE network to your authorized participating providers in accordance with this Notice and applicable law. For instance, if you receive a blood test from one authorized participating provider and you are later treated by a second authorized participating provider, the two providers can share your test results electronically through Jersey Health Connect's secure network. If you choose to opt out of Jersey Health Connect, your information will continue to be accessed, used, and disclosed, in accordance with this Notice; however, we will not share your information through the HIE.

You can obtain additional information about the Jersey Health Connect HIE by visiting <http://www.jerseyhealthconnect.org/>. We will provide you with an informational brochure about Jersey Health Connect upon request.

HIE Opt Out:

If you do not wish to allow otherwise authorized doctors, nurses, and other clinicians involved in your care to electronically share your health information with one another through Jersey Health Connect as explained in this Notice, you may complete, sign, and submit the *Jersey Health Connect Opt-Out Form* as instructed on that form, and we will honor your opt-out selection. The *Jersey Health Connect Opt-Out Form* can be obtained directly from any of your providers participating in Jersey Health Connect, or you can download the form from www.jerseyhealthconnect.org/opt-out-form. Any exception that denies an individual from opting out of having their information transmitted through the Jersey Health Connect HIE, shall be fully supported under federal and state law.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy: With certain exceptions, you have the right to inspect and to receive a copy of your health records. You have the right to obtain, upon request, a copy of your health information in an electronic format if we maintain your health information electronically (in our computers). You may also request that we transmit a copy of your health information to another company or person you have designated. However, this right is subject to a few

exceptions, including psychotherapy notes, information collected for certain legal proceedings, and any medical information restricted by law.

In order to inspect and copy your health information, you must submit your request in writing to Medical Associates of Englewood, PC's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the cost of copying and mailing your records, as well as for other costs associated with your request. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Right to Request a Restriction: You have the right to request a restriction or limitation on the health information we use and disclose about you for treatment, payment, and health care operations. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full. To request a restriction, you must make your request in writing to Medical Associates of Englewood, PC's Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health matters by alternative means or at alternative locations. To make such a request, you must submit your request in writing to Medical Associates of Englewood, PC's Privacy Officer.

Right to Request an Amendment: You have the right to request an amendment to your health information. In order to request an amendment to your health information, you must submit your request in writing to Medical Associates of Englewood, PC Privacy Officer, along with a description of the reason for your request. If we agree to your request, we will amend your record(s) and notify you of such. We have the right to deny your request for amendment. If we deny your request for an amendment, we will provide you with a written explanation of why we denied the request and to explain your rights.

Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by us to individuals or entities other than you, in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to Medical Associates of Englewood, PC's Privacy Officer. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the cost of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you have previously agreed to electronically receive this Notice. You can always request a written copy of our most current version of this Notice from Medical Associates of Englewood, PC Privacy Officer.

CHANGE TO THIS NOTICE

We must comply with the provisions of this Notice as currently in effect, although we reserve the right to change the terms of this Notice from time to time and to make the revised Notice effective for all health information we maintain. This Notice will contain the effective date on the last page. If we amend this Notice, we will provide the revised version on our website, and we will provide you with a copy of the Notice that is currently in effect, upon your request.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of Health & Human Services. You may contact Medical Associates of Englewood, PC at (201) 894-3077 and ask to speak to the Privacy Officer for additional information pertaining to a complaint. We will not take any retaliatory action against you for filing a complaint.

CONTACT PERSON

If you have any questions or would like further information about this Notice, please contact Medical Associates of Englewood, PC at (201) 894-3077 and ask to speak to the Privacy Officer.

This Notice is effective July 25, 2013, and replaces all earlier versions.