Barnabas Health Medical Group | RWJBarnabas HEALTH

Today's Date: ____________________

Patient ID# ____________ (for office use only)

Referring Physician ____________________

PATIENT REGISTRATION FORM

Patient Information

Last Name: ____________________ First Name: ____________________ MI: __________

Date of Birth: __________ Gender M ☐ F ☐ Social Security#: ____________________

For Minors please indicate responsible Parent/Guardian: ____________________

Address: ____
Street City State/Zip

Home Phone: ( ) __________ Cell Phone: ( ) __________ Work Phone: ( ) __________

Email: ____________________ Driver's License#: ____________________

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Employer: ____________________ Occupation: ____________________

Emergency Contact: ____________________ Telephone: ____________________

How did you hear about us?

Please check as many corresponding boxes that apply:

Website	☐	Facebook	☐
Google/Yahoo/Bing	☐	Other Internet Ad	☐
Newspaper/Magazine Ad	☐	Direct mailing (letter, postcard, etc.)	☐
Friend or family __________	☐	Physician	☐
Other (e.g.CVS) __________	☐		

I would like to receive email newsletters, general health tips and information from Barnabas Health: Yes ☐ No ☐

If yes, please provide email address: ____

Responsible Party
Complete only if Patient is Not the Responsible Party

Last Name: ____________________ First Name: ____________________ MI: __________

Date of Birth: __________ Age: ______ SS#: ____________________ Sex (M/F): __________

Address: ____________________ City/State: ____________________ Zip: __________

Home Telephone: ( ) ____________________ Work Telephone: ( ) ____________________

Insurance Information (Present Insurance Card(s) to Receptionist

Primary Insurance: ____________________ Policy/ID #: ____________________

Group/Plan #: ____________________ Relationship to Subscriber: ____________________

Effective Date of Primary Insurance: ____

Subscriber Information:

Last Name: ____________________ First Name: ____________________ MI: __________

Date of Birth: __________ Age: ______ SS#: ____________________ Sex (M/F): __________

Address: ____________________ City/State: ____________________ Zip: __________

Home Telephone: ( ) ____________________ Work Telephone: ( ) ____________________

Secondary Insurance: ______________________________ Policy/ID #:________________

Group/Plan #: _________________________ Relationship to Subscriber: ______________________

Effective Date of Secondary Insurance:____

Subscriber Information:

Last Name: __________________________________First Name: ___________________________MI: ___________

Date of Birth: ______________Age: ______SS#: ____________________________Sex (M/F): ________________

Address:____City/State:_________________________Zip: __________

Home Telephone: (   ) ___________________________ Work Telephone: (   ) ________________________

Demographic Information Request

In order to comply with federal regulations, we are required to ask you for the following information:

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Patient Declined

Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Patient Declined

Advance Directives

Do you have a health care proxy/living will? ☐ Yes ☐ No Do you want to discuss this with your physician? ☐ Yes ☐ No

Smoking Status

Please indicate your smoking history:

☐ Never Smoked ☐ Past Smoker ☐ Current smoker – Indicate how many and how often you smoke _________

Communication Preferences

I understand that the staff and/or physicians of Barnabas Health Medical Group ("BHMG") may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Preferred Language __________________ Preferred method for communication: ☐ Home ☐ Work ☐ Cell

Can we leave a message on machine or with whoever answers? (Circle **Yes** or **No**) **Home** Y / N **Work** Y / N **Cell** Y / N

DO NOT CALL: ☐ Home ☐ Work ☐ Cell

Disclosure to Designated Family/Friends/Caregivers

I allow BHMG to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing any time.

Print Name	Date of Birth	Relationship	Phone Number

Preferred Pharmacy

Please indicate your preferred Pharmacy /Pharmacies below:

Pharmacy Name: ______________________ Phone Number: ( ) ______________

Address: ____

____

(Indicate City and Cross Streets, Zip Code, if known)

Pharmacy Name: ______________________ Phone Number: ( ) ______________

Address: ____

____

(Indicate City and Cross Streets, Zip Code, if known)

Authorization to Access Electronic Prescription Records

I authorize Barnabas Health Medical Group ("BHMG") and its affiliated providers to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my BHMG medical record.

Health Information Exchange (HIE)

BHMG also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize BHMG and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs, and instructions on how to do that can be found in the BHMG Notice of Privacy Practices, the HIE brochure which is available from participating BHMG offices, or may be requested from BHMG's Privacy Officer.

Authorization for Photographs and Release for use in Medical Records

I hereby authorize and consent to the taking of photographs and moving pictures of me by BHMG, its agents or employees. I hereby authorize and consent to the use and storage of such photographs and moving pictures for identification purposes and as part of my medical record.

I hereby release BHMG, its medical staff, agents and employees from all liability related to the making, storage, and use of such photographs and moving pictures for identification purposes and as part of my medical record.

Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the providers in BHMG for services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments and benefits services that are out of network, denied and/or not covered by my health insurance plan. I authorize BHMG or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

Consent to Treat

I, the undersigned, voluntarily consent to and authorize BHMG through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my BHMG physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

Acknowledgments and Agreement

- I acknowledge that I have been advised of my right to an Advance Directive.
- I acknowledge receipt of the BHMG Financial Policy, and agree to all the terms and conditions contained therein.
- I acknowledge receipt of the Notice of Privacy Practices.
- I agree to allow access to my electronic prescription records as described above.
- I agree to the release and assignment of benefits as described above.
- I agree to treatment as described above.
- I have read this form, my questions have been answered, and I understand and agree to its content.

______________________________________ ________________

Patient/Representative's Signature Date

______________________________________ ______________________________

If signed by Authorized Representative, print name of Signatory Relationship to Patient/Authority to Sign for Patient

FINANCIAL POLICY

RWJBarnabas Physicians Services is dedicated to providing our patients with the best possible care and service, while keeping the cost to you from rising at unreasonable rates.

We ask for your help by understanding and cooperating with our **FINANCIAL POLICY.**

It is important for you to understand that health insurance coverage is an agreement between you and your insurance company.

AND

Your doctor's bill for services provided is an agreement between you and your doctor.

YOUR RESPONSIBILITY: Our Physicians participate with several insurance companies. It is ***your*** responsibility to call your insurance company to verify that the doctor you are seeing is participating.

If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you; however, we will expect payment from you. If you do not have valid insurance information, or we cannot confirm coverage, we will consider you "self-pay" and ask for full payment at the time of service or for a deposit for scheduled procedures.

All co-payments or payments for non-covered services are the patient's responsibility and will be collected by our staff at time of service.

In the event that your insurance carrier denies payment for authorized services, you may be asked to help resolve these issues with your carrier.

PRIMARY CARE OFFICES: If you are required to choose a Primary Care Physician ("PCP"), be sure that you have chosen one of the Physicians in the office where you have an appointment. You must contact your insurance company prior to scheduling an appointment to make this PCP selection. If your insurance company requires referrals for services at a Specialist's office, please allow five (5) business days for non-emergency services prior to seeing that specialist or facility. If you go to the Specialist's office without a referral, you may be responsible for the entire bill.

SPECIALIST OFFICES & REFERRALS: If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

You understand that it is your responsibility to know and abide by the terms of your benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. You also understand that you are responsible for full payment for services provided if you fail to supply all required referral forms.

PAYMENT FOR SERVICES PERFORMED:

1. Our offices accept Visa, MasterCard, Discover and American Express, as well as Cash, Debit Cards and Personal Checks for payment of services.
2. All payments are expected at the time of service. Should your account require the action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.
3. You may be asked for payment of deductibles or co-insurance as required by your insurance company at the time of service or at the time of procedure scheduling.

RETURNED CHECK FEE IS: $30.00

CHARGES TO ACCOUNT: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

MISSED APPOINTMENT FEE: Patients who do not show up on time for an appointment, or fail to reschedule or cancel with less than 24 hours' notice will be charged a $25.00 fee. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

MISSED TEST FEE: Patients who do not show up on time for a scheduled office based test, or fail to reschedule or cancel with less than 24 hours' notice will be charged a $150.00 fee. This charge will not be reimbursed by your insurance.

MISSED PROCEDURE FEE: Patients who do not show up on time for a scheduled procedure, or fail to reschedule or cancel with less than 48 hours' notice will be charged a $250.00 fee. This charge will not be reimbursed by your insurance.

RELEASE OF RECORDS: If you require a copy of your records for personal use, you must submit a request and pay a copying fee of $1.00 per page up to a maximum of $100.00.

Copies of records, including payment history, will be provided at no charge to other healthcare providers pursuant to a valid HIPAA authorization*.

RIGHT TO AMEND: You understand and agree that BHMG may amend the terms of this Financial Policy at any time without prior notification to the patient.

UNINSURED PATIENTS: Patients who are uninsured at the time of service will be afforded a 30% discount from posted charge if payment is made at the point of service. This discount will be extended for a period of up to 30 days after a scheduled procedure or discharge from a facility. Failure to satisfy all outstanding balances or establish an acceptable payment plan within these timeframes will result in the forfeiture of this discount.

Uninsured patients will be required to provide a 30% deposit of the estimated patient fee at the time of scheduling elective procedures. Actual fees may vary based on the clinical circumstances at the time of the procedure. Consistent with Medicare payment methodology, multiple procedure discounting will be applied allowing 50% reduction to the self-pay payment rate of secondary and subsequent procedures performed during the same encounter.

Valid HIPAA Authorization: Please note that certain information (e.g., HIV, alcohol and/or substance abuse, mental health treatment records, genetic information, family planning) require confidentiality protections. Questions concerning the disclosure of this information should be brought to the attention of the Privacy Officer.

PATIENTS WHO QUALIFY FOR HOSPITAL BASED CHARITY CARE: The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care which is provided to patients who receive inpatient and outpatient services at acute care hospitals throughout the State of New Jersey. Hospital assistance and reduced charge care are available only for necessary hospital care. ***Some services such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions are separate from hospital charges and may not be eligible for reduction.***

While RWJBarnabas Physician Services does not accept Charity Care in community based physician offices, providers will honor hospital charity care determinations when providing services in hospital based clinics or while providing services in an emergency, on-call situation in an RWJBarnabas Health facility. Charity Care determinations will be honored for one post-procedure office visit when the procedure was performed on an emergent basis during an on-call situation at an RWJBarnabas Health facility.

Patient/Representative's Signature ______________________ Date ______________________

If signed by Authorized Representative, print name of Signatory ______________________ Relationship to Patient/Authority to Sign for Patient ______________________

Revised September 21, 2017

Barnabas Health Medical Group | **RWJBarnabas HEALTH**

Practice location info here

Name: ______________________________

Date of Birth: ___/___/______ ☐ Male ☐ Female Today's Date: ______________

What is the reason for today's visit? ______________________________

☐ No Known Allergies

Allergies: ☐ Latex ☐ Food ______________ ☐ Medications: ______________

MEDICATIONS: list all medications you take, (including over the counter, herbal, natural remedies)

HEALTH HISTORY: have you ever had or been diagnosed with having (check all that apply)

Anemia		Cataracts		Glaucoma		Kidney Disease		Rheumatic Fever	
Angina		Chicken Pox		Heart Attack		Kidney Stones		Seizure/Epilepsy	
Arthritis		Dementia		Heart Disease		Lung Disease		Sleep Apnea	
Asthma		Depression / Anxiety		Heart Murmur		Measles		Stomach Ulcers	
Bleeding Disorder		Diabetes		Hemorrhoids		Migraines/s Headaches		Stroke	
Blood Clots (DVT/PE)		Digestive Disorders		High Blood Pressure		Pneumonia		Thyroid Disease	
Blood Transfusion		Frequent Infections		High Cholesterol		Pre-Diabetes		Tuberculosis	
Cancer		type of cancer:		Jaundice or Liver Disease		Prostate Enlargement		Other:	

Have you had Surgery, or been Hospitalized? Have you been to the Emergency Room in the past year?

Type of Surgery/Reason for Hospitalization/ Reason for Emergency Room visit	Date

IMMUNIZATIONS (check if yes and indicate year of last injection)

	Vaccine	Year		Vaccine	Year
	Influenza			Zoster (Shingles)	
	Tetanus			Hepatitis B	
	Pneumonia			MMR (Measles, Mumps & Rubella)	
	Varicella (Chicken Pox)			Other:	
	Tdap (Tetanus, Diphtheria & Pertussis)				

Name: ______________________________ Date of Birth: _____/_____/_______

HEALTH HABITS: check which apply (if current please indicate amount)

	Never	Past	Current	Amount
Tobacco Use				
Alcohol Use				
Seat Belt Use				
Exercise				

HEALTH MAINTENANCE: Have you had any of the following? (if YES indicate when)

	NO	YES	DATE
Mammography (Females age 40-69)			
Pap Smear (Females age 18-75)			
Colonoscopy (age 50-75)			
Bone Density (age >65)			
Last Menstrual Period (females)			
Gynecologist (females)	**NAME**		

FAMILY HISTORY

Relation	√ If Alive	Age at Death	Medical conditions/ Cause of Death
Mother			
Father			
Brothers			
Sisters			
Children			
Grandparents			

DO ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THE FOLLOWING?

Disease		Relationship to You
Anemia		
Arthritis		
Asthma		
Blood Clots		
Cancer		
Diabetes		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Stroke		
Other:		

PATIENT NAME

Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = ____________

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.

Barnabas Health Medical Group

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO THE
BARNABAS HEALTH MEDICAL GROUP PRACTICE OF PLEASE FILL IN PRACTICE NAME

PATIENT NAME____ DOB____________________

SOCIAL SECURITY NUMBER ____

ADDRESS ____

CITY ______________________________ STATE ________________ ZIP ____________

I hereby authorize ____
____

To disclose my health information to the Barnabas Health Medical Group practice ________________

The information to be disclosed to and used by the above is for the following purpose: ______________________
____

This authorization is limited to the following dates of treatment:
FROM ______________________________ TO ______________________________

Information to be disclosed:

☐ Emergency Room Record
☐History & Physical Exam
☐Operative Reports & Pathology
☐Discharge Summary
☐Consultations
☐Progress notes
☐Labs, Xrays & Tests
☐Nurses' Notes
☐Email Correspondence
☐Complete Record
☐Abstract
☐Billing Information
☐Other____________________

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS< SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, and email correspondence as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Barnabas Health Medical Group practice of Dr. fill in physician or practice name. I understand that this revocation will not apply to the extent of any actions that the practice has already taken in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: ______________________________.

I understand that authorizing the disclosure of this health information in voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Barnabas Health Medical Group practice of Dr. fill in physician or practice name at insert phone number.

PATIENT SIGNATURE:______________________________ DATE________________

If legal representative, sign below and state relationship and authority to do so and attach the document of authority.

LEGAL REPRESENTATIVE:______________________________ DATE________________

RELATIONSHIP:______________________________

WITNESS: ______________________________ DATE________________

(Two signatures required for verbal consent)

ORIGINAL – MAIL TO DISCLOSING PROVIDER **COPY – RECORD** **COPY – PATIENT**