BARNABAS HEALTH
Ambulatory Care Center

BARNABAS HEALTH REGISTRATION FORM

Date: _____

Patient Name: _____ Gender: Male / Female

Address: _____

City: _____ State_____ Zip_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security: _____ DOB: _____ Age: _____

E-MAIL: _____ (Used for Confirmations)

Race: _____ Ethnicity: _____

Languages Spoken: _____

Referring MD: _____

Primary Care Physician: _____

Insurance Name: _____ Subscriber: _____

ID# _____ Group# _____

Referral Required Yes/No Co-pay_____

Secondary Insurance Name: _____ Subscriber: _____

ID# _____ Group# _____

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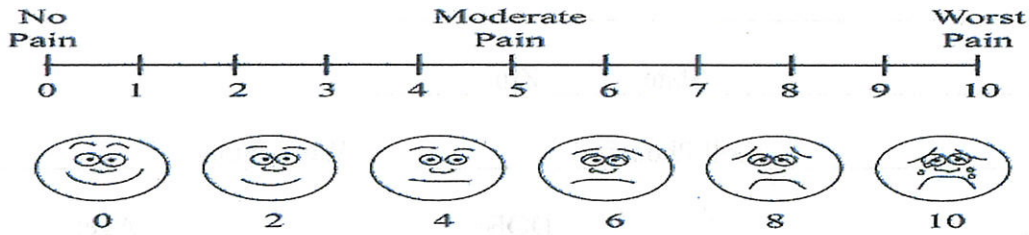
MEDICAL INFORMATION

HEIGHT: _____ WEIGHT: _____

Reason for Today's Visit: _____
(Where is your pain located?)



Pain Assessment

Location | Laterality | Pain (0-10) | Acceptable Pain (0-10) | Onset | Duration

Time Pattern
- ☐ Acute
- ☐ Chronic
- ☐ Constant
- ☐ Intermittent
- ☐ Other:

Radiates

Radiation Characteristics

Quality
- ☐ Aching
- ☐ Burning
- ☐ Cramping
- ☐ Dull
- ☐ Heavy
- ☐ Pressure
- ☐ Radiating
- ☐ Sharp
- ☐ Tightness
- ☐ Unable to describe
- ☐ Other:

Associated Symptoms
- ☐ None
- ☐ Other:
- ☐ Nausea
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Sweating
- ☐ Vomiting

Aggravating Factors
- ☐ None
- ☐ Breathing
- ☐ Movement
- ☐ Palpation
- ☐ Other:

Interventions
- ☐ Cold
- ☐ Heat
- ☐ Medications
- ☐ Repositioning
- ☐ Rest
- ☐ Other:

Alleviating Factors
- ☐ None
- ☐ Assistive devices
- ☐ Cold therapy
- ☐ Deep breathing
- ☐ Exercise
- ☐ Immobilization
- ☐ Massage
- ☐ Medications
- ☐ Moist heat
- ☐ Repositioning
- ☐ Other:

Comments

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Please indicate the date or year of Medical History

	Current	Past
CARDIOVASCULAR		
HIGH BLOOD PRESSURE		
STROKE		
HEART ATTACK		
HIGH CHOLESTEROL		
CONGESTIVE HEART FAILURE		
HEART MURMUR		
OTHER HEART PROBLEMS		
PULMONARY		
PNEUMONIA OR TUBERCULOSIS		
EMPHYSEMA		
ASTHMA		
BRONCHITIS		
OTHER LUNG PROBLEMS		
GASTROINTESTINAL		
STOMACH ULCERS		
GASTROINTESINAL BLEEDING		
COLITIS		
COLON POLYPS		
DIVERTICULITIS		
HEPATITIS OR CIRRHOSIS		
PANCREATITIS		
OTHER STOMACH PROBLEMS		
URINARY PROBLEMS		
URINARY INCONTINENCE		
KIDNEY PROBLEMS		

	Current	Past
SEIZURES		
REQUENT OR SEVERE HEADACHES		
OTHER NEUROLOGICAL PROBLEMS		
GLAUCOMA		
DIABETES		
OSTEOPOROSIS		
THYROID PROBLEMS		
BREAST PROBLEMS		
ABNORMAL PAP SMEAR		
OTHER GYNECOLOGICAL PROBLEMS		
CANCER: **(INDICATE)**_____		
ARTHRITIS		
SKIN DISEASES		
DEPRESSION OR ANXIETY		
SIGNIFICANT WEIGHT CHANGE		
PLEASE LIST ANY SURGERIES/DISEASES BELOW:		
1)		
2)		
3)		
4)		
DO YOU SMOKE? CURRENT/PAST, **(IF SO, HOW MANY A DAY?)**		
DO YOU DRINK ALCOHOL? **(Socially/Weekly/Daily, Etc)**		
ANY HISTORY OR DRUG ABUSE?		
EVER HAD BLOOD TRANSFUSIONS?		
DO YOU DRINK COFFEE/TEA?		
FAMILY HISTORY: (List which family Member)		
CANCER		
HEART DISEASE		
HIGH CHOLESTEROL		
DIABETES		
HIGH BLOOD PRESSURE		
INHERITABLE DISEASES		
OTHER ILLNESSES		

Notes/Comments:

_____

_____

_____

_____

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MEDICATION AND ALLERGY LIST

***Allergies** : (List Medication Allergies, Latex, Foods, or Seasonal)*

Current medications from home

(Please include all prescribed, over the counter, herbal medications and supplements.)

Medication Name:	**Dose:**	**Frequency/Route**

BARNABAS HEALTH
Ambulatory Care Center

SAINT BARNABAS OUTPATIENT CENTER
SPORTS AND PHYSICAL MEDICINE INSTITUTE

MEDICATION AGREEMENT

I (Patient) AGREE TO THE FOLLOWING:

- My prescriptions will be filled **ONLY** at the pharmacy noted below and at the **BHOC** Pharmacy, *if desired*. I will notify the office of any pharmacy changes.
- I will take this medication as prescribed and I will not change the amount or frequency without authorization from my physician. Unauthorized changes may result in my running out of medicine early, and early refills will not be authorized.
- I understand that due to the potential for abuse of these medications, the following rules apply: I will **NOT** be allowed to obtain early refills or receive replacement of lost or stolen medication. Refills will only be provided during regular office hours.
- I consent to random urine or blood tests, if requested, by my physician to assess compliancy and efficacy. New patients who are on pain medications or the physician is considering pain medications are screened at the initial consultation.
- For safety and security reasons, **PRESCRIPTIONS WILL NOT BE MAILED.** Prescriptions are made available in the office between the hours of 9am-4pm Monday through Thursday and 9am-2pm on Friday.
- My prescriptions will be refilled **ONLY** when taken as ordered and **ONLY** when due for renewal. It is my responsibility to notify the office for the need of refills by calling the medication refill line.
- ***A MINIMUM OF SEVEN BUSINESS DAYS IN ADVANCE IS REQUIRED TO REFILL PRESCRIPTIONS***. Refill requests will not be processed on weekends or holidays.
- Only the Sports and Physical Medicine Institute Physician will prescribe medications for my pain. I will notify my physician of any medications ordered by another physician for any other condition.
- I must be seen by the physician for scheduled appointments at no greater than **2 month** intervals in order to continue to receive prescribed medications.
- The physician will work with me to set functional goals. If I do not achieve adequate functional goals, then medication may be discontinued at the physician's discretion.
- Lost prescriptions will not be replaced.

Goals: Decrease pain; improve function, optimal relief with minimum use of medication.

COMPLICATIONS: Dependence, constipation, difficult urination, drowsiness, nausea, itching, difficulty breathing and reduced sexual function.

OVERUSE: (above the dose described) can result in organ damage, coma or death. Abrupt discontinuation of prescribed narcotic medication can result in dangerous withdrawal symptoms.

Please notify us if you are pregnant or planning to become pregnant.

ALLERGIES: _____
(Medications, Latex, Seasonal, Food)

Listed Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone #: _____

I UNDERSTAND THAT THIS AGREEMENT WILL BE CANCELLED IF:

- Prescriptions are forged or sold
- Other physicians prescribe my pain medication
- I give my medication to anyone else
- I do not keep my appointments or fail to comply with any part of the above agreement

IF CANCELLATION OF MY AGREEMENT OCCURS:

- The Sports and Physical Medicine Institute Physician will no longer prescribe these medications

I HAVE READ AND UNDERSTAND THIS AGREEMENT. I HAVE BEEN GIVEN A COPY.

PATIENT SIGNATURE: _____

WITNESS: _____

DATE: _____

BARNABAS HEALTH
Ambulatory Care Center
Sports and Physical Medicine Institute

No Show Protocol

No-Show/Cancellation Protocol Effective June 2013

To: All Sports and Physical Medicine Institute Patients

Failure to keep a scheduled appointment without adequate notification.

Please note that if you are unable to keep your scheduled appointment, you must notify us at least 24 hours in advance. We will then be able to use that allotted time to accommodate another patient on our waiting list.

Beginning June 2013, there will be a standard charge of ***$25.00*** fee for any same day cancellations and "No Show" appointments. You will be expected to pay this fee prior to your next scheduled appointment.

Emergency situations will be considered on a case by case basis.

I, _____ agree to this policy and will abide by it.

Signature: _____ Date: _____

Witness: _____ Date: _____

Saint Barnabas Medical Center
Barnabas Health

PATIENT'S NAME: _____

MR# _____

PT# _____

SEX _____ AGE _____

(AFFIX LABEL)

GENERAL CONSENT: INPATIENT, OUTPATIENT & EMERGENCY DEPARTMENT

1. **ADMISSION CONSENT:** I request and authorize Saint Barnabas Medical Center, Attending Physician and such associates, assistants and/or residents as may be selected by the said physician to provide such hospital care and to administer such routine diagnostic, radiological and/or therapeutic procedures and treatment including, but not limited to, the administration of pharmaceutical products, and intravenous medication, as in the judgement of the above physician(s) they deem necessary or advisable in my diagnosis, care and treatment. I am aware that the practice of medicine and surgery is not an exact science and I understand that no guarantee or assurance of beneficial results has been promised or implied as a result of the above-mentioned diagnostic and therapeutic procedures. I certify that I have read and fully understand this consent for diagnostic and/or therapeutic procedures and treatment. I understand that Saint Barnabas Medical Center is a teaching hospital and that medical students and residents may participate in my care and treatment. I understand that no guarantees have been made to me about the outcome of this care.
2. **MATERNITY DIVISION:** If I am admitted to have a baby, this consent shall also apply to the admission and Hospital treatment of the baby(ies) who is/are delivered by me during the hospitalization.
3. **RECURRING VISITS:** If the services rendered qualify me for recurring status, my signature hereon shall be valid for care rendered throughout this period. If, during this period, any of my registration information changes, i.e. address, phone, employment, insurance, guarantor, etc., I will notify the department where the registration originated of the change.
4. **RELEASE FROM RESPONSIBILITY FOR PATIENT'S VALUABLES:** I hereby certify that I have been advised and fully understand that Saint Barnabas Medical Center and its employees are not responsible for any and all personal articles, clothing or cash that I retain in my possession or on my person while a patient in the hospital. I acknowledge being advised not to retain more than $5.00 cash and to deposit valuables in excess of that amount for safekeeping with the hospital.
5. **RELEASE OF INFORMATION:** I understand that my medical records are kept in both hard copy and electronic form and that physicians and persons involved in my care have access to both forms of records. This may include remote access to electronic records from physician offices. The Medical Center also participates in electronic health information exchanges (HIEs) with various other health care providers. I authorize Saint Barnabas Medical Center and the HIEs with which it participates to share my health information, through the HIE networks, for purposes of 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 HIV/AIDS status, mental health treatment records, genetic tests 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 Notice of Privacy Practices. The Medical Center may seek, release and verify all or part of the patient's medical and/or financial records to any person, corporation, or government agency which is or may be liable under a statute, regulation, or contract to the hospital, the patient, a family member, or employer of the patient, for all or part of the Medical Center's charges. **I consent to the release of medical information for purposes of discharge planning. I consent to the release of my identification, general condition, and room telephone number. I understand that limited information will be utilized for Saint Barnabas Medical Center patient satisfaction surveys.**
6. **FINANCIAL AGREEMENT:** For and in consideration of services rendered, I agree to make prompt payment to Saint Barnabas Medical Center (SBMC) when billed for any and all charges not covered by valid insurance benefits. I understand that I am responsible for any health insurance deductibles, copayments, and/or coinsurance. If I am classified as a self-pay patient, a deposit will be requested. **I realize it is my obligation to obtain a referral, pre-certification or a second opinion should it be required prior to services.** If SBMC, or my insurance carrier, or its intermediaries, or the Quality Improvement Organization deems that medical and/or professional services to be given or already given are not medically necessary and/or non-covered services, I must pay for those services deemed patient responsibility. New Jersey requires 6% gross receipt tax on or after 9/1/2004 for certain cosmetic medical procedures to be collected directly from the patient. Cosmetic medical procedures are performed in order to improve a person's appearance, but without significantly serving to prevent or treat illness or disease or to promote proper functioning of the body. **I understand that the Hospital will not deny emergent or urgent treatment and/or admission based on my, or the patient's, inability to pay.**
7. **AUTHORIZATION FOR TESTING:** In the event that any healthcare provider or first responder (including emergency medical service workers and police officers) involved in my care is exposed to my blood or bodily fluids and makes a request for testing and results of such testing, I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not limited to, Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I understand and agree that the results of the blood test shall be released to me and the healthcare provider/first responder exposed to my blood or bodily fluids. To the extent possible, these results will be provided to the healthcare provider/first responder without disclosing my name.
8. **ASSIGNMENT OF BENEFITS:** I hereby assign, transfer and sign over to Saint Barnabas Medical Center all and sufficient monies, claims and/or benefits to which I may be entitled from governmental agencies, insurance carriers, union welfare funds or any other parties that are financially liable to pay the charges for the care, treatment and supplies that I was rendered and furnished or that were rendered and furnished to the patient for whom I have financial responsibility.
9. **FINANCIAL ASSISTANCE:** I have received a copy of the notice of Financial Assistance (back of patient copy of consent) and reduced Charge Financial Assistance. I understand I may be eligible for Hospital Care Payment Assistance or other forms of financial assistance but must apply to receive it.
10. **SAINT BARNABAS MEDICAL CENTER RELATIONSHIP TO CERTAIN PHYSICIANS AND PHYSICIAN GROUPS:** I understand that most of the physicians on the staff at Saint Barnabas Medical Center are not agents, servants or employees of the Saint Barnabas Medical Center but, rather are members of its Medical Staff who have been granted the privilege of using its facilities for the care and treatment of their patients. Saint Barnabas Medical Center contracts with independent groups of specialized doctors, who are neither employees nor agents of the Saint Barnabas Medical Center and are separate from the hospital and your private physicians. As such, the Saint Barnabas Medical Center has no direct or indirect liability for any act or omission of these groups or any physician, practitioner, or other employee associated with such groups. These groups may include, without limitation, the group staffing the Emergency Department, Radiology Department, the Laboratory Department, Radiation Oncology, Anesthesia and other physicians called upon to interpret certain diagnostic tests (e.g., EDG's, Echocardiographs, etc.).
11. **MEDICARE-AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST:** 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 or my physician(s) any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physicians or organization to submit a claim to Medicare for payment to me. THE SERVICE I RECEIVE MAY NOT BE COVERED BY MY MEDICARE INSURANCE. IN THE EVENT, I WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED.

ADVANCE DIRECTIVE:				☐ **Under 18**
I have an Advance Directive/Living Will/Health Care Agent	☐ **YES**	☐ **NO**	☐ **UNKNOWN**	
I would like Advance Directive Information	☐ **YES**	☐ **NO**	☐ **UNKNOWN**	
I am providing a copy to Saint Barnabas Medical Center	☐ **YES**	☐ **NO**	☐ **UNKNOWN**	☐ **Requested Copy**

- I acknowledge receipt of the "Important message from TriCare" (back of patient copy of consent) My signature only acknowledges my receipt of this message and does not waive any of my rights to request a review or make me liable for payment.
- I acknowledge receipt of the Patient's Bill of Rights.
- I have been advised of my right to an Advance Directive.
- I understand that if I do not comply with the pre-certification requirements, I will be responsible for hospital charges.
- I acknowledge receipt of the "Privacy Notice."
- I acknowledge receipt of Physician and Physician Group Relationship and Related Billing Information.
- I have read this form, my questions have been answered, and I understand and agree to its content.

Patient Signature/Authorized Representative _____ Relationship _____ Date _____

The Patient is unable to sign because: _____ Witness to signature only _____