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, post card, 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

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)

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.

Financial Responsibility

I grant permission and consent to RWJBH Physician Services, the Hospital, its assignees, all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, and third party collection agents (1) to contact me by phone at any number associated with me including wireless cell numbers, (2) to leave answering machine and voicemail messages for me and include in any such messages, information required by law (including debt collection laws) and/ or regarding amounts owed by me (3) to send me text messages or emails using any email addresses I provide and; (4) to use pre-recorded/ artificial voice messages and/or an automatic dialing device (an auto-dialer) in connection with any communications made to me or any related scheduled services and my account.

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 Patient 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

RWJBarnabas HEALTH

PATIENT FINANCIAL POLICY

RWJBH Physicians Services (includes both legacy BHMG and legacy RWJPE) is dedicated to providing our patients with the best possible care and service.

We ask for your support 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. Benefits are set by them as it relates to seeking care, notification to your plan and following your plans proscribed requirements.

AND

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

YOUR RESPONSIBILITY: Our Physicians participate with many insurance companies. It is ***your*** responsibility to call your insurance company to verify that the doctor you are seeing is participating. We also provide a listing of insurances that our physicians are participating with on our website.

If we do not participate with your insurance company and decide to move forward with seeking care in our practice, 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. This will be set at 115% of the Medicare fee as defined in New Jersey state law.

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 your service to a future date. 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. Any co-payments, deductibles or co-insurance as required by an insurance company must be paid at the time of service.
3. All payments are expected at the time of service, inclusive of current copays and incurred open balances for prior dates 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.

RETURNED CHECK FEE IS $30

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 RWJBH Physician Services may amend the terms of this Financial Policy at any time without prior notification to the patient.

*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.

UNINSURED PATIENTS: Patients who are uninsured at the time of service will be afforded a discount from posted charge if payment is made at the point of service. This discount will reflect 115% of the current stated Medicare fee. This discount will be extended for a period of up to 30 days after a scheduled procedure or discharge from a facility. Payment in full or a deposit equal to 75% of the expected outstanding balance is required prior to service.

Uninsured patients will be required to provide a 75% deposit of the estimated patient fee at the time of scheduling elective procedures. Actual fees may vary based on the actual clinical circumstances at the time the procedure.

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.***

RWJBH Physician Services, however, effective 1/1/2019 does accept Charity Care both for employed hospital physicians and in our community based physician offices. RWJBH is a leader in NJ healthcare and believes that access to our physician community along with our Hospital services is one component of insuring the health of our communities for all who require preventive, sick or emergent care. Our providers will honor hospital charity care determinations when providing services in hospital based clinics, in an emergency, on-call situation or in their established practice. Charity Care determinations along with required documents must be completely submitted and will be honored for the duration of Charity Care provision.

FINANCIAL RESPONSIBILITY: I grant permission and consent to RWJBH Physician Services, the Hospital, its assignees, all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, and third party collection agents (1) to contact me by phone at any number associated with me including wireless cell numbers, (2) to leave answering machine and voicemail messages for me and include in any such messages, information required by law (including debt collection laws) and/ or regarding amounts owed by me (3) to send me text messages or emails using any email addresses I provide and; (4) to use pre-recorded/ artificial voice messages and/or an automatic dialing device (an auto-dialer) in connection with any communications made to me or any related scheduled services and my account.

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

BARNABAS HEALTH
Medical Group

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACKNOWLEDGEMENT

PRIVACY NOTICE:
I acknowledge receipt of the "Privacy Notice."

SIGNATURES:

Name of Patient _____
Print

Date _____

Name of Patient Representative _____
Print

Relationship of Patient Representative to Patient _____

Date _____

If unable to obtain Patient's signature, please state reason and sign:

_____

_____

Signature _____

Gyn Cancer & Pelvic Surgery LLC

New Patient Medical Information Sheet

Patient's Name:_____ Preferred Name:_____DOB:_____

Date:_____Referring Doctor:_____ Pronoun:_____

Reason for Visit:_____

Do you have any allergies to medications? O Yes (list below) O No Known Drug Allergies

_____

_____

Do you take medications/vitamins on a regular basis? O Yes (list below) O No Daily Medications

1._____2._____3._____

4._____5._____6._____

Past Medical History: O Yes (see list below) O No Past Medical Problems

O Diabetes	O Hepatitis/Liver Disease	O Osteoporosis
O Heart Disease	O Blood Clots in Veins or Lungs	O Glaucoma
O High Blood Pressure	O Thyroid Over/Under Active	O Emotional Disorders
O Kidney Disease	O Bladder Problems	O Pulmonary Disorders
O Arthritis	O Sexually Transmitted Diseases	O Other:_____

Social History: Recreational Drugs: O Yes O No _____

Alcohol: O Yes O No How Often:_____ Smoking: O Yes O No Amount:_____

History of Previous Surgeries: O Yes (list below) O No Previous Surgeries

1._____Date:_____

2._____Date:_____

3._____Date:_____

Pharmacy's name/address/phone number:

_____

Family Medical History: O Yes (see list below) O No Family Medical History

O Diabetes O Hypertension O Heart Disease O Kidney Disease O Cancer

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Family History of Cancer(s): (Any Ovarian, Uterine, Breast, Colon, Stomach, Kidney, Brain)

Relative:_____Age:_____Type:_____

Relative:_____Age:_____Type:_____

Relative:_____Age:_____Type:_____

Gender History:

Sex Assigned at Birth: O Male O Female

Current Gender Identity: O Male O Female O Transgender Male (Female to Male)

O Transgender Female (Male to Female) O Gendergueer (Neither Exclusively Male or Female)

Sexual History:

Age of First Intercourse:_____Number of Sexual Partners:_____Sexual Orientation:_____

Sexually Transmitted Diseases:_____

Sexual Problems:_____

Menstrual History:

Age of Onset of Menses:_____Duration:_____Amount:_____

Days Intervening: _____Date of Last Menses: _____Menopause (Year): _____

Pregnancies: _____# Deliveries:_____# Vaginal:_____# C/S:_____# Abortions/Miscarriage:_____

Date of Last Mammogram:_____Date of Last Pap Smear:_____

Weight:_____Height:_____

Review of Systems: (fill in all that apply that have occurred in the last 48 hours or apply to your reason for this visit)

Gynecological:
O heavy periods O hot flashes O abnormal vaginal discharge
O infertility O painful intercourse O frequent yeast infections
O pelvic pain O vaginal dryness O postmenopausal bleeding

Constitutional:
O weight gain/loss O fever O night sweats O insomnia
O fatigue

Eyes:
O glasses/contacts O blurred vision O tunnel or double vision
O unusual sensitivity to light O excessive tearing or dry eyes
O cataracts O floater spots O halos O flashing lights

ENT:
O hearing loss O dizziness O earaches O hoarseness
O infection or discharge O nose bleeding O loss of smell
O sinus problems O excessive dryness/salivation
O ulceration/bleeding in mouth O difficulty swallowing

Cardiovascular:
O palpitations O chest pain O pressure or tightness
O swelling of limbs O difficulty breathing O feeling of suffocation
O heart murmur O varicose veins O cold hands or feet

Respiratory:
O coughs with/without mucus O spitting blood O night sweats
O shortness of breath O wheezing O pain with breathing
O SOB upon exertion How many pillows do you sleep on?_____

Gastrointestinal:
O changes in appetite O heartburn O excessive belching/gas
O nausea O vomiting O vomiting blood O sour stomach
O belly pain O change in bowel habits O constipation
O diarrhea O rectal bleeding O itching O tarry or bloody stools

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Genitourinary:
O excretion of large amounts of urine O frequent urination at night
O pain or burning upon urination O blood in urine
O difficulty urinating O incontinence

Review of Systems (continued):

Musculoskeletal: O joint pain O stiffness O backache O sciatica
O pain in calves when walking O weakness O warm or hot joints

Integumentary/Breast: O rashes O lumps O itching O dryness O hives
O changes in skin O changes in nails O new moles
O changes in moles O breast lumps O breast tenderness
O nipple discharge or bleeding O breast swelling

Neurological: O dizziness O drowsiness O confusion O numbness
O tingling O tremors O weakness O paralysis O fainting
O blackouts O seizures O headaches

Psychiatric: O nervousness O tension O mood swings O depression
O phobias O fear/panic O anxiety O dementia

Endocrine: O sensitivity to cold/heat O excessive sweating O excessive thirst
O excessive hunger O excessive urination O hot flashes
O missed periods O dry skin O infertility

Hematological/Lymphatic: O bruise easily O transfusion reactions O bleeding gums
O nose bleeds O swollen or tender lymph nodes

Allergy: O hay fever O sneezing O hives O itching
O multiple colds O slow healing O allergies to foods
O allergies to plants O allergies to dyes O allergies to tape