Advanced Care Oncology & Hematology Associates, LLC

Springfield 385 Morris Avenue Springfield NJ 07081 ● **West Orange** 741 Northfield Ave. Suite 203 West Orange, NJ 07052
Morristown Carol G. Simon Cancer Center / 100 Madison Avenue, Third Floor Morristown, NJ 07960
Hackettstown 657 Willow Grove St., Suite 303 Hackettstown, NJ 07840 ● **Rockaway** 333 Mt. Hope Ave. Suite 230 Rockaway, NJ 07866
Practitioners Maithili Rao, M.D. / Ashish Khot, M.D. / Charlesse Pondt, M.D. / Joshua Strauss, M.D. / Ashish Shah, D.O. Ramsey Asmar, M.D. / Nikki Bajaj, M.D. / Jessica Taff, M.D. / Ved Desai, M.D. / Marlene Schmitz, APN / Edgar "Joed" LaChica, APN / Kari Sierant, APN Jessica Surloff, PA / Cherry Rudge, APN / Jennifer Figueroa, PA / April Gheller, APN
Phone: 973.379.2111 ● Fax: 973.379.2807 ● info@njacoha.com ● www.njacoha.com

NEW PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Patient Name _____ _____ _____ ❑ Female ❑ Male **Age** _____ **Birthdate** ___/___/_____
Last Name First Name M.I.

SSN _____ - _____ -_____ **Marital Status**: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Ethnicity: ☐Hispanic ☐Non-Hispanic **Race**: ☐Caucasian ☐African-American ☐Asian ☐American India ☐Pacific Islander ☐Other

Language Spoken at Home: _____

Address _____ _____ _____ _____
Street City State Zip Code

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

Preferred Method of Contact: ☐ Home ☐Cell ☐ Work ☐ Email

May we leave lab / x-ray results on your answering machine? ❑ Yes ❑ No
Primary email contact _____
May we contact you via email for routine issues and appointments? ❑ Yes ❑ No

Pharmacy Name _____
Location _____

EMPLOYMENT INFORMATION

Occupation _____ **May we contact you at work?** ❑ Yes ❑ No

Employer Name: _____ **Phone:** _____

Address_____
Street City Zip Code

Primary Care Physician/Other: _____ **Phone:** _____**Fax:** _____
Address_____
Street City State Zip Code

Allergies to Medications: _____

☐ **No Known Allergies**

EMERGENCY CONTACTS

1. **Name** _____ **Relationship to Patient** _____
   Home Phone:_____ **Cell** _____ **Work** _____

2. **Name** _____ **Relationship to Patient** _____
   Home Phone: _____ **Cell** _____ **Work** _____

I have reviewed all previously documented information on the registration form and acknowledge that it is complete and accurate.

Signature: _____ **Print Name:** _____ **Date:** ___/___/ 20___

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

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

I acknowledge that I have your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

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

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) – pg.2

This authorization also permits Advanced Care Oncology & Hematology Associates LLC (ACOHA) to release my medical health information to the person I indicated below, family, member or person involved with my health care or payment relating to my healthcare.

For the purpose of ACOHA making the limited disclosures described above. I understand that I am not required to list anyone. I further understand that I may change this list at any time in writing.

Name: _____

Name: _____

Name: _____

Name: _____

I fully understand and accept the terms of this authorization.

Name: _____

Patient Signed: _____ **Date:** _____

Or Patient's Representative: _____ **Date:** _____

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FINANCIAL DISCLOSURE

1. Upon arrival, please sign in at the front desk and present your insurance card(s) and additional form of identification.

2. It is your responsibility to fully understand your benefit plan. It is also your responsibility to know if an insurance referral is required. If incorrect information was given resulting in non-payment of your claim, you will be responsible for the charges.

3. You are responsible for all co-payments according to your insurance plan at the time of service. When claims are processed you will be responsible for any co-insurance / deductible per your insurance company.

4. Charity care patients will be charged a nominal fee for office visits. An uninsured patient will make arrangements with the billing office at the time of service.

5. Monthly payment plans can be arranged. Please contact the billing office at 973-379-2111 to discuss payment arrangements during our hours of operations: Monday-Friday 9:00am-5:00pm.

I have read and understand the above financial policy and agree to comply and accept the responsibility for any payment that becomes due.

Patient's Name: _____

Date: _____

Patient's Signature: _____

Patient Consent

I understand the fees for services rendered are payable at the time of service unless previous arrangements have been made, or hospitalization is required. We accept assignment of Medicare and most insurance plans. I have read and give my consent for benefits to be paid directly to the above named doctors when lifetime assignment is indicated. I hereby authorize medical and billing information to be released to my insurance company.

I understand that any outstanding balance not covered or paid by my insurance will be my responsibility to pay. If my accounts are turned over to an attorney or collection agency to obtain payment, I shall be responsible for the attorney's fee. Court costs, and any other costs incurred by the collection agency.

Patient Signature: _____ Date: ____/_____/ 20____

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APPOINTMENT CANCELLATION POLICY

We strive to render excellent patient care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

OUR POLICY IS AS FOLLOWS:
We require that you give our office more than 24 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $25.00 may be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.

Additionally, missed procedures not canceled with 24 hours prior notice may be subject to a $250.00 processing fee.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for being our valued patient.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____
Print Name

_____
Signature of Patient / POA / Guardian

_____
Date

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THIS FORM IS USED IN CASE WE NEED ADDITIONAL RECORDS FROM AN OUTSIDE PROVIDER

REQUEST TO RELEASE MEDICAL RECORDS

Patient Name: _____
Date of Birth: _____

1. I authorize the use or disclosure of the above named individuals health information as described below.

2. The following individual(s) or organizations(s) are authorized to make the disclosure:

3. The type of information to be used or disclosed is as follows
(check the appropriate boxes and include other information where indicated)

____ Initial History and Physical
____ Pathology Report
____ All diagnostic imaging reports
____ Progress notes
____ 3 Most recent lab reports
____ Chemotherapy / Treatment History
____ Other (please describe) _____

4. The information identified above may be used by or disclosed to the following individuals or organization(s):

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5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of patient or legal representative: _____ Date _____

If signed by legal representative, relationship to patient: _____ Date _____

Signature of witness: _____ Date _____