Atlantic Health System

DT7013

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS INCLUDING ADMISSION AND MEDICAL TREATMENT AUTHORIZATION

This form cannot be modified. Any handwritten changes to this form shall not be legally binding or enforceable.

GENERAL CONSENT, AUTHORIZATION, PATIENT RIGHTS AND RESPONSIBILITIES

I authorize Atlantic Health System (referred to as "the Hospital"), Atlantic Medical Group ("AMG"), Hospital staff, AMG staff and the physician(s) participating in my care to render hospital and medical care for my condition, which may include routine diagnostic procedures and such other medical treatment as may be deemed advisable by the physician(s) participating in my care. This may or may not include admission to the Hospital. I acknowledge that no guarantees have been made to me about the outcome of my medical care and treatment. I understand and acknowledge that the majority of the physicians at the Hospital are members of the Voluntary Medical Staff and are not employees or agents of the Hospital, but are either independent contractors or independent practitioners who have been granted the privilege of using the Hospital's facilities for the care and treatment of their patients. This includes, but is not limited to, Emergency Department physicians, anesthesiologists, cardiologists, neonatologists, obstetricians, pathologists, radiologists, surgeons, the on call physician, telehealth providers and other consultants who may treat me. I understand that telehealth involves the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services. I consent to treatment and care by AHS affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through telehealth. I understand that doctors in training, medical and nursing students and paramedical personnel may observe and participate in my care under the supervision of the Hospital or AMG staff and my physician(s). I authorize the Hospital to arrange for the disposition of all specimens and tissues. These consents and authorizations shall also apply to the admission and medical treatment of a newborn infant who is delivered by me during my hospitalization. I understand that it may be necessary for my healthcare provider(s) to take photographs, films, recordings and/or other like images and that the presence of a vendor representative may be required for medical, educational and/or continuity of care purposes.

I hereby acknowledge receipt of a Statement of Patient Rights and Responsibilities. I understand that professional personnel are available to explain the Statement. **Not applicable to Emergency Department Treatment Authorization.**

The hospital maintains a current list of patients and their location in the hospital. ☐ **I do not permit my location to be provided to friends, family and/or visitors.**

FINANCIAL ARRANGEMENTS

I understand the Hospital charges do not include the fees of my treating physician or the fees for services provided by other Voluntary Medical Staff who may treat me. I understand that I am financially responsible for the payment of my physician fees and these fees may not be covered by my insurance plan. I authorize payment of medical insurance benefits (including managed care, Medicare and Medicaid, when applicable) directly to the Hospital and/or any physician(s) participating in my care. I understand that some insurance and managed care entities require pre-approval of certain hospitalizations, procedures and surgeries, and it may be my responsibility to obtain appropriate pre-approvals. If I am receiving hospital billed services, a copy of "An Important Message from Medicare", "An Important Message from TRICARE", and/or "Notice of Charity Care and Reduced Charge Charity Care" has been made available to me. I understand my rights as outlined in the document I have received, if any. In addition, a deposit may be requested if I have been classified as a self-pay patient. **Not applicable to Emergency Department Treatment Authorization.**

I authorize the Hospital and all clinical providers who have provided care to me, along with any billing services, collection agencies, attorneys or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology. ☐ **I do not authorize such contact at this time.**

PROTECTED HEALTH INFORMATION

I have received a copy of the Notice of Privacy Practices for Protected Health Information (the "Notice"). This Notice provides a complete description of the uses and disclosures of my Personal Protected Health Information ("PHI"). I have had an opportunity to review this information before signing this form. I consent to the Hospital, AMG and/or any physician(s) participating in my care releasing my PHI (either in writing or verbally) in order to carry out treatment, payment or health care operations. This includes any medical information (including drug and alcohol abuse treatment information, psychiatric treatment information, and HIV related information including HIV testing results (if applicable), which may be needed to process claims for medical insurance (or managed care) benefits relative to this hospitalization (including precertification or verification, if necessary), or which may be needed to conduct continued care planning.

AUTHORIZATION TO DRAW BLOOD

In the event that any individual participating in my care is accidentally exposed to my blood or bodily fluids, I authorize the Hospital to draw my blood and test it for the presence of blood borne pathogens such as the Human Immunodeficiency Virus ("HIV"). I understand that if such testing is necessary the Hospital or my physician will make all reasonable efforts to notify me. I consent to the confidential disclosure of the test results to the authorized medical provider treating the person who has been exposed to my blood or bodily fluids, so that appropriate treatment determinations may be made.

____ **By initialing here I decline to be tested for HIV and I refuse the disclosure of my blood test results.**

VALUABLES

I understand that the Hospital recommends all personal belongings and valuables be sent home with a family member or friend. I assume all risk for loss or damage to any personal belongings retained by me. The Hospital will not replace or reimburse me for any personal belongings which are lost, broken or stolen during my admission.

OUTPATIENT SERVICES IN HOSPITAL SETTING

I understand that I am having care, testing, procedure(s) or treatment that is considered an outpatient procedure in a hospital setting. As such, there may be different requirements for deductibles and/or copays than for a doctor office visit. I understand that it is my responsibility to fully understand the requirements of my insurance company or managed care entity and that I am responsible for payment of any copayments, deductibles, and charges as required.

_____ ***(Initial) I understand that there will be two components to my bill: the professional services provided by my physician and the tests and/or procedures conducted by the Hospital.***

_____ _____ _____ (am) (pm)
SIGNATURE OF PATIENT Date Time

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility which I would not otherwise have for the services rendered

_____ _____ _____ (am) (pm)
SIGNATURE OF PERSON SIGNING ON BEHALF OF PATIENT Date Time

_____ _____
PRINTED NAME OF PERSON SIGNING ON BEHALF OF PATIENT Relationship

PATIENT UNABLE TO SIGN BECAUSE: _____

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 303 Rockaway, NJ 07866
Practitioners Maithili Rao,MD / Ashish Khot, MD / Charlesse Pondt, MD / Joshua Strauss, MD / Ashish Shah, DO/ Ved Desai DO / Arunabh Sekhri, MD / Anita Sultan, MD./ Matthew Stuart, MD / Se young Han, MD / Marlene Schmitz, APN / Kari Sierant, APN/ Joed LaChica, APN / Cherry Rudge, APN / Kimberly Koval, APN / Kathleen Escobia, APN / Jessica Surloff, PA / Daniella Greaves, PA
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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INSURANCE INFORMATION OR COMPENSATION INFORMATION

Primary Insurance Name _____

Policy ID# _____ Claim/Group # _____

Address: _____

Policy Holder Name _____ Policy Holder Birthdate _____

Relation to Patient: _____

Secondary Insurance Name _____

Policy ID# _____ Claim/Group # _____

Address: _____

Policy Holder Name _____ Policy Holder Birthdate _____

Relation to Patient: _____

PRESCRIPTION DRUG INSURANCE INFORMATION

Prescription Drug Coverage _____

ID# _____ Group # _____

RX BIN# _____ RX PCN# _____

Address: _____

Phone Number: _____

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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 _____