Mountain Lakes Office
333 Route 46 West
Mountain Lakes, NJ 07046
(P) 973.316.1701 (F) 973.316.1708

Carol G. Simon Cancer Center
Morristown Memorial Hospital
100 Madison Avenue, Suite C3402
Morristown, NJ 07962
(P) 973.267.9543 (F) 973.267.2550

Welcome to our Practice:

If you have not already done so, please complete the new patient forms prior to your appointment. Please complete a detailed list of any and all medications you are taking as this is particularly important for the physician.

Please remember to bring your insurance card(s) as well as a photo I.D. with you when you come in.

IF YOUR INSURANCE REQUIRES A REFERRAL – PLEASE OBTAIN A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN PRIOR TO YOUR APPOINTMENT. YOU WILL NOT BE ABLE TO BE SEEN WITHOUT A REFERRAL IF YOUR INSURANCE REQUIRES ONE. PLEASE CHECK WITH YOUR INSURANCE CARRIER IF YOU ARE UNCERTAIN IF YOUR POLICY REQUIRES ONE.

ALSO, EACH PATIENT IS RESPONSIBLE FOR THEIR DEDUCTIBLES, CO-INSURANCE AND ANY OUT OF POCKET COSTS.

Thank you for your assistance,

Oncology & Hematology Specialists, P.A.

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PATIENT INFORMATION

Name (Last, First, MI)	Social Security #	Date of Birth	Age	Sex	Marital Status

Race	Ethnic Origin	Primary Language	Home Phone	Cell Phone	Work Phone

Street Address	City	State	Zip Code

Mailing Address (if Different than above)	City	State	Zip Code

E-mail Address

Employement Status	Employer Name	Occupation
◯ Full Time ◯ Part-Time ◯ Retired ◯ Unemployed ◯ Student		

Employer Address	City	State	Zip Code

INSURANCE INFORMATION

Primary Insurance Company	Subscriber's Name	Date of Birth	Relationship	Policy Number	Group Number

Secondary Insurance Company	Subscriber's Name	Date of Birth	Relationship	Policy Number	Group Number

Prescription Card	RX ID Number	Rx BIN Number	RX PCN Number	RX Group Number

Fill Out Only if Patient is NOT the Subscriber

Name of Subscriber OR Patient's Spouse	Social Security #	Date of Birth	Sex	Relationship to Patient

Street Address	City	State	Zip Code	Home Phone

Employer Name and Address	City	State	Zip Code	Work Phone

PHYSICIANS

Primary Care Physician	Referring Physician

EMERGENCY CONTACT INFORMATION

Contact Name (Last, First, MI)	Relationship	Primary Phone Number	Secondary Phone Number

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Patient/Guardian Signature: _____ Date: _____

Original Date:

Dates Revised:

Personal Health History

Patient Name

Immunizations & Dates Pneumonia Influenza:

Screening Dates: Mammogram Colonoscopy:

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ Yes ☐ No

LIST YOUR PREFERRED PHARMACY(S) & THEIR ADDRESS

LIST YOUR PRESCRIBED DRUGS AND OVER –THE COUNTER DRUGS, SUCH AS VITAMINS & INHALERS (If you need more room please use a separate piece of paper).

Name of the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name of the Drug	Reaction You Had

Health Habits & Personal Safety

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL & WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol Do you drink alcohol? ☐ Yes ☐ No

If "Yes" what kind?

How many per week?

Tobacco Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes – pks./day ☐ Chew - #/day

☐ Pipe - #/day ☐ Cigars - #/day

Personal Safety

Do you have an Advance Directive or Living Will? ☐ Yes ☐ No

Would you like information on the preparation of these? ☐ Yes ☐ No

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INFORMATION FOR OUR MEDICARE PATIENTS

Routine Waiver of Copayments or Deductibles Unlawful

The Medicare **deductible** is the amount that must be paid by a Medicare patient before Medicare will pay for any services for that individual. Currently, for the year of 2018, the Medicare Part B deductible is $183.00 per year.

Copayment (or coinsurance) is the portion of the cost of service which the Medicare patient has to pay. Currently, Medicare Part B copayment is 20 percent of the Medicare allowed amount. If the Medicare allowed amount is $100.00, the Medicare patient (who has met his/her deduction) must pay 20% ($20.00) of the physician's bill, and Medicare will pay 80%.

In certain cases, a physician who routinely waives Medicare copayments or deductibles could be held liable under the Medicare and Medicaid anti-kickback statue, 42 U.S.C. 1320a-7b(b). This statue makes it illegal to offer, pay, solicit, or receive anything of value as an inducement to generate business payable by Medicare or Medicaid. When physicians routinely forgive the debt for financial hardship without specific information from patient to justification, they may be unlawfully inducing that patient to purchase services.

Signature: _____ Date: _____

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FINANCIAL POLICY STATEMENT

To help our patients fully understand our billing process, we ask that you read and sign our financial policy statement.

As a courtesy to you, Oncology & Hematology Specialists, P.A., will submit a claim to your insurance carrier. Depending on your individual policy, your coverage, your deductible and/or co-payment requirements, you may be billed for the balance.

Although Oncology & Hematology Specialist, P.A., participates with most insurance carriers, it is your responsibility at the time of service to verify with your insurance carrier if the particular physician or the service/test that you are scheduled to have is accepted by your plan.

For claims not submitted as a courtesy, Oncology & Hematology Specialists, P.A., accepts cash, checks, debit cards, Discover Card, MasterCard or Visa for payment. For insurance plans that do not allow courtesy submission of claims, you must pay at the time of service.

When our doctor participates fully in your insurance plan, you are still responsible for paying any co-insurance, deductible of co-payment(s) as indicated by your carrier, as well as any non-covered service(s) under their contract. Once payment has been made or payment has been denied by the insurance company you will be billed and be responsible to pay the balance.

You are responsible for bringing the necessary referrals(s) to the office on the day of your appointment. If you do not have the required referral form(s) on the day of the appointment, you are responsible for payment at the time of service and must sign a waiver.

Although Oncology & Hematology Specialists, P.A., may on occasion, as a courtesy to you file private insurance claims, we will not become involved in disputes between you and your insurance carrier regarding covered charges, secondary insurance issues or "usual and customary" charges other than supply factual information as requested by the insurance carrier.

THANK YOU FOR TAKING THE TIME TO REVIEW THE ONCOLOGY & HEMATOLOGY SPECIALISTS, P.A., FINANCIAL POLICY STATEMENT. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS, COMMENTS OR SPECIAL CONCERNS!

Responsible Party Signature: _____ Date: _____

PRINT NAME _____

ONCOLOGY & HEMATOLOGY SPECIALISTS, P.A.
NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1988 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

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

I acknowledge that I have been advised of your Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information and that a copy of these practices was made available to me. I understand that this organization has the right to change or update its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

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

Patient Name _____ Signature: _____

Other: _____ Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's/designee's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: Unable to sign _____ Refused to sign _____

ONCOLOGY & HEMATOLOGY SPECIALISTS, P.A.

HIPAA CONSENT

Oncology & Hematology Specialists (OHS) requires written authorization to discuss your care with family, friends or others.

Patient Name:

Date of Birth:

Street Address:

City/State/Zip:

The following names listed are those that I give Oncology & Hematology Specialists authorization to discuss my care:

	Relationship		Phone Number		
	Relationship		Phone Number		
	Relationship		Phone Number		

Or, ☐ DO NOT PROVIDE health information to anyone but me.

Do you have a Medical Power of Attorney: ☐ Yes ☐ No

If yes:

Name: Relationship Phone Number:

This authorization will remain in effect until I have completed and signed an updated authorization or I provide a written Notice of revocation to Oncology & Hematology Specialists.

If I have questions about disclosure of my health information, I can contact OHS at 973-316-1701 or email via the patient portal.

Patient/Legal Representative **Date**:

I need not sign this form in order to assure treatment.
(To be completed if patient refuses to sign acknowledgement).

Date Name of person providing notice.

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individuals also provide the right to request confidential communications or that a communication of PHI is made by alternative means.

I wish to be contacted in the following manner for appointments and test results:

Check all that apply

Home/Cell Number _____ Work Number _____

- ☐ Leave message with appointment date & time
- ☐ Leave messages with test results
- ☐ Leave message with dietary restrictions for scheduled tests
- ☐ Leave a call back number only
- ☐ DO NOT leave message

OHS may leave PHI on my voice mail/answering machine	☐ Yes	☐ No
OHS may leave PHI with an adult who answers your home phone	☐ Yes	☐ No
If you use a transportation service to bring you to appointments/treatments, may we release limited PHI such as end of treatment time to the driver/transportation company?	☐ Yes	☐ No

_____ _____

Patient/Legal Representative **Date**