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

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.

*****NOTICE: A $50 fee will now be charged for appointments that are missed or canceled with less than 24 hours' notice*****

Thank you for your assistance,
Oncology & Hematology Specialists, LLC.

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Mountain Lakes, NJ 07046
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PATIENT INFORMATION						
Name (Last, First, MI)			Social Security #	Date of Birth	Age	Sex Assigned at Birth
Marital Status	Race	Ethnic Origin	Primary Language	Sexual Orientation		Gender Identity
Email Address			Home Phone	Cell Phone		Work Phone
Home Street Address			City	State		Zip Code
Mailing Address (*if different from above*)			City	State		Zip Code
Employment Status					Occupation	
☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student						
Employer Name	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 (Last, First, MI)	Social Security #	Date of Birth	Sex	Relationship to Patient
Home Street Address	City	State		Zip Code
Employer Name & Address	City	State		Zip Code

PHYSICIANS	
Primary Care Physician (PCP)	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 INTREST 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:** _____

Personal Health History

Patient Name

IMMUNIZATIONS & DATES		
Pneumonia *(date)* :	Influenza *(date)* :	Other Vaccinations (*names & dates*):

SCREENING DATES		
Mammogram *(date)* :	Colonoscopy *(date)* :	Other Screenings(*names & dates*):

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

BLOOD TRANSFUSIONS

Have you ever had a blood transfusion? ☐ YES ☐ NO

PREFERRED PHARMACY(S)

Primary Pharmacy Name		Phone	
Street Address	City	State	Zip Code
Secondary Pharmacy Name		Phone	
Street Address	City	State	Zip Code

ALLERGIES TO MEDICATIONS

Name of the Drug	Reaction you had

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

HEALTH HABITS & PERSONAL SAFETY

ALCOHOL

Do you drink Alcohol? ☐ Yes ☐ No

If "Yes" what kind?

How many drinks per week?

TOBACCO

Do you use tobacco? ☐ Yes ☐ No

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

☐ Pipe: ☐ Cigars - #/day:

LIVING WILL OR ADVANCED DIRECTIVE

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

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

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, LLC., 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 Specialists, LLC., 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 no submitted as a courtesy, Oncology & Hematology Specialists, LLC., accepts cash, checks, debit cards, Discover Card, Master Card, or Visa for payment. For insurance plans that do not allow courtesy submissions 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 coinsurance, 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 referral(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, LLC, 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, LLC., Financial Policy Statement. Please let us know if you have any questions, comments or special concerns.

Patient/Guardian Signature:		Print Name:		**Date:**	

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1988 (HIPPA), 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 & directly communicate 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 & disclosure 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:		**Patient/Guardian Signature:**	
Guardian/Custodian Name		**Relationship to patient:**	**Date:**

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 2025, the Medicare Part B deductible is $240 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% 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 cold be held liable under the Medicare and Medicaid anti-kickback statute, 42 U.S.C. 1320z-7b(b). This statute makes it illegal to offer, pay, solicit, or received 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 the patient to justification, they may be unlawfully inducing that patient to purchase services.

Patient/Guardian Signature:		**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:	

HIPAA Consent for Oncology & Hematology Specialists, LLC

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:

Name	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 and updated authorization or I provide a written "Notice of Revocation" to Oncology & Hematology Specialists.

The HIPAA privacy rule gives individual 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 messages

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 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

I need not sign this form in order to insure treatment. If I have any questions about disclosure of my health information, I can contact OHS at 973-316-1701 or email via the patient portal.

Patient/Guardian Signature: _____ **Date:** _____

******OFFICE USE ONLY******

(To be completed if patient refuses to sign acknowledgement).

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

Patient Info Packet.

You may detach these following pages from the intake papers and keep for your records.

Oncology & Hematology Specialists, LLC

Policy Number and Title DRX2-1B New Patient Pack Contents for Dispensary Patients
Scope: Administration, HR, Operations Staff
Effective: 1/10/2025

Dispensary Contact Information

Oncology & Hematology Associates, LLC
333 Route 46 West
Mountain Lakes, NJ 07046

(P) 973-394-9903
(F) 973-316-1708
Toll Free - 888-708-8585

Weekday Hours

Monday - Friday: 8:30 am to 5:00 pm
CLOSED - Saturday, Sunday & major holidays

After-Hours Services:

An answering service will answer OHS dispensary phones after normal business hours. You may leave a message or inform the operator that you wish to speak to a company representative and the on-call staff will be contacted.

Disaster Services:

In the event of a disaster and all three OHS phone numbers are down, please call Dispensary Manager email at coakes@ohsnj.com and a refill and new prescription information can be obtained.

OHS will contact those patients whose prescriptions can be picked up from OHS alternate site at 100 Madison Avenue, Suite 3101 Morristown, NJ.

For Grievances/Complaints:

Please contact Compliance Officer - Christie Oakes 973-532-8603

Email contact@ohsnj.com

Website: www.ohsnj.com

Authored by: Christie Oakes, Compliance Officer

Created: 1/1/2020
Revised: 2/20/2025

Take our Servey! How are we doing?

https://ohsnj.com/survey/

Oncology & Hematology Specialists, PA

Oncology & Hematology Specialists, LLC
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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS -You have the right to get a written explanation from your Medicare drug plan if:
--Your doctor or pharmacist tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed by your doctor.
--You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.
The Medicare drug plan ' s written explanation will give you the specific reasons why the prescription drug is not covered and will explain how to request an appeal if you disagree with the drug plan ' s decision.
You also have the right to ask your Medicare drug plan for an exception if:
--You believe you need a drug that is not on your drug plan ' s list of covered drugs. The list of covered drugs is called a " formulary; " or
--You believe you should get a drug you need at a lower cost-sharing amount.
WHAT YOU NEED TO DO:
--Contact your Medicare drug plan to ask for a written explanation about why a prescription is not covered or to ask for an exception if you believe you need a drug that is not on your drug plan ' s formulary or believe you should get a drug you need at a lower cost-sharing amount.
--Refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.
When you contact your Medicare drug plan, be ready to tell them:
1. The prescription drug(s) that you believe you need.
2. The name of the pharmacy or physician who told you that the prescription drug(s) is not covered.
3. The date you were told that the prescription drug(s) is not covered.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice: 6/10/2025

This Notice of Privacy Practices applies to the following organizations.

Oncology & Hematology Specialists, LLC

Christie Oakes
Security & Privacy Officer
coakes@ohsnj.com 973.316-1701