RWJBarnabas HEALTH | RWJBarnabas Renaissance Primary Care

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Last First MI

Social Security #:_____ Sex: ❑ M ❑ F Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Address: _____Apt:_____City:_____ State:_____ Zip:_____

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

OK to leave detailed message? ❑Yes ❑No OK to leave detailed message? ❑Yes ❑No OK to leave detailed message? ❑ Yes ❑No

Patient Email:_____ Patient Driver's License:_____

Occupation:_____ Employer Name:_____ Employer Phone:_____

Notify in case of emergency:_____ Relationship:_____ Phone:_____

How did you hear about us? ❑ Friend/Family ❑ Physician Referral _____ ❑ Online Search ❑ Other_____

INSURANCE POLICY INFORMATION

This information will be used for billing purposes; please present your insurance card and a photo ID to the front desk receptionist.

Primary Insurance Name: _____ Phone: _____

Policy / Claim #: _____ Group #: _____

Subscriber Name: _____ Authorization / Pre-Certification: _____

Subscriber Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other Subscriber Date of Birth"_____

Subscriber Social Security #:_____ Subscriber Employer:_____

Secondary Insurance Name: _____ Phone:_____

Policy / Claim #: _____ Group #:_____

Subscriber Name: _____ Authorization / Pre-Certification: _____

Subscriber Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other Subscriber Date of Birth:_____

ACCIDENT INFORMATION

Did you have Surgery: ❑ Yes ❑ No Surgery Date: _____ Accident/Injury type: ❑Workers Comp* ❑Auto ❑Other:_____

Accident / Injury Date / Date Doctor was seen for this problem: ____/____/____ Briefly describe accident: _____

*If Worker's Comp - Employer: _____ State: _____

Adjuster Name:_____ Adjuster Phone:_____Case #:_____

PATIENT SIGNATURE

I have reviewed the above information and verify that it is correct.

Patient / Guardian signature: _____ **Date:** _____

PLEASE NOTE: Payment is expected at the time of visit unless other arrangements are made in advance. (Prior to appointment)

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Have you ever had or are you now subject to any of the following? Please check:

1.	_____	Asthma	17.	_____	Kidney stone or disease
2.	_____	Allergies	18.	_____	Neurological disorders
3.	_____	Diabetes	19.	_____	Pneumonia
4.	_____	Anemia	20.	_____	Arthritis
5.	_____	Cancer	21.	_____	Depression
6.	_____	Abnormal Bleeding	22.	_____	Skin disorders
7.	_____	Colds	23.	_____	Tuberculosis
8.	_____	Ear/nose/sinus/throat disorders	24.	_____	Shortness of breath
9.	_____	Chronic Cough	25.	_____	Venereal disease
10.	_____	Eye disorders	26.	_____	Chest pain
11.	_____	Digestive Disturbances	27.	_____	Indigestion, difficulty swallowing
12.	_____	Epilepsy	28.	_____	Intestine disorders
13.	_____	Thyroid disease	29.	_____	Back pain
14.	_____	Headaches	30.	_____	Surgery
15.	_____	Heart ailments	31.	_____	Fainting spells
16.	_____	High blood pressure			

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

Women only: Are you pregnant? ❑ YES ❑ NO Are you planning on getting pregnant? ❑ YES ❑ NO

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

HABITS

Smoke: Packs Daily	_____	Coffee: Cups Daily	_____	Sleep: Difficulty falling asleep?	_____
How Long?	_____	Other caffeine?	_____	Continuity Disturbances?	_____
Interested in stopping?	_____	Alcohol: Type/Amount?	_____	Snoring?	_____
Exercise Routine?	_____	Diet: Salt Intake?	_____	Early morning awakening?	_____
_____		Diet: Fat Intake?	_____	Daytime drowsiness?	_____

Contact with blood or body fluid at work?_____

Allergic to any medications? Y / N If yes, please list:_____

Please list medications you are taking:_____

_____

To the best of my knowledge and belief, the above statements are complete and true.

Signature:_____ **Date:**_____

INTERNAL USE ONLY – Intake reviewed by:_____

NOTICE OF PRIVACY PRACTICES

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information", or "PHI" for short and it includes information that can be used to identify you that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in main reception area. You can also request a copy of this notice from the contact person listed in Section IV below at any time.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclosure your PHI without your authorization for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.

2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.

3. **For health care operations.** We may disclose your PHI in order to operate this practice. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds: or when ordered in a judicial or administrative proceeding.

5. **For public health activities.** For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

6. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

7. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

8. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions**. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

B. Use and Disclosure Where You Have the Opportunity to Object:

1. **Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. **All Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

D. **Incidental Uses and Disclosures.** Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure.

However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient at a nursing station that might be overheard by personnel not involved in the patient's care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your requires, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you $1 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care Operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or in compliance with National Instant Criminal Background Check System as of 1/7/14.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $10 for each additional request.

E. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 30 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATIN ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Physicians' Practice Enhancement, LLC, Attn: Theresa DeRogatis; 66 West Gilbert Street, Suite 100; Red Bank, New Jersey 07701-4918; (732) 212-0060 ext. 274; e-mail: tderogatis@ppenet.com

VII. EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on January 1, 2015.

RWJBarnabas HEALTH | RWJBarnabas Renaissance Primary Care

Patient Agreements – Consent for Treatment

Please read the following statements and indicate your acknowledgement and/or authorization for each below:

I, _____ am authorized and hereby give consent for the medical staff of
(Patient/Guardian)
RWJBarnabas Renaissance Primary Care to examine and render care to _____.
(Name of Patient/Self)

Your privacy is of utmost concern to us at RWJBarnabas Renaissance Primary Care, and we strictly adhere to HIPAA regulations. These regulations do allow us to call you at a phone number provided by you for specific purposes. We can call you to remind you of upcoming appointments and to leave either a voice mail message or a message with the person who answers the phone asking you to call us back. We do not leave Personal Health Information (PHI) unless authorized by you.

Please read the following statements and indicate your acknowledgement and/or authorization for each below with your initials:

_____ I acknowledge that I have received/read a copy of RWJBarnabas Renaissance Primary Care HIPAA information.

_____ I authorize staff of RWJBarnabas Renaissance Primary Care to leave detailed messages only via voice mail on the phone number provided. These messages may contain Personal Health Information (PHI) such as the results of tests.

_____ I authorize the staff of RWJBarnabas Renaissance Primary Care to leave detailed messages containing PHI with any person answering the below phone numbers(s).

Authorized Phone Number(s):_____ or _____ . .

_____ RWJBarnabas Renaissance Primary Care collects information including your email address or mobile phone number to deliver patient statements, alerts, and/or e-newsletters. You can opt out of these communications at any time. We will never sell, rent, or give away our email list for 3rd party marketing.

Patient Permission to Share Protected Health Information

_____ I hereby authorize the staff of RWJBarnabas Renaissance Primary Care to use or disclose my health information (referred to as "Protected Health Information") to any healthcare provider and/or employee of RWJBarnabas Renaissance Primary Care. The Protected Health Information (PHI) I am authorizing for use of disclosure is the standard release of information (includes typed diction and therapy notes) and specific information from my chart which includes: _____.

_____ I hereby authorize and request RWJBarnabas Renaissance Primary Care to disclose my PHI to the person(s) or institution(s) listed below. I understand that this authorization will expire 180 days from signing, unless an earlier date is indicated:

Authorized Name(s)	Relationship to patient	Discuss PHI	
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No

FOR INTERNAL USE ONLY:

Intake reviewed by: _____ Date: _____ rev.06/2020

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_____ I understand that RWJBarnabas Renaissance Primary Care has the right to bill me $1.00 per page for each copy of my PHI.

Receipt of Notice of Privacy Practices

_____ I have received and reviewed the Notice of Privacy Practices.

Revoking Rights for Patient Agreement

_____ I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if RWJBarnabas Renaissance Primary Care has taken action in reliance upon this Authorization or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy. I understand that I may revoke this Authorization by sending a written request to:
RWJBarnabas Renaissance Primary Care
217 Chestnut Street
Newark, NJ 07105

This consent shall remain in effect until revoked in writing.

By signing this Authorization, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature (Patient) Date Signature (Authorized Representative) Date

_____ _____
Name Printed Relationship of Authorized Representative to Patient

_____ _____
Patient's Telephone # Patient's Date of Birth

FOR INTERNAL USE ONLY:

Intake reviewed by: _____ Date: _____ rev.06/2020

RWJBarnabas HEALTH | RWJBarnabas Renaissance Primary Care

Financial Policy Statement

RWJBarnabas Renaissance Primary Care calls your insurance company in advance of your treatment to verify what they will and/or will not cover, and what your responsibility may be. This is an "estimation" of your benefits and not a guarantee they will pay that way. Your total share may be more than the payments (i.e., co-pays) you have made to the facility.

The explanation of benefits itemizes what was covered/paid to both the patient and to RWJBarnabas Renaissance Primary Care. RWJBarnabas Renaissance Primary Care will send a letter/bill asking for any further amounts due for that billing period, if any. You may also receive an automated reminder call for any balance due. If at any time you feel your insurance company processed your claim incorrectly, please contact them directly.

It is your responsibility for the payment of your account. Please understand that if you fail to make any of the payments for which you are responsible, in a timely manner, you will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

NO SHOW POLICY

It is the policy of this facility to charge a "no show" fee of $25.00 to patients who have missed 2 consecutive appointments without 24 hours' notice. This fee may be waived at the discretion of the Office Manager based on individual circumstances of the patient (e.g., family illness or accident).

Please be advised that you may have to make a copay/co-insurance payment for each visit with RWJBarnabas Renaissance Primary Care. Your copay/co-insurance amount is as per your insurance company. By signing below, you agree to make your copay/co-insurance payment on each visit. We accept Visa, MasterCard, Checks, Money Orders, and Cash.

If you do not pay your copay at time of services, there will be an additional $15 charge.

If at any time your insurance changes, please inform facility front desk as soon as possible.

Every employee on the RWJBarnabas Renaissance Primary Care team is committed to delivering exceptional service to our patients. Thank you for choosing RWJBarnabas Renaissance Primary Care.

By signing below you are stating that you have read and understand this form:

_____
Patient Name

_____ _____
Patient or Legal Guardian Signature Date

FOR INTERNAL USE ONLY:

Intake reviewed by: _____ Date: _____ rev.06/2020