**Barnabas Health**
**Medical Group**

Today's Date: _____

Patient ID # _____ [for office use only]

Referring Physician _____

## PATIENT REGISTRATION FORM

### Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: M □ F □ Social Security #: _____

For Minors please indicate responsible Parent/Guardian: _____

Address: _____
Street City State/Zip

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Email: _____ Driver's License #: _____

Marital Status: Single □ Married □ Widowed □ Separated □ Divorced □

Employer: _____ Occupation: _____

Emergency Contact: _____ Telephone: _____

### How did you hear about us?

Please check as many corresponding boxes that apply:

| | | | |
|---|---|---|---|
| Website | □ | Facebook | □ |
| Google/Yahoo/Bing | □ | Other Internet Ad | □ |
| Newspaper/Magazine Ad | □ | Direct mailing (letter, post card, etc.) | □ |
| Friend or family_____ | □ | Physician | □ |
| Other (e.g., CVS)_____ | □ | | |

I would like to receive email newsletters, general health tips and information from Barnabas Health: Yes □ No □
If Yes, please provide email address: _____

### Responsible Party
### Complete Only if Patient is Not the Responsible Party

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

### Insurance Information (Present Insurance Card(s) to Receptionist)

**Primary Insurance:** _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Effective Date of Primary Insurance: _____

**Subscriber Information**:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

**Secondary Insurance:** _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Effective Date of Secondary Insurance: _____

**Subscriber Information**:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: (  ) _____ Work Telephone: (  ) _____

## Demographic Information Request

In order to comply with federal regulations, we are required to ask you for the following information:

**Race**
- □ American Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Other Pacific Islander
- □ White
- □ Patient Declined

**Ethnicity**
- □ Hispanic or Latino
- □ Not Hispanic or Latino
- □ Patient Declined

## Advance Directives

Do you have a health care proxy/living will? □ Yes □ No Do you want to discuss this with your physician? □ Yes □ No

## Smoking Status

Please indicate your smoking history:

□ Never Smoked □ Past Smoker □ Current smoker – Indicate how many and how often you smoke _____

## Communication Preferences

I understand that the staff and/or physicians of Barnabas Health Medical Group ("BHMG") may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Preferred Language _____ Preferred method for communication: □ Home □ Work □ Cell

Can we leave a message on machine or with whoever answers? (Circle **Yes** or **No**) **Home** Y / N **Work** Y / N **Cell** Y / N

**DO NOT CALL:** □ Home □ Work □ Cell

## Disclosure to Designated Family/Friends/Caregivers

I allow BHMG to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing any time.

| Print Name | Date of Birth | Relationship | Phone Number |
|---|---|---|---|
| | | | |
| | | | |

## Preferred Pharmacy

Please indicate your preferred Pharmacy /Pharmacies below:

Pharmacy Name: _____ Phone Number: (  ) _____

Address: _____

_____

(Indicate City and Cross Streets, Zip Code, if known)

Pharmacy Name: _____ Phone Number: (_____)_____

Address: _____

_____

(Indicate City and Cross Streets, Zip Code, if known)

## Authorization to Access Electronic Prescription Records

I authorize Barnabas Health Medical Group ("BHMG") and its affiliated providers to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my BHMG medical record.

## Health Information Exchange (HIE)

BHMG also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize BHMG and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs, and instructions on how to do that can be found in the BHMG Notice of Privacy Practices, the HIE brochure which is available from participating BHMG offices, or may be requested from BHMG's Privacy Officer.

## Authorization for Photographs and Release for use in Medical Records

I hereby authorize and consent to the taking of photographs and moving pictures of me by BHMG, its agents or employees. I hereby authorize and consent to the use and storage of such photographs and moving pictures for identification purposes and as part of my medical record.

I hereby release BHMG, its medical staff, agents and employees from all liability related to the making, storage, and use of such photographs and moving pictures for identification purposes and as part of my medical record.

## Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the providers in BHMG for services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments and benefits services that are out of network, denied and/or not covered by my health insurance plan. I authorize BHMG or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

## Consent to Treat

I, the undersigned, voluntarily consent to and authorize BHMG through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my BHMG physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

## Acknowledgments and Agreement

- I acknowledge that I have been advised of my right to an Advance Directive.
- I acknowledge receipt of the BHMG Financial Policy, and agree to all the terms and conditions contained therein.
- I acknowledge receipt of the Notice of Privacy Practices.
- I agree to allow access to my electronic prescription records as described above.
- I agree to the release and assignment of benefits as described above.

- I agree to treatment as described above.
- I have read this form, my questions have been answered, and I understand and agree to its content.

Patient/Representative's Signature

Date

If signed by Authorized Representative, print name of Signatory

Relationship to Patient/Authority to Sign for Patient

RWJBarnabas HEALTH

# PATIENT FINANCIAL POLICY

RWJBH Physicians Services (includes both legacy BHMG and legacy RWJPE) is dedicated to providing our patients with the best possible care and service.

We ask for your support by understanding and cooperating with our **FINANCIAL POLICY.**

***It is important for you to understand that health insurance coverage is an agreement between you and your insurance company. Benefits are set by them as it relates to seeking care, notification to your plan and following your plans proscribed requirements.***

**AND**

***Your doctor's bill for services provided is an agreement between you and your doctor.***

**YOUR RESPONSIBILITY:** Our Physicians participate with many insurance companies. It is ***your*** responsibility to call your insurance company to verify that the doctor you are seeing is participating. We also provide a listing of insurances that our physicians are participating with on our website.

If we do not participate with your insurance company and decide to move forward with seeking care in our practice, we will bill your insurance carrier as a courtesy to you; however, we will expect payment from you. If you do not have valid insurance information, or we cannot confirm coverage, we will consider you "self-pay" and ask for full payment at the time of service or for a deposit for scheduled procedures. This will be set at 115% of the Medicare fee as defined in New Jersey state law.

All co-payments or payments for non-covered services are the patient's responsibility and will be collected by our staff at time of service.

In the event that your insurance carrier denies payment for authorized services, you may be asked to help resolve these issues with your carrier.

**PRIMARY CARE OFFICES:** If you are required to choose a Primary Care Physician ("PCP"), be sure that you have chosen one of the Physicians in the office where you have an appointment. You must contact your insurance company prior to scheduling an appointment to make this PCP selection. If your insurance company requires referrals for services at a Specialist's office, please allow five (5) business days for non-emergency services prior to seeing that specialist or facility. If you go to the Specialist's office without a referral, you may be responsible for the entire bill.

**SPECIALIST OFFICES & REFERRALS:** If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule your service to a future date. You agree to be responsible for payment of your account regardless of referral status.

You understand that it is your responsibility to know and abide by the terms of your benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. You also understand that you are responsible for full payment for services provided if you fail to supply all required referral forms.

**PAYMENT FOR SERVICES PERFORMED:**

1. Our offices accept Visa, MasterCard, Discover and American Express, as well as Cash, Debit Cards and Personal Checks for payment of services.
2. Any co-payments, deductibles or co-insurance as required by an insurance company must be paid at the time of service.
3. All payments are expected at the time of service, inclusive of current copays and incurred open balances for prior dates of service. Should your account require the action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

**RETURNED CHECK FEE IS $30**

**CHARGES TO ACCOUNT:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

**MISSED APPOINTMENT FEE:** Patients who do not show up on time for an appointment, or fail to reschedule or cancel with less than 24 hours' notice will be charged a $25.00 fee. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

**MISSED TEST FEE:** Patients who do not show up on time for a scheduled office based test, or fail to reschedule or cancel with less than 24 hours' notice will be charged a $150.00 fee. This charge will not be reimbursed by your insurance.

**MISSED PROCEDURE FEE:** Patients who do not show up on time for a scheduled procedure, or fail to reschedule or cancel with less than 48 hours' notice will be charged a $250.00 fee. This charge will not be reimbursed by your insurance.

**RELEASE OF RECORDS:** If you require a copy of your records for personal use, you must submit a request and pay a copying fee of $1.00 per page up to a maximum of $100.00.

Copies of records, including payment history, will be provided at no charge to other healthcare providers pursuant to a valid HIPAA authorization*.

**RIGHT TO AMEND:** You understand and agree that RWJBH Physician Services may amend the terms of this Financial Policy at any time without prior notification to the patient.

*Valid HIPAA Authorization: Please note that certain information (e.g., HIV, alcohol and/or substance abuse, mental health treatment records, genetic information, family planning) require confidentiality protections. Questions concerning the disclosure of this information should be brought to the attention of the Privacy Officer.

**UNINSURED PATIENTS:** Patients who are uninsured at the time of service will be afforded a discount from posted charge if payment is made at the point of service. This discount will reflect 115% of the current stated Medicare fee. This discount will be extended for a period of up to 30 days after a scheduled procedure or discharge from a facility. Payment in full or a deposit equal to 75% of the expected outstanding balance is required prior to service.

Uninsured patients will be required to provide a 75% deposit of the estimated patient fee at the time of scheduling elective procedures. Actual fees may vary based on the actual clinical circumstances at the time the procedure.

**PATIENTS WHO QUALIFY FOR HOSPITAL BASED CHARITY CARE:** The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care which is provided to patients who receive inpatient and outpatient services at acute care hospitals throughout the State of New Jersey. Hospital assistance and reduced charge care are available only for necessary hospital care. ***Some services such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions are separate from hospital charges and may not be eligible for reduction.***

RWJBH Physician Services, however, effective 1/1/2019 does accept Charity Care both for employed hospital physicians and in our community based physician offices. RWJBH is a leader in NJ healthcare and believes that access to our physician community along with our Hospital services is one component of insuring the health of our communities for all who require preventive, sick or emergent care. Our providers will honor hospital charity care determinations when providing services in hospital based clinics, in an emergency, on-call situation or in their established practice. Charity Care determinations along with required documents must be completely submitted and will be honored for the duration of Charity Care provision.

**FINANCIAL RESPONSIBILITY:** I grant permission and consent to RWJBH Physician Services, the Hospital, its assignees, all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, and third party collection agents (1) to contact me by phone at any number associated with me including wireless cell numbers, (2) to leave answering machine and voicemail messages for me and include in any such messages, information required by law (including debt collection laws) and/ or regarding amounts owed by me (3) to send me text messages or emails using any email addresses I provide and; (4) to use pre-recorded/ artificial voice messages and/or an automatic dialing device (an auto-dialer) in connection with any communications made to me or any related scheduled services and my account.

_____ _____

Patient/Representative's Signature Date

_____ _____

If signed by Authorized Representative, print name of Signatory

Relationship to Patient/Authority to Sign for Patient

**Barnabas Health**
**Medical Group**

# NOTICE OF PRIVACY PRACTICES

**Effective April 14, 2003; Last revised as of July 9, 2014**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

I. We are required by law to protect the privacy of your health information often referred to as protected health information or "PHI" which may include individually identifiable information that relates to your past/present/future physical or mental health condition and provision of health care and/or past/present/future payment for health care.

We are required to provide you with a copy of this notice describing the privacy practices and legal duties and to explain how, when, and why Barnabas Health Medical Group (BHMG) may use or disclose your protected health information.

BHMG recognizes and respects your right to confidentiality, and we maintain numerous safeguards to protect your privacy. We are required by law to abide by the terms of this notice currently in effect. We reserve the right to change this notice from time to time and to make the Notice effective for all PHI we maintain. You can always obtain a copy of our most current notice by contacting the Privacy Officer.

**If you have questions or want additional information regarding subjects covered in the notice, contact the Privacy Officer, BHMG, 95 Old Short Hills Rd, West Orange, NJ 07052, 973-322-4613 or** bhmgprivacyofficer@barnabashealth.org.

## II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The following categories describe different ways that we may use or disclose medical information about you. For each category, we have provided some examples:

- **Treatment** means the provision, coordination, or management of your health care, including consultations between doctors, nurses, and other providers, regarding your care and referrals for care from one provider to another. For example, your primary care doctor may disclose your protected health information to a cardiologist if he is concerned that you have a heart problem. We also may, for example, allow one specialist within our practice who treats you to see the electronic medical reports from other specialists within BHMG who have treated you, or we may, for example, allow all the physicians in BHMG who examine you to see certain entries in your electronic medical records such as vital signs, allergies, and medications, so that BHMG may provide more coordinated care to you, and avoid adverse treatment interactions.
- **Payment** means the activities we carry out to bill and collect for the treatment and services provided to you. For example, we may provide information to your insurance company about your medical condition to determine your current eligibility and benefits. We may also provide PHI to outside billing companies and others that process health care claims.
- **Health Care Operations** means the support functions that help operate BHMG such as quality improvement studies, case management, responding to patient concerns, and other important activities. For example, we may use your PHI to evaluate the performance of the staff that cared for you or to determine if additional services are needed.

## III. OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your protected health information for treatment, payment, and health care operations, we may also use your information in the following ways:

- **Appointment Reminders and Health-Related Benefits or Services.** We may use PHI to contact you for a medical appointment or to provide information about treatment alternatives or other health care services that may benefit you.
- **Disclosures to Family, Friends, and Others.** We may disclose your PHI to family, friends, and others identified by you as involved in your care or the payment of your care. We may use or disclose PHI about you to notify others of your general condition. We may also allow friends and family to act or you and pick-up prescriptions, x-rays, etc. when we determine it is in your best interest to do so. If you are available, we will give you the opportunity to object to these disclosures.
- **To Avoid Harm.** As permitted by law and ethical conduct, we may use or disclose protected health information if we, in good faith, believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.
- **Fundraising & Marketing Activities.** We may contact you as part of our fundraising and marketing activities as permitted by law. You have the right to opt out of receiving such fundraising communications.

- **Research Purposes.** In certain circumstances, we may use and disclose PHI to conduct medical research. Certain research projects require an authorization which will be made available to you prior to using your PHI.
- **Law Suits & Disputes.** If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request, or other process by others involved in the dispute. We will only disclose information with assurance that efforts were made to inform you about the request or to obtain an order protecting the information requested.
- **Required by Law Enforcement.** We may release health information about you if asked to do so by law enforcement in response to a court order, subpoena, warrant, summons, or similar process. We also may disclose information to identify or locate a suspect, fugitive, material witness, or missing person. In addition, we may disclose information about a crime victim or about a death we believe may be the result of criminal conduct. In emergency situations, we may disclose PHI to report a crime, to help locate the victims of the crime, or the identity/description/location of the person who committed the crime.
- **Disaster Relief.** When permitted by law, we may coordinate our uses and disclosures of protected health information with other organizations authorized by law or charter to assist in disaster relief efforts. For example, a disclosure to the Red Cross or a similar organization.
- **To Employers.** In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Hospital as required by applicable law.

Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

## IV. SPECIAL SITUATIONS

- **Organ and tissue donation.** If you are an organ donor, we may disclose PHI to an organ procurement organization.
- **Military personnel.** If you are a member of the armed forces, we may release PHI about you as required by military authorities. We may also release PHI about foreign military personnel to appropriate foreign military authorities.
- **Worker's compensation.** We may disclose PHI about your work-related illness or injury to comply with worker's compensation laws.
- **Public health activities.** We routinely disclose information about you for public health activities to:
  - Prevent or control disease, injury or disability:
  - Report births and deaths;
  - Report child abuse or neglect;
  - Persons under the jurisdiction of the Food & Drug Administration for activities related to product safety and quality and to report reactions to medications or products;
  - Notify people who may have been exposed to a disease or are at risk of contracting or spreading a disease;
  - Notify government agencies if we believe an adult has been the victim of abuse, neglect, or domestic violence, if the adult patient agrees or when required by law.
- **Health Oversight Activities.** We may disclose information to government agencies that oversee our activities. These activities are necessary to monitor the health care system and benefit programs, and to comply with regulations and the law.
- **National Security.** We may disclose PHI to authorized officials for national security purposes such as protecting the President of the United States or other persons, or conducting intelligence operations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of law enforcement, we may release PHI about you to the correction facility or law enforcement officials. This would be necessary for the institution to provide you with health care; to protect your health and safety and the health and safety of others; or for the safety and security of the correctional institution.
- **Health Information Exchanges (HIEs).** We and other health care providers participate with regional health information exchanges (HIEs). These exchanges allow patient information to be shared electronically with among health care providers, through a secured connected network. HIEs give your health care providers who participate in the same exchanges electronic access to some of your pertinent medical information for treatment and continuity of your care. If you do not opt-out of the HIEs, we may release your health information through the HIEs to your participating providers, and we may also access information about you that has been made available through the HIEs. If you do opt-out of the exchanges, following the opt-out instructions near the end of this notice, your PHI will

not be made accessible to other providers through the HIEs, and your information may not be as quickly accessible by your other health care providers.

- **Other Uses of Your Health Information.** Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under federal privacy laws and rules. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

## V. YOUR RIGHTS

You have the following rights with respect to your protected health information:

**Right to Request Limits on Uses and Disclosures of your PHI**. You have the right to request restrictions to how we use and disclose your PHI. Your request must be in writing, and sent to the Privacy Officer. We will review your request but we are not required to agree to your request. We are, however, required to comply with your request if it relates to a disclosure to your health plan regarding health care items or services for which you have paid the bill in full. If we agree to your request, we will document the restrictions and abide by them, except in emergency situations, as necessary. You may not limit the uses and disclosures that we are legally required or allowed to make.

**Right to Request Confidential Communications**. You have the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. For example, sending information to your work address rather than to your home address, or asking that we contact you by mail rather than telephone. To request confidential communications, you must specify your instructions in writing on a form provided on request. You must specify where and how you wish to be contacted. We will accommodate all reasonable requests.

**Right to Inspect and Obtain Copies of your Protected Health Information**. In most cases, you have the right to inspect and obtain copies of protected health information used to make decisions about your care, subject to applicable law. To inspect or copy your medical record, you must make a request in writing to the Privacy Officer. If you request copies of your health information, we may charge a fee for copying, postage, and other supplies associated with your request.

**Right to Amend your Protected Health Information**. If you believe that the protected health information we have about you is incorrect or incomplete, you may request that we amend the information. To request an amendment, you must make your request in writing to the Privacy Officer, and specify a reason that supports you request. We may deny your request for an amendment subject to applicable law.

**Right to Obtain a List of Disclosures We Have Made**. You have the right to request an "accounting of disclosures" of your protected health information. Your request must be made in writing and include a time period no longer than six years prior to the date of the request. There are several exceptions to the disclosures we must account for. Examples include disclosures for treatment, payment, and health care operations; those made to you; those made as a result of an authorization by you; and those made for national security or intelligence purposes. Requests for an accounting of disclosures must be made in writing to the Privacy Officer. The first accounting you request within a 12-month period is free. For additional accountings, we may charge you for the cost of providing it. We will notify you of the cost before processing your request so you may withdraw or modify your request before costs are incurred.

**Right to Be Notified of Breaches**. You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Federal privacy laws and rules.

**Right to Opt-Out of Health Information Exchanges.** With regard to health information exchanges (HIEs) only, if you do not wish to allow other health care providers involved in your care to electronically share your PHI with each other through HIEs, you have the right to opt-out of the HIE, by contacting the Privacy Officer in writing, or you can complete, sign and submit the HIE "opt-out" form(s) available during registration, and mail the form(s) as instructed on the form(s), and your information will not be accessible through the HIEs. If you do opt out of the HIEs, your information will not be accessible from the exchange networks; however, all other typical uses and releases of your information will continue in accordance with this notice and applicable law.

## VI. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with us, please contact the **Privacy Officer, BHMG, 95 Old Short Hills Road, West Orange, NJ 07052, 973-322-4613 or by email at** bhmgprivacyofficer@barnabashealth.org. We will not take action against you for filing a complaint.

**BARNABAS HEALTH**
Medical Group

## HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACKNOWLEDGEMENT

**PRIVACY NOTICE:**
I acknowledge receipt of the "Privacy Notice."

**SIGNATURES:**

Name of Patient _____
Print

Date _____

Name of Patient Representative _____
Print

Relationship of Patient Representative to Patient _____

Date _____

If unable to obtain Patient's signature, please state reason and sign:

_____

_____

Signature _____

Name: _____ DOB: _____

Initial Encounter History

Date of Intake: _____ Age at Intake: _____

**Family Identification and Data**

Father:_____ Age:_____ Occupation: _____

Mother: _____ Age: _____ Occupation: _____

Sibling Name and DOB:_____

_____

**Perinatal History**:

Pregnancy:

| | |
|---|---|
| Length: | Gravida/Parity: |
| Prior fetal losses/stillbirths: | Mother's blood type: |
| Medical complications: | Exposures (drugs, alcohol, cigarettes) |
| Maternal Medications taken: | Prenatal labs (GBS, Hepatitis): |

Labor and Delivery:

| | |
|---|---|
| Type: Vaginal or C-Section | Birth weight: |
| Apgars: | Discharge weight: |
| Feeding: Breast/Formula/Both | Baby's Blood type: |
| Bilirubin: | Other: |

**Patient History**:

Allergies: _____

Daily medications: _____

Surgeries: _____

Hospitalizations: _____

Other providers involved in patient care (dentist, eye dr, specialist) _____

_____

Name: _____ DOB: _____

Initial Encounter History

Have you ever had, or been diagnosed as having any of the following (circle all that apply):

| | | | |
|---|---|---|---|
| Head | Headache, dizziness, concussion | Heart | Chest pain, murmur, blue color, high blood pressure |
| Eyes | Blurry vision, infection, lazy eye, watery eye | Abdomen | Vomiting, diarrhea, constipation, chronic pain |
| Ears | Hearing problems, recurrent infection | Urinary | Pain with urination, blood in urine, bed wetting |
| Nose | Chronic congestion, bleeding | Neurological | Seizures, developmental delay, early intervention |
| Mouth | Tooth decay, poor bite | Endocrine | Short stature, weight loss or gain excessive thirst, hair loss, heat/cold intolerance |
| Throat | Frequent infections, large tonsils | Musculoskeletal | Joint pain, joint swelling |
| Neck | Stiffness, swollen glands | Hematologic | Anemia, abnormal bleeding |
| Chest | Chronic cough, pneumonia, asthma, croup | Skin | Rashes, infections |

Other/explanation:_____

**Family History**:

| Relation | Age | Medical conditions |
|---|---|---|
| Mother | | |
| Father | | |
| Brother/s | | |
| Sister/s | | |
| Maternal Grandmother | | |
| Maternal Grandfather | | |
| Paternal Grandmother | | |
| Paternal Grandfather | | |
| Other | | |

**Social and Environmental History**:

Who lives in the house with patient?_____

What languages are spoken at home?_____

Are parents Married/Divorced/Separated/Living together/Other (please explain)_____

Childcare: _____

Tobacco use: In patient (over age 13)_____ By other family member living in house_____

Pets: _____ Are there smoke and carbon monoxide detectors? _____