ENGLEWOOD HEALTH
PHYSICIAN NETWORK

Patient Information Form

TODAYS DATE / /

LAST NAME | FIRST NAME | MI | SEX ☐ Male ☐ Female | GENDER IDENTITY (optional) ☐ Male ☐ Female ☐ Other ☐ Transgender Male (FTM) ☐ Transgender Female (MTF)

ADDRESS | CITY | STATE | ZIP CODE

MARITAL STATUS ☐ Married ☐ Divorced ☐ Single ☐ Widowed | DATE OF BIRTH / / | EMAIL | SSN # - -

HOME PHONE ( ) ☐ Preferred?
May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

CELL PHONE ( ) ☐ Preferred?
May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

WORK PHONE ( ) ☐ Preferred?
May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

Are you part of the Bloodless Medicine Program? ☐ YES ☐ NO

Do you have a Living Will/Advance Directive? ☐ YES ☐ NO

RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ White

ETHNICITY ☐ Hispanic or Latin ☐ Non Hispanic or Latin ☐ Prefer not to answer

PRIMARY LANGUAGE ☐ Chinese ☐ English ☐ Farsi ☐ French ☐ Greek ☐ Hindi ☐ Indian ☐ Italian ☐ Japanese ☐ Korean ☐ Russian ☐ Spanish ☐ Other

DO YOU NEED A TRANSLATOR? ☐ YES ☐ NO

PHARMACY NAME | PHONE ( )

PHARMACY ADDRESS | CITY | STATE | ZIP CODE

EMERGENCY CONTACT #1 | RELATIONSHIP | EMERGENCY CONTACT PHONE ( )

EMERGENCY CONTACT #2 | RELATIONSHIP | EMERGENCY CONTACT PHONE ( )

Which provider do you see to meet most of your healthcare needs?

PRIMARY CARE PROVIDER | PHONE ( )

PRIMARY CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

REFERRING CARE PROVIDER | PHONE ( )

REFERRING CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

OTHER CARE PROVIDER | PHONE ( )

OTHER CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

OTHER CARE PROVIDER | PHONE ( )

OTHER CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

(continued on next side)

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EMPLOYMENT INFORMATION

EMPLOYER NAME | OCCUPATION/POSITION

EMPLOYMENT STATUS
☐ Employed Full-time ☐ Employed Part-Time ☐ Self-employed ☐ Retired ☐ On active military duty ☐ Reserves ☐ Other

INSURANCE/PAYMENT INFORMATION

PRIMARY INSURANCE *Which insurance should be billed first?*

SUBSCRIBER NAME | IN WHOSE NAME IS YOUR HEALTH INSURANCE POLICY?

SUBSCRIBER SSN # - - | SUBSCRIBER DATE OF BIRTH / / | RELATIONSHIP TO SUBSCRIBER

SUBSCRIBER EMPLOYER

SUBSCRIBER EMPLOYER ADDRESS | CITY | STATE | ZIP CODE

SUBSCRIBER GENDER
☐ Male ☐ Female ☐ Transgender ☐ Other

PRIMARY INSURANCE COMPANY | POLICY # | GROUP #

INSURANCE COMPANY ADDRES | CITY | STATE | ZIP CODE

EMERGENCY CONTACT PHONE #
( )

ADDITIONAL INSURANCE *Which insurance should be billed second? This may not apply to you.*

SUBSCRIBER NAME | IN WHOSE NAME IS YOUR HEALTH INSURANCE POLICY?

SUBSCRIBER SSN # - - | SUBSCRIBER DATE OF BIRTH / / | RELATIONSHIP TO SUBSCRIBER

SUBSCRIBER EMPLOYER

SUBSCRIBER EMPLOYER ADDRESS | CITY | STATE | ZIP CODE

SUBSCRIBER GENDER
☐ Male ☐ Female ☐ Transgender ☐ Other

OTHER INSURANCE COMPANY | POLICY # | GROUP #

ACKNOWLEDGEMENT/AUTHORIZATION

I CERTIFY THAT ALL INFORMATION I PROVIDED ABOVE IS ACCURATE AND TRUE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR ANY SERVICES FURNISHED TO ME BY THIS PHYSICIAN GROUP. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I AUTHORIZE THE RELEASE OF MY INFORMATION CONCERNING MY HEALTHCARE TO MY INSURANCE COMPANY FOR THE PURPOSE OF REVIEWING AND PROCESSING MEDICAL CLAIMS FOR PAYMENT.

SIGNATURE | RELATIONSHIP TO PATIENT | DATE / /

ENGLEWOOD HEALTH
PHYSICIAN NETWORK

DESIGNATION OF RELATIVES, FRIENDS, AND CAREGIVERS
TO RECEIVE NECESSARY TREATMENT-RELATED INFORMATION

Patient Name: _____ **Date:** _____

Patient DOB: _____

I agree that Englewood Health Physician Network may disclose certain portions of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care.

Englewood Health Physician Network will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

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

☐ I choose not to designate any individual at this time.

☐ I designate the following contacts listed below as persons involved with my health care or payment relating to my health care for Englewood Health Physician Network to make the limited disclosures described above.

I understand that I am not required to list anyone, and can change this list at any time in writing.

Contact Name: _____ **Contact's DOB (required):** _____

Relationship: _____

Contact Name: _____ **Contact's DOB (required):** _____

Relationship: _____

Contact Name: _____ **Contact's DOB (required):** _____

Relationship: _____

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

ENGLEWOOD HEALTH
PHYSICIAN NETWORK

PATIENT INFORMATION:
Patient Name:_____

Address (number and street) _____

City, State, Zip Code_____

Telephone_____Date of Birth _____

I hereby authorize and request Englewood Health Physician Network to:

☐ Release information to ☐ Obtain information from

Name/Facility: _____

Address: _____

City, State, Zip Code:_____

FOR THE PURPOSE OF: _____

INFORMATION TO BE RELEASED/OBTAINED

Please specify visit date(s):

_____

_____

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type:

_____AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection

_____Psychiatric Care _____Genetic Information

_____Treatment for alcohol and/or drug abuse _____Sexually Transmitted Disease(s)

_____Tuberculosis

I authorize the above person/organization and/or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in this authorization. I further agree to release the facility and its employees and agents from all liability that may arise from the release of information herein requested.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon. I understand that this authorization will expire on_____. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. I understand that I will be given a copy of this form after I sign it.

_____ _____

Signature of Patient or Legal Representative Date

_____

If signed by Legal Representative, Relationship to Patient

ENGLEWOOD HEALTH
PHYSICIAN NETWORK

Leonia Medical Associates, PA
25 Rockwood Place, Ste. 120
Englewood, NJ 07631
Tel: 201-568-3335
Fax: 201-568-2450

CONSENT FOR TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

The following is what you are signing for: Please see the front desk staff before leaving to sign for this form.

CONSENT FOR TREATMENT: I consent to any x-rays, laboratory or other medical procedures or examination rendered to me under the general and specific instruction of my physician (s). I acknowledge that no guarantees have been made to me as to the result of treatment/examination in EHPN. I also consent to the testing of my blood for Human Immunodeficiency Viruses (HIV) and/or other blood borne pathogens in the event that any individual at EHPN practice is accidently exposed to my blood or body fluids, or my physician believes such testing is medically indicated. Results of such test will be reported to me, noted on my medical record and reported to the State Department of Health as required by law.

RELEASE OF INFORMATION: EHPN is hereby authorized to release any/all of my medical records to the person(s) liable for my financial obligation resulting from services and to use data from my medical record for quality, epidemiology and education studies to which no identifying information will be made public. I authorize EHPN to download my historical medication information from Sure Scripts.

ASSIGNMENT OF INSURANCE BENEFITS: In the event the patient is entitled to physician benefits of any type arising out of any policy of insurance coverage from the patient or any other party liable for the patient, said benefits are hereby assigned to EHPN and/ or treatment physician. In the event the patient's insurer denies medical benefits, coverage or payment, consent is hereby authorized to allow EHPN and/or treating physician to appeal such decisions on the patient's behalf.

MEDICARE BENEFITS (IF APPLICABLE): I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I assign the benefits payable for services to EHPN or the physician furnishing the services and authorize EHPN or the treating physician to submit a claim to Medicare for payment.

MEDICAID: I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for practice services to EHPN and/or treating physician. I authorize EHPN or the physician to submit a claim to Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

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Leonia Medical Associates, PA
25 Rockwood Place, Ste. 120
Englewood, NJ 07631
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OTHER PHYSICIAN SERVICE (OUTSIDE OF OUR PRACTICE): In the event the patient is entitled to benefits of any type arising out of any policy of insurance covering the patient, that said benefits are also hereby assigned to any other physicians (outside of our practice) providing services to you at our request. I understand that it is the responsibility of the patient to obtain information from his/her insurance company to determine if the above mentioned physicians are participating in the patient's insurance plan. Participation by EHPN in any given insurance plan does not indicate participation by other physicians outside of this practice. I understand that I am responsible to the other physicians' practices for any charges not covered by my insurance plan.

FINANCIAL AGREEMENT: I agree, whether signing as agent or patient that in consideration of the services rendered to the patient, I am hereby individually obligated to make payment to EHPN in accordance with the regular rates and terms of EHPN. I understand that I am responsible to EHPN for any amounts billed to and not covered by any insurance carrier(s) including any amounts denied by the insurance carrier for no pre-certification or referral. Should the account be referred for collection after a default, I agree to pay costs of collection, including reasonable attorney's fee. All delinquent accounts bear interest at legal rates.

By signing, I have read and understand the foregoing, receiving a copy thereof if requested, and as a patient or the patient's agent, authorized to execute his agreement, accept its terms.

PLEASE SEE THE FRONT DESK STAFF
BEFORE LEAVING
TO SIGN FOR THIS FORM