NJHOA NEW JERSEY HEMATOLOGY ONCOLOGY ASSOCIATES

EXCEPTIONAL CARE WITHOUT EXCEPTION

General Patient Information

Today's Date: _____

Name: _____

Address: _____

_____

Home Phone No: _____ Email Address: _____

Cell Phone No: _____ Can we leave a detailed message? _____ Yes _____ No

If yes, which phone number can we leave the message: _____

Date of Birth: _____ Soc. Sec #_____ Marital Status: _____

Are you currently employed? ___ Yes ___ No

Employer: _____

Address: _____

Phone No: _____

Primary Insurance: _____

Primary Insured: _____

Primary Insured Date of Birth and Soc. Sec #:_____

Insurance ID#: _____

Secondary Insurance: _____

Secondary Insured: _____

Secondary Insured Date of birth: _____

Secondary Insurance ID#: _____

Emergency Contact: _____ Phone No: _____

Relationship to Patient: _____

Referring Physician: _____ Phone No:_____

Primary Medical Doctor: _____ Phone No: _____

PLEASE LIST THE DRUG STORE/PHARMACY THAT YOU USE:

Name: _____ Location: _____ Phone: _____

Patient History and Information Sheet

Reason(s) for your visit today: _____

Name: _____ Age: _____ Today's Date: _____

_____

Referring Physician: _____

Other physicians you have seen (include location): _____

Current Height: _____ Current Weight: _____

PAST HISTORY: Please list all of your health problems, such as asthma, diabetes, heart disease, high blood pressure, kidney stones, etc.

1. _____Year _____
2. _____Year _____
3. _____Year _____
4. _____Year _____

Surgical Operations: Please list all of the operations you have had, such as appendix removal, heart bypass, etc.

1. _____Year _____
2. _____Year _____
3. _____Year _____
4. _____Year _____

Allergies: Please check for any allergies that you know about:

___ Aspirin ___ Codeine ___Penicillin ___Anesthetics ___Demerol ___Sulfa Drugs

___ None ___ Others (please list) _____

WOMEN: Please fill in the spaces: Pregnancies (including miscarriages) ____ Miscarriages ____

How many children born? ____ Last menstrual period (Date and/or Year) _____

Medications: Please list all the medications that you are taking now:

1. _____Dosage_____ 4. _____Dosage_____
2. _____Dosage_____ 5. _____Dosage_____
3. _____Dosage_____ 6. _____Dosage_____
7. _____Dosage_____ 8. _____Dosage_____

How many aspirin do you take each day (if any)? ____ How many laxatives do you take each day? ___

Do you take birth control pills? _____ How many sedatives or tranquilizers do you take each day? ___

REVIEW OF SYSTEMS: Please check any of the following problems that you are currently experiencing:

___ Headaches
___ Seizures or fits
___ Numbness or tingling hands or feet
___ Difficulty in balance
___ Dizziness
___ Fainting or blackout spells
___ Ringing of the ears
___ Difficulty hearing
___ Double vision
___ Excessive Sneezing
___ Nasal Congestion
___ Shortness of breath
___ Nose bleeds
___ Swelling of ankles or feet
___ Palpitation of the heart
___ Chest pain or tightness
___ Change in shoe or glove size
___ High blood cholesterol
___ Excessive thirst
___ excessive bleeding after laceration or tooth extraction
___ Chronic fatigue/weakness
___ High blood pressure
___ Swelling of the legs

___ Cough
___ Coughing up blood
___ Wheezing (asthma)
___ Night Sweats
___ Fever more than 5 days
___ Difficulty swallowing
___ Vomiting
___ Diarrhea (less than 2 wks)
___ Diarrhea (more than 2 wks)
___ Constipation
___ Bloody bowel movements
___ Black bowel movement
___ Abdominal pain
___ Jaundice (yellow skin)
___ Hemorrhoids
___ Weight loss lbs _____
___ Weight gain lbs _____
___ Loss of appetite
___ Trouble sleeping, insomnia
___ Difficulty remembering or thinking clearly
___ Frequent urination
___ Urination during night
___ # of times during night

___ Pain during urination
___ Blood in urine
___ Reduction of urine
___ Difficulty start urine
___ Leakage of urine
___ Stiff neck
___ Back pain: High
___ Back pain: Low
___ Pain in legs (walking)
___ Joint Pain
___ Loss of hair
___ Increase in hair growth
___ Skin rash
___ Dry Skin
___ Hives
___ Itchiness (pruritis)
___ Wide swings in mood
___ Crying spells, depression
___ Anxiety/Nervousness
___ Excessive drug use/abuse

Women:
___ Excessive menstruation: date of last period
___ Bleeding between periods
___ Vaginal discharge
___ Last pelvic exam/Pap
___ Breast lumps/discharge

FAMILY HISTORY: Relative Age State of health Cause of death if deceased

Father: _____

Mother: _____

Brother(s): _____

_____

Sister(s): _____

_____

Children: Sex _____Sex _____

Sex _____Sex _____

Do you have any relatives who have had breast cancer?_____ Colon Cancer? _____ Diabetes? _____

High blood pressure?_____ Bleeding tendency? _____ Clotting problems (blood clots, etc)? _____

Are you: ___ Married ___ Divorced ___ Single ___ Widowed____ Living with _____

Alcohol use ___yes ___no Usual type of drink _____ Quantity and Frequency _____

Do you smoke or chew tobacco? ___Yes Number of packs per day _____ Date Started _____

___No Did you smoke in the past? _____ Date Stopped _____

Girish S. Amin, M.D. | Apurv Agrawal, M.D. | Jayne Pavlak-Schenk, D.O. | Randi Katz, D.O. | Sara Kovaly, APN, OCN

Consent for Release of Information

Patient Name: _____ Date of Birth: _____

I hereby authorize and request the release of all of my medical records, including history and physical radiology reports, operative reports, pathology reports, lab work and consultations to New Jersey Hematology Oncology Associates, LLC.

_____
Date

Signed: _____
Patient

Signed: _____
Next of kin may only sign if patient is incompetent or physically unable to do so.

_____
State relationship

NJHOA NEW JERSEY HEMATOLOGY ONCOLOGY ASSOCIATES

EXCEPTIONAL CARE WITHOUT EXCEPTION

I _____ give permission to New Jersey Hematology-Oncology Associates, LLC to release medical and financial information to the following people:

_____ Relationship to Patient _____

_____ Relationship to Patient _____

_____ Relationship to Patient _____

_____ Relationship to Patient _____

I understand that no information will be released to anyone that is not listed above.

Patient Signature: _____ Date: _____

Financial Policy

We are pleased that you have chosen New Jersey Hematology Oncology Associates. The trust that you have in our practice is greatly appreciated, and we will do our best to fulfill our responsibilities to you. In turn, we trust that you understand that payment for services rendered is your responsibility and is part of our relationship with you. This statement of our financial policy is being provided to you in an effort to avoid misunderstandings.

MEDICARE: New Jersey Hematology Oncology Associates participates with Medicare. We will submit claims to Medicare for services rendered. You are responsible for payment of your annual deductible, co-payments, and **ANY SERVICES NOT COVERED BY MEDICARE**. Patients that do not participate in a Medicare supplement plan are required to pay their 10% coinsurance at time of service.

MANAGED CARE PLANS: We contract with a number of HMO, PPO, and other managed care plans, and attempt to keep up with their numerous and often changing guidelines.
However, we must ask that you are familiar with the rules of your insurance carrier. You need to know your financial responsibilities (co-payments and deductibles), referral stipulations, and which serviced are or are not covered. If your plan requires a referral, we will not see you without one. Your appointment will be rescheduled for a later date.

CO-PAYMENTS: Co-payments are due at the time of service. Please do not ask us to bill you for this. If you do not have your copay at your visit your appointment will be rescheduled for a later date.

INSURANCE: As a courtesy to you, we will submit a claim to your insurance provider. We accept the contracted rates of all the insurance companies we participate with. If for any reason your company fails to pay the claim, you will be responsible for any charges incurred based on the contracted fee schedule.

OUTSIDE LAB WORK: Be advised that NJHOA may send your blood specimen or bone marrow biopsy to a third-party lab for testing. We will make every attempt to send the sample to a lab that is in network with your insurance company. NJHOA **WILL NOT** be responsible if you have a co-pay, deductible and/or a co-insurance for laboratory services. It is the responsibility of the patient to know their insurance benefits for services rendered.

Returned Checks: A $35.00 fee will be assessed if a check is returned by your financial institution.
Payments sent to you directly by your insurance carrier for serviced rendered at our office should be signed over to New Jersey Hematology Oncology Associates LLC upon receipt. Past due balances are expected to be paid in full before future appointments are made.

NJHOA accepts Cash, check, Visa, Mastercard or Discover Card.

Refusal to sign this policy will result in the cancellation of your appointment.

I have read and fully understand the financial policy provided to me by New Jersey Hematology Oncology Associates, LLC and agree to its terms. The terms of this financial policy may be amended by the practice, without prior notification to the patient.

Patient Signature: _____ Date: _____

ALL PATIENTS TO SIGN

Authorization to release medical records to insurance carrier for payment

I authorize NJHOA to release medical information to Medicare or commercial carriers or authorized agents needed to process a claim. I certify that the service(s) covered by this claim has/have been received and request payment in accordance with program policy either to New Jersey Hematology Oncology Associates, LLC or myself, if the provider does not accept assignment.

Patient Name: _____

Patient Signature: _____ Date: _____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been used in our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health care providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as in the front office, examination rooms, etc. Those records will not be available to persons other than office staff. You agree to normal procedures utilized within the office for handling charts, patient records, PHI and other documents of information.

2. It is the policy of the office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any other means convenient for the practice and/or requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. The vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documentation which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

10. We will notify you if your unsecured PHI has been breached by mail.

11. Copy of HIPAA consent form furnished upon request.

I, _____ Date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this date forward.

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I, _____ (print last name), _____ (print first name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand that it is important that any and all recommendations by my doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who as attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to a blood test or radiology test, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test(s) for which I was referred immediately; this can risk my current health or increase future health risks.

I understand that I will follow up on a regular basis to discuss test results ordered by the physicians and that unless otherwise arranged with my physician, test results will be discussed in-person at my next office visit.

I understand that it is my sole responsibility to follow any medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Signature: _____ Date: _____

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Physicians and practices are now required by Center for Medicare and Medicaid Services (CMS) to capture the following information. Please take a moment to answer the questions below:

Email Address for Patient Portal: _____

Do you have a Living Will? _____ Yes _____ No

Do you have a Durable Power of Attorney (POA)? _____ Yes _____ No

Do you have a Do Not Resuscitate Order (DNR)? _____ Yes _____ No

NJSA Clinical Laboratory Patient Demographic Requirement

N.J.S.A. 45:9-42.46(a)(1) requires clinical laboratories to record the race, ethnicity, sexual orientation, and gender identity of each patient who presents with a non-electronic order for testing at a clinical laboratory patient service center.

Race:
- ☐ American Indian or Alaska Native;
- ☐ Asian;
- ☐ Black or African American;
- ☐ Native Hawaiian or Other Pacific Islander;
- ☐ White;
- ☐ Other;
- ☐ Unknown;
- ☐ Asked but unknown;
- ☐ Choose not to disclose.

Ethnicity:
- ☐ Hispanic or Latino;
- ☐ Non-Hispanic or Non-Latino;
- ☐ Other;
- ☐ Unknown;
- ☐ Asked but unknown;
- ☐ Choose not to disclose.

Sexual Orientation:
- ☐ Lesbian, gay, or homosexual;
- ☐ Straight or heterosexual;
- ☐ Bisexual;
- ☐ Something else, please describe;
- ☐ Don't know;
- ☐ Choose not to disclose.

What is your preferred pronoun?
- ☐ He / Him
- ☐ She / Her
- ☐ They / Them
- ☐ Xe / Xem
- ☐ No preference

Gender Identity:
- ☐ Male;
- ☐ Female;
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man;
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman;
- ☐ Genderqueer, neither exclusively male nor female;
- ☐ Additional gender category or other, please specify;
- ☐ Choose not to disclose.

QUALITY MEASURE QUESTIONS

Colorectal Screening

Have you had one of the colorectal screenings below within the designated time frame?

Fecal occult blood test (FOBT): _____ No _____ Yes _____ Date

Flexible sigmoidoscopy within the last four years: _____ No _____ Yes _____ Date

Colonoscopy within last the nine years: _____ No _____ Yes _____ Date

Computed tomography (CT) colonography within the last 4 years: _____ No _____ Yes _____ Date

Fecal immunochemical DNA test (FIT-DNA) within the last 2 years: _____ No _____ Yes _____ Date

Breast Cancer Screening

Have you had one or more mammograms during the last 15 months: _____ No _____ Yes _____ Date

Vaccinations Screening

Have you had a Pneumonia vaccination within the past 5 years _____ No _____ Yes _____ Date

When did you receive your last Influenza immunization? _____ Date

Have you had a shingles (herpes zoster) Vaccination _____ Date

Have you ever received a Tdap (Tetanus, Diphtheria, Pertussis) vaccination _____ No _____ Yes

When was the last time you saw your Primary Medical Doctor? _____ Date

Name: _____ DOB: _____

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Patient Health Questionnaire

Name: _____ Today's Date: _____

Patient Declined: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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10 Question SDOH Survey
(Social Determinants of Health)

The Medicare & Medicaid Innovation Center and Our Practice are committed to reducing health disparities and achieving health equity. We are gathering this information to ensure all patients have access to quality care, clinical trials, and individualized care plans.
As a patient, you can choose not to provide this information.

Decline Survey: ___

		YES / NO
	Are you worried that in the next 2 months, **you may not have a safe or stable place to live?** (risk of eviction, being kicked out, homelessness)	Y N
	Are you worried that the **place you are living now is making you sick?** (has mold, bugs/rodents, water leaks, not enough heat)	Y N
	In the past 12 months, has the **electric, gas, oil or water company threatened to shut off services to your home?**	Y N
	In the last 12 months, did you worry that **your food could run out before you got money to buy more?**	Y N
	In the last 12 months, has **lack of transportation kept you from medical appointments or getting your medications?**	Y N
	In the last 12 months, did you have to **skip buying medications or going to doctor's appointments to save money?**	Y N
	Do you **need help getting child care or care for an elderly or sick adult?**	Y N
	Do you **need legal help?** (child/family services, immigration, housing discrimination, domestic issues, etc)	Y N
	Are you **finding it hard to get along with a partner, spouse, or family members?**	Y N
	Does anyone in your life **hurt you, threaten you, frighten you or make you feel unsafe?**	Y N