

New Jersey Hematology Oncology Associates, LLC  
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: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Secondary Insured: \_\_\_\_\_

Secondary Insured Date of birth: \_\_\_\_\_

Secondary Insurance ID#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone No: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Referring Physican: \_\_\_\_\_ Phone No: \_\_\_\_\_

Primary Medical Doctor: \_\_\_\_\_ Phone No: \_\_\_\_\_

**New Jersey Hematology-Oncology Associates LLC**

**Patient History and Information Sheet**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason(s) for your visit today: \_\_\_\_\_  
\_\_\_\_\_

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, including and steroid drugs (cortisone, prednisone) that you have taken during the past year:

1. \_\_\_\_\_ 4. \_\_\_\_\_
2. \_\_\_\_\_ 5. \_\_\_\_\_
3. \_\_\_\_\_ 6. \_\_\_\_\_

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? \_\_\_\_\_

PLEASE LIST THE DRUG STORE/PHARMACY THAT YOU USE:

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Cough  | <input type="checkbox"/> Pain during urination                          |
| <input type="checkbox"/> Seizures or fits   | <input type="checkbox"/> Coughing up blood                            | <input type="checkbox"/> Blood in urine                                 |
| <input type="checkbox"/> Numbness or tingling hands or feet                         | <input type="checkbox"/> Wheezing (asthma)                            | <input type="checkbox"/> Reduction of urine                             |
| <input type="checkbox"/> Difficulty in balance                                      | <input type="checkbox"/> Night Sweats                                 | <input type="checkbox"/> Difficulty start urine                         |
| <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Fever more than 5 days                       | <input type="checkbox"/> Leakage of urine                               |
| <input type="checkbox"/> Fainting or blackout spells                                | <input type="checkbox"/> Difficulty swallowing                        | <input type="checkbox"/> Stiff neck                                     |
| <input type="checkbox"/> Ringing of the ears  | <input type="checkbox"/> Vomiting                                     | <input type="checkbox"/> Back pain: High                                |
| <input type="checkbox"/> Difficulty hearing   | <input type="checkbox"/> Diarrhea (less then 2 wks)                   | <input type="checkbox"/> Back pain: Low                                 |
| <input type="checkbox"/> Double vision  | <input type="checkbox"/> Diarrhea (more then 2 wks)                   | <input type="checkbox"/> Pain in legs (walking)                         |
| <input type="checkbox"/> Excessive Sneezing   | <input type="checkbox"/> Constipation                                 | <input type="checkbox"/> Joint Pain                                     |
| <input type="checkbox"/> Nasal Congestion   | <input type="checkbox"/> Bloody bowel movements                       | <input type="checkbox"/> Loss of hair                                   |
| <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Black bowel movement                         | <input type="checkbox"/> Increase in hair growth                        |
| <input type="checkbox"/> Nose bleeds  | <input type="checkbox"/> Abdominal pain                               | <input type="checkbox"/> Skin rash                                      |
| <input type="checkbox"/> Swelling of ankles or feet                                 | <input type="checkbox"/> Jaundice (yellow skin)                       | <input type="checkbox"/> Dry Skin                                       |
| <input type="checkbox"/> Palpatation of the heart                                   | <input type="checkbox"/> Hemorrhoids                                  | <input type="checkbox"/> Hives  |
| <input type="checkbox"/> Chest pain or tightness                                    | <input type="checkbox"/> Weight loss lbs _____                        | <input type="checkbox"/> Itchiness (pruritis)                           |
| <input type="checkbox"/> Change in shoe or glove size                               | <input type="checkbox"/> Weight gain lbs _____                        | <input type="checkbox"/> Wide swings in mood                            |
| <input type="checkbox"/> High blood cholesterol                                     | <input type="checkbox"/> Loss of appetite                             | <input type="checkbox"/> Crying spells, depression                      |
| <input type="checkbox"/> Excessive thirst   | <input type="checkbox"/> Trouble sleeping, insomnia                   | <input type="checkbox"/> Anxiety/Nervousness                            |
| <input type="checkbox"/> excessive bleeding after laceration<br>or tooth extraction | <input type="checkbox"/> Difficuly remembering or<br>thinking clearly | <input type="checkbox"/> Excessive drug use/abuse                       |
| <input type="checkbox"/> Chronic fatigue/weakness                                   | <input type="checkbox"/> Frequent urination                           | <b>Women:</b>   |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Urination during night                       | <input type="checkbox"/> Excessive menstruation:<br>date of last period |
| <input type="checkbox"/> Swelling of the legs                                       | <input type="checkbox"/> # of times during night                      | <input type="checkbox"/> Bleeding between periods                       |
|   |   | <input type="checkbox"/> Vaginal discharge                              |
|   |   | <input type="checkbox"/> Last pelvic exam/Pap                           |
|   |   | <input type="checkbox"/> 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 tendancy? \_\_\_\_\_ Clotting problems (blod clots, etc)? \_\_\_\_\_

Social:  
 Are you: \_\_\_ Married \_\_\_ Divorced \_\_\_ Single \_\_\_ Widowed \_\_\_ Living with \_\_\_\_\_  
 Alcohol use \_\_\_ yes \_\_\_ no Usual type of drink \_\_\_\_\_ Quantity and Frequency \_\_\_\_\_  
 Do you smoke or chew tabacco? \_\_\_ yes Number of packs per day \_\_\_\_\_ Date Started \_\_\_\_\_  
 \_\_\_ No Did you smoke in the past? \_\_\_ Date Stopped \_\_\_\_\_

**NEW JERSEY HEMATOLOGY – ONCOLOGY ASSOCIATES, LLC**

**Girish S. Amin, M.D.**

**Apurv Agrawal, M.D.**

**Jayne Pavlak-Schenk, D.O.**

**Randi Katz, D.O.**

**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

\_\_\_\_\_

**NEW JERSEY HEMATOLOGY-ONCOLOGY ASSOCIATES, LLC**

**Girish S. Amin, MD  
Apurv Agrawal, MD  
Jayne Pavlak-Schenk, DO  
Randi Katz, D.O**

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.

\_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature

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**1608 Route 88 West, Suite 250, Brick, NJ 08724 · Telephone: (732) 840-8880  
508 Lakehurst Road Suite 1B, Toms River NJ 08755 · Telephone (732) 244-1440  
Fax: (732) 840-3939**

**NEW JERSEY HEMATOLOGY - ONCOLOGY ASSOCIATES, LLC**  
**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% co-insurance 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 services 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 co-pay 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.

**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 services 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's Signature and/or POA

\_\_\_\_\_  
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: \_\_\_\_\_

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## **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](http://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.

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**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.

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: \_\_\_\_\_



NEW JERSEY HEMATOLOGY – ONCOLOGY ASSOCIATES, LLC  
Exceptional Care Without Exception

Dear Patients,

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:

Do you have a Living Will? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you interested in receiving one? \_\_\_\_\_ Yes \_\_\_\_\_ No

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

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

Are you interested in having a DNR order? \_\_\_\_\_ Yes \_\_\_\_\_ No

What is your preferred language?

- \_\_\_\_\_ English
- \_\_\_\_\_ Chinese
- \_\_\_\_\_ French
- \_\_\_\_\_ Italian
- \_\_\_\_\_ Japanese
- \_\_\_\_\_ Portuguese
- \_\_\_\_\_ Russian
- \_\_\_\_\_ Spanish
- \_\_\_\_\_ Vietnamese
- \_\_\_\_\_ Patient Declined

What is your ethnicity?

- \_\_\_\_\_ Hispanic or Latino
- \_\_\_\_\_ Not Hispanic or Latino

What is your race?

- \_\_\_\_\_ Native American / Alaskan Native
- \_\_\_\_\_ Asian
- \_\_\_\_\_ Black or African American
- \_\_\_\_\_ Native Hawaiian or Other Pacific Islander
- \_\_\_\_\_ White / Caucasian

QUALITY MEASURE QUESTIONS

*Colorectal Screening*

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

Fecal occult blood test (FOBT) in 2018: \_\_\_\_\_ 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 four 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

If no, would you like to receive the vaccine? \_\_\_\_\_ No \_\_\_\_\_ Yes

Have you received the Influenza Immunization in the last quarter of 2018 or within the first quarter of 2019? \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ Date

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

Name: \_\_\_\_\_ DOB: \_\_\_\_\_