

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
or tooth extraction | <input type="checkbox"/> Difficuly remembering or
thinking clearly | <input type="checkbox"/> Excessive drug use/abuse |
| <input type="checkbox"/> Chronic fatigue/weakness | <input type="checkbox"/> Frequent urination | Women: |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Urination during night | <input type="checkbox"/> Excessive menstruation:
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

**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.

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 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: _____

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.

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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: _____