CarePoint Health
Medical Group

PATIENT REGISTRATION FORM

Today's Date:

Referring Physician:			PCP:	

PATIENT INFORMATION

Patient's last name: First: Middle:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
(Former name):	Social Security no.:	Main phone no.: ( )	Birth date: / /	Age: Sex: ❑ M ❑ F
Street address:		Main Language: Interpreter Preferred: ❑ Y ❑ N		Race: Ethnicity:
City: Occupation:	State: Employer:	ZIP:		Name Of Pharmacy:
Legal Guardian: ( ) Self ( ) Other Day to Day Caregiver ( )Self ( ) Other	Advanced Directive ( )Y ( ) N If No- Would you like additional info: ( ) Y ( ) N			Pharmacy Phone: ( )

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Main phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Please indicate primary insurance:

Policy no: Group no:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION, PARTICIPATION IN THE NJIIS AND THE ELECTRONIC SUBMISSION OF PRESCRIPTIONS

PRINT PATIENT NAME _____ MEDICAL RECORD # _____

HOME ADDRESS _____

SS# _____ DATE OF BIRTH _____ TELEPHONE _____

1. I hereby authorize _____ to release information from my medical record to:

NAME _____ ADDRESS _____ TELEPHONE _____

2. For the purpose of: (please check one)

__ Continued Treatment __ Attorney __ Insurance __ other (please list: personal reasons, etc.) _____

3. Description of information to be released (please check specific items)

__ Abstract __ Emergency Room Record __ Diagnostic test (e.g. Lab, X-Ray, and Radiology), please specify _____

-- Inpatient Record __ Outpatient Record Please specify _____ _____ __ Other_____

Covering records from on or about (date) _____ to (date) _____

CONFIDENTIAL INFORMATION

4. If the requested portion of the record contains information pertaining to the treatment for abuse, physical and/or mental illness, drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

_____ I understand that if my record contains information pertaining to the treatment for abuse, physical and/or mental illness, drug or alcohol treatment, such information will be released pursuant to this consent.

_____ I understand that if my record contains information contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV information is any information indicating that a person had an HIV related test, or has an HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

_____5. This authorization to obtain medical records will automatically expire within 90 days from the date of signature.

_____6. 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.

_____7. ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy.
The medication history information would include medications prescribed by your health care provider at Carepoint Health Medical Group as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information***
By signing this consent form you are agreeing that your provider at CarePoint Health Medical Group may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

Print Patient Name: _____

Signature of Patient or Personal Representative: _____

Print Name Personal Representative: _____

Date: _____

Description of Personal Representative's Authority: _____

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- The patient refused to sign despite good faith efforts
- The patient was unaccompanied and/or not alert and disoriented
- The patient was unaccompanied and needed emergency care
- Other (explain): _____

Employee Signature: _____ Employee Title: _____

Print Name: _____ Date: _____

Acknowledgement subsequently obtained, (see above).

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CONSENT FOR TREATMENT

I, _____ do hereby acknowledge that I have voluntarily sought medical assistance from CarePoint Health Medical Group (CPMG) through the division of Ambulatory Care.

I authorize CPMG, through its medical staff, to provide me and/or my minor dependents medical assistance encompassing routine laboratory diagnostic or medical/surgical treatment which, CPMG may deem necessary and advisable.

I **AUTHORIZE** CPMG to disclose any part of the medical record, to any person or cooperation when required for the collection of benefits or payment for charges.

I **AGREE** to make prompt payment when billed, for all charges not covered by valid insurance benefits and that this obligation extends to the patient's heirs, executors and estate.

Any information provided about my family's income is accurate to the best of my knowledge. I will be responsible for reporting any change in income status, and will be responsible for any charge for services, which have been reduced to an incorrectly determined income status.

I HAVE READ THIS AGREEMENT, IT HAS BEEN EXPLAINED TO ME, AND I UNDERSTAND THE CONTENTS AND THE RESPONSIBILITIES TO WHICH I AM AGREEING:

PERSON RESPONSIBLE: _____ **Date:**_____
Persona Responsible:

OTHER PERSON RESPONSIBLE: _____ **Date:**_____
Otra Persona Responsible:

WITNESS: _____ **Date:** _____
Testigo:

CAREPOINT HEALTH MEDICAL GROUP

FINANCIAL POLICY AGREEMENT

Thank you for choosing CarePoint Health Medical Group for your healthcare needs. We are committed to excellent patient care. Below we have provided an explanation of our Financial Policy Agreement (FPA). Patients must complete the FPA and the Patient Information Form (PIF) prior to receiving any medical care from us. **Please initial and then sign the following:**

_____1. Each patient is responsible for his or her own bill. Payment of all insurance co-payments, co-insurances and deductibles are to be paid in full at each visit and prior to any procedures. Your insurance policy is a contract between you and your insurance company. We accept cash, checks and major credit cards. Payment arrangements are available on a claim by claim basis, with a minimum required per month and to be paid in full within 5 months of treatment depending on balance owed.

ALL COPAYS ARE DUE AT TIME OF SERVICE: Appointments may be delayed or rescheduled if you arrive for your appointment without your copay at time of service.

_____2. As a courtesy, Carepoint Health Medical Group will file claims to your insurance carrier(s). To accomplish this, you must provide all insurance policy information and changes to our office. If this insurance company(s) that you designate is incorrect, or is provided too late to file, or has pre-service requirement that were not met due to your failure to provide accurate insurance in the time frame required by your insurance, you will be responsible for payment of the visit. Your bill is your responsibility, whether or not your insurance company pays.

_____3. "Self-pay" patients (those without coverage or limited benefits or having services not covered under your plan) are required to pay 100% of our discounted rates for services rendered at each visit. New patients should be prepared to pay for the visit and any additional services the Provider may perform. For extended treatments, payment arrangements are available and can be made with the front office staff prior to any medical evaluation, procedure or treatment.

_____4. Carepoint Health Medical Group hires an outside vendor to collect on patient balances outstanding after claims are processed by the insurance company.

_____5. Bills unpaid for more than 90 days will be turned over to a third party and/or collection agency. Additional fees may be incurred in the collection of any outstanding balances and may also result in your dismissal from the practice.

_____6. For the CPHMG specialists, some insurance companies require that an authorization or referral be obtained prior to your visit. It is your responsibility to know if your insurance requires this and ensure the applicable referral/authorization is obtained. If this is not done by the day of your appointment, you will be asked to reschedule or to pay for the FULL amount of the visit. If a claim is rejected because a valid authorization or referral was not in place, the cost of the visit will be your responsibility.

_____7. If a claim is rejected due to limitations and exclusions under your plan such as medical necessity policies, max benefit reached, non-covered services, etc the cost of the service will be your responsibility.

_____8. A $30.00 fee will be charged on all returned checks.

_____9. From time to time, you may ask us to complete various forms (such as disability forms). There is a $25.00 service fee to complete these forms. Payment is due prior to us giving those completed forms to you. This charge is not covered by your insurance company and offsets the costs we incur to complete these forms. Please allow 7 to 10 business days.

_____10. We charge for the reproduction of your medical records based on guidelines from the State of New Jersey and the Federal Government. Payment is due prior to us giving you a copy of your records. Please allow 7 to 10 business days. Please note there is no charge for records to be forwarded directly to another servicing Provider involved in your care.

_____11. *I understand that failure to maintain a current account with CarePoint Health Medical Group may result in further non-emergent medical treatments not being provided and/or dismissal from the care of CarePoint Health Medical Group.*

_____12. AUTHORIZATION TO PAY BENEFITS: I authorize and direct said agency or insurance company to pay benefits, or insurance payments made on my behalf, directly to CarePoint Health Medical Group for professional services rendered, I understand this in no way relieves me of my personal responsibility for paying my responsible portion when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

_____13. COMMUNICATIONS: *You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.*

_____14. Annual Wellness Visit: Most insurance plans allow for an annual exam which are exempt from any copayment, deductible and/or coinsurance that may normally apply. Please be advised that this visit will not cover you for specific medical problems that may be addressed at this time and if these are addressed, you will be subject to copays, deductibles and/or coinsurance for that part of the visit. Most plans DO NOT cover screening as part of your Annual Wellness Visit, you will be financially responsible it is declined by your insurance.

_____15. Annual visits are checkups to review your overall health and provide preventative care. In the course of preventative/annual checkup the Provider may address health issues that are treated and billed as separate and distinct from the well visit. This may apply to your plan copay, deductible, coinsurance. Please refer to your plan benefits or call the Member services phone# of your insurance for specific coverage questions.

By signing below, I acknowledge receipt of this FPA.

X _____ X _____ Date: _____

Signature of patient or responsible party

CarePoint Health Medical Group Representative