Barnabas Health
Medical Group

Today's Date: _____

Patient ID # _____ [for office use only]

Referring Physician _____

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: M □ F □ Social Security #: _____

For Minors please indicate responsible Parent/Guardian: _____

Address: _____
Street City State/Zip

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Email: _____ Driver's License #: _____

Marital Status: Single □ Married □ Widowed □ Separated □ Divorced □

Employer: _____ Occupation: _____

Emergency Contact: _____ Telephone: _____

How did you hear about us?

Please check as many corresponding boxes that apply:

Website	□	Facebook	□
Google/Yahoo/Bing	□	Other Internet Ad	□
Newspaper/Magazine Ad	□	Direct mailing (letter, post card, etc.)	□
Friend or family_____	□	Physician	□
Other_____	□		

I would like to receive email newsletters, general health tips and information from Barnabas Health: Yes □ No □
If Yes, please provide email address: _____

Responsible Party
Complete Only if Patient is Not the Responsible Party

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Insurance Information (Present Insurance Card(s) to Receptionist)

Primary Insurance: _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Effective Date of Primary Insurance: _____

Subscriber Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Secondary Insurance: _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Effective Date of Secondary Insurance: _____

Secondary Insurance: _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Subscriber Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Demographic Information Request

In order to comply with federal regulations, we are required to ask you to provide the following information:

Race

□ White/Caucasian
□ African American
□ Asian
□ Hispanic
□ Other _____
□ I prefer not to disclose

Ethnicity

□ Hispanic or Latino
□ Not Hispanic or Latino
□ Unknown/Unreported

Advance Directives

Do you have a health care proxy/living will? □ Yes □ No Do you want to discuss this with your physician? □ Yes □ No

Smoking Status

Please indicate your smoking history:

□ Never Smoked □ Past Smoker □ Current smoker – Indicate how many and how often you smoke _____

Communication Preferences

I understand that the staff and/or physicians of Barnabas Health Medical Group ("BHMG") may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Preferred Language _____ Preferred method for communication: □ Home □ Work □ Cell □ Email

Can we leave a message on machine or with whoever answers? (Circle **Yes** or **No**) **Home** Y / N **Work** Y / N **Cell** Y / N

DO NOT CALL: □ Home □ Work □ Cell

Disclosure to Designated Family/Friends/Caregivers

I allow BHMG to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing anytime.

Print Name	Date of Birth	Relationship	Phone Number

Preferred Pharmacy

Please indicate your preferred Pharmacy below:

Pharmacy Name: _____ Phone Number: ( ) _____

Address: _____

_____

(Indicate City and Cross Streets, Zip Code, if known)

Authorization to Access Electronic Prescription Records

I authorize Barnabas Health Medical Group ("BHMG") and its affiliated providers to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my BHMG medical record. MY SIGNATURE BELOW CERTIFIES THAT I AUTHORIZE THE ACCESS TO MY PRESCRIPTION RECORDS.

Photograph Release for Medical Records

Please indicate if the photograph release is applicable: □ Yes □ No

I hereby authorize and consent to the taking of photographs and moving pictures of me by BHMG, its agents or employees. I hereby authorize and consent to the use of such photographs and moving pictures for identification purposes in my medical record.

I hereby release BHMG, its medical staff, agents and employees from all liability related to the making and use of such photographs and moving pictures for the purpose as stated above.

Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the providers in BHMG for services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments and benefits services that are out of network, denied and/or not covered by my health insurance plan. I authorize BHMG or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

Consent to Treat

I, the undersigned, voluntarily consent to and authorize BHMG through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my BHMG physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

Acknowledgments and Agreement

- I acknowledge that I have been advised of my right to an Advance Directive.
- I acknowledge receipt of the BHMG Financial Policy, and agree to all the terms and conditions contained therein.
- I acknowledge receipt of the Notice of Privacy Practices, and agree to all the terms and conditions contained therein (unless I have opted out alone).
- I agree to allow access to my electronic prescription records as described above.
- I agree to the release and assignment of benefits as described above.
- I agree to treatment as described above.
- I have read this form, my questions have been answered, and I understand and agree to its content.

_____ _____

Patient/Representative's Signature Date

_____ _____

If signed by Authorized Representative, Print Name Relationship to Patient/Authority to Sign

BARNABAS HEALTH
Medical Group

Patient Name _____ Date of Birth _____

FINANCIAL POLICY

We are dedicated to providing our patients with the best possible care and service, while keeping the cost to you from rising at unreasonable rates.

We ask for your help by understanding and cooperating with our **FINANCIAL POLICY**

It is important for you to understand that health insurance coverage is an agreement between you and your insurance company.

AND

Your doctor's bill for services provided is an agreement between you and your doctor.

YOUR RESPONSIBILITY: Our Physicians participate with several insurance companies. It is ***your*** responsibility to call your insurance company to verify that the *doctor* you are seeing is participating.

If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you, however, we will expect payment from you at the time of service. If you do not have valid insurance information, and we cannot confirm coverage, we will consider you a self-pay and ask for full payment at time of service.

All co-payments or payments for non-covered service are the patient's responsibility and will be collected by our staff at time of service.

PRIMARY CARE OFFICES: If you are required to pick a Primary Care Physician, be sure that you have chosen one of the Physicians in the office where you have an appointment. You must contact your insurance company prior to the appointment to make this PCP selection. If your insurance company requires referrals for services at a Specialist office, please allow five (5) business days for non-emergency services prior to seeing that specialist or facility. If you go to the Specialist office without a referral, you may be responsible for the entire bill.

SPECIALIST OFFICES & REFERRALS: If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

I understand that it is my responsibility to know and abide by the terms of my benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. I also understand that I am responsible for full payment for services provided if I fail to supply the referral forms, when required.

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HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACKNOWLEDGEMENT

PRIVACY NOTICE:
I acknowledge receipt of the "Privacy Notice."

SIGNATURES:

Name of Patient _____
Print

Date _____

Name of Patient Representative _____
Print

Relationship of Patient Representative to Patient _____

Date _____

If unable to obtain Patient's signature, please state reason and sign:

_____

_____

Signature _____

PAYMENT FOR SERVICES PERFORMED:

1. Our office accepts Visa, MasterCard, Discover and American Express, as well as Cash, Debit Cards and Personal Checks for payment of services.
2. Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement; we cannot bill you for these.
3. All payments are expected at the time of service. Should your account require the action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

RETURNED CHECK FEE IS $30

CHARGES TO ACCOUNT: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

MISSED APPOINTMENT FEE: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a $25 fee. A $150 fee will be charged for any test or new patient appointment missed, and $250 for any missed procedures. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

FORMS FEE: There is a charge for the completion of forms brought into the office without a patient visit. This does not include those that are completed at the time of visit or with the exception of disability forms. The fee for this service is $25 and will be completed within five (5) business days.

TRANSFERRING OF RECORDS: If you require a copy of your records, you must submit a request and pay a copying fee. You are authorizing us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history. The fee will be $1/page to a maximum of $100.

AGREEMENT: I have read and fully understand the Financial Policy set forth by BHMG, and I agree to the terms of this policy. I also understand and agree that BHMG may amend the terms of this Financial Policy at any time without prior notification to the patient.

EFFECTIVE DATE: Once you have signed this Agreement, you agree to all of the terms and conditions contained herein, and the Agreement will be in full force and effect.

_____ _____

Signature of Patient/Guarantor Date