Hackensack
Meridian *Health*
Medical Group
Atlantic Hematology Oncology

NEW PATIENT INSTRUCTIONS

Thank you for choosing Atlantic Hematology oncology for your health care needs.

Your appointment is with Dr._____ on _____ at _____

_____ Brick (OUMC) 425 Jack Martin Blvd. Brick, NJ 08724

_____ Hope Tower 19 Davis Ave, Neptune, NJ 07753

Please review the below instructions carefully, and feel free to contact our office if there are any questions.

1. Please have your referring physician forward all pertinent medical records (pathology, radiology, lab testing,office notes etc.) to our office prior to your visit. Fax: 732-528-4695 or 732-528-0764.
2. Enclosed you will find a patient information packet that needs to be filled out completely and signed wherever indicated.
3. **Please bring your insurance cards and photo ID.**
    a. ***If your insurance requires a referral from your primary care physician, you must have it with you at the time of your visit- you can not be seen without it. It is your responsibility to obtain this referral.***
4. Bring a list of all medications and supplements you are taking.
5. If you have a Living Will/Advanced Directive or POLST, please bring a copy.
6. If your insurance has a co-payment please have it with you.

Please provide at least 48 hours notice if you are unable to keep your appointment. In the event 48 hours notice is not given, or if the required referral is not presented at the time of the appointment, there will be a $100.00 missed appointment fee. This charge must be paid prior to another appointment being scheduled. *We set aside a significant amount of time for the care of each new patient and respectfully request that you allow for this time as well. Please review and comply with our cancellation policy.*

We will make every effort to reach you in order to confirm your appointment, but if you do not hear from our office, please call 732-528-0760 to confirm.

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Patient Registration

PERSONAL INFORMATION

Patient Name: (Last) _____ (First) _____ (Middle) _____

Birth date: _____ Sex: M or F Marital Status: S M D W

Language: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian /Other Pacific Islander ☐ White ☐ Choose not to answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Choose not to answer

Address: (Street) _____ (City/State) _____ (Zip) _____

Preferred Phone: _____ Type: Cell or Home or Business Preferred Method of Contact: Phone or US Mail

E-mail: _____ Employment Status: _____

Guarantor Name: _____ Relationship to Guarantor: _____

Guarantor Address: (Street) _____ (City/State) _____ (Zip) _____

Emergency Contact: _____ Phone: _____ Relationship: _____

AKA/Nickname: _____ Patient Needs: _____

Referring Physician: _____ Address: _____

INSURANCE INFORMATION

Primary Insurance Co. Information: (name, address and phone # of person responsible for payment)

Insurance Company Name: _____ Phone: _____

Policy/ID Number: _____ Group #: _____ Effective Date: _____

Subscriber's Name: _____ Relationship to Patient _____

Subscriber's DOB: _____ Subscriber's Sex: _____

Address: _____ Phone: _____

Subscriber's Employer: _____

Secondary Insurance Co. Information: (name, address and phone # of person responsible for payment)

Insurance Company Name: _____ Phone: _____

Policy/ID Number: _____ Group #: _____ Effective Date: _____

Subscriber's Name: _____ Relationship to Patient _____

Subscriber's DOB: _____ Subscriber's Sex: _____

Address: _____ Phone: _____

Subscriber's Employer: _____

Signature: _____ Date: _____

For Internal Use Only:

Revised 2/18

Hackensack
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Authorization for Release of Information

Patient Name _____
Address (number and street) _____
City, State, Zip Code _____ Telephone _____
Date of Birth _____
Email address _____

I authorize Hackensack Meridian *Health* Medical Group to release my health information to:
Name _____
Address _____
City, State, Zip _____
Telephone # _____ Fax # _____

I authorize Hackensack Meridian *Health* Medical Group to obtain records from:

_____
(Name of provider and address)

This authorization applies to the following information:
____ Complete Medical Record
____ Other (Please list) _____

The purpose of the release is:
____ For treatment purposes
____ At the request of the patient
____ Other (please specify) _____

_____ I authorize the above provider and members of its staff to furnish the information, including copies or faxed copies, as directed in this authorization. I further agree to release the provider and its employees and agents from all liability that may arise from the release of information herein requested.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance on it. I understand that this authorization will expire on _____, and if I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by Legally Authorized Representative, Relationship to Patient

NOTICE TO RECIPIENT OF INFORMATION

PROHIBITATION ON REDISCLOSURE: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, federal regulations may prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by federal regulations.

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Acknowledgment of Receipt of Notice and Approval of Privacy Practices

I, _____, hereby acknowledge that I have received the corresponding HIPAA Notice of Privacy Practices. I also further acknowledge and approve the uses and disclosures of my PHI as described in the HIPAA Notice of Privacy Practices.

Date:_____.20____ _____

Signature of Patient or Representative

Patient Contact Authorization

I, _____ (Please Print Name) authorize and give permission to Hackensack Meridian *Health* Medical Group, or any practice staff members, to leave messages regarding my medical information on the following telephone(s):

Home: ( )_____

Cell: ( )_____

I authorize and give permission to (insert practice name), or any practice staff member, to speak with the following people regarding my medical status and/or treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

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CONSENT FOR TREATMENT:
I acknowledge that I have elected on my own behalf or on behalf of my dependent to receive medical services that may or may not be covered by my health plan or any number of reasons.

I understand and acknowledge that I am financially responsible for, and therefore shall pay for, all services rendered to me or my dependent that are not paid or contractually adjusted by my insurance, in whole or in part, by my health plan for any reason whatsoever.

RELEASE OF INFORMATION:
I authorize the release of all information necessary to process my insurance claims and pertinent to my medical care. This release will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original.

ASSIGNMENT OF BENEFITS:
I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, BCBS, HMO plans, and commercial insurance to (insert practice name) This assignment will remain in effect until revoked by me in writing. I hereby authorize the above to release information to secure payment on my behalf.

I understand that I am financially responsible for all charges. I have read this information and understand it.

Patient Name: _____

DOB: _____

Signature: _____

Signature of Parent or Guardian (if patient is a minor): _____

Date: _____

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NOTICE TO MEDICARE PATIENTS

As a Medicare participating provider it is required that we have all or our patients complete this form which is the standard authorization that allows us to bill Medicare on your behalf each time you receive services from Hackensack Meridian *Health* Medical Group. When you complete this form, we can bill Medicare directly, receive Medicare's portion of the reimbursement, and then bill you or your secondary insurance for the uncovered services and any balance for which you are directly responsible according to Medicare rules and regulations.

_____ _____
Name of Beneficiary/Member Medicare Number
(Print name as it appears on your card)

_____
Patient ID Number

"I request that payment of authorized Medicare benefits be made on my behalf to _____, or any of its individual providers, for any services furnished to me by any of its individual providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization will remain in effect until revoked by me or my legal representative in writing"

_____ _____
Medicare Patient Signature Date (Must complete)

"I request that payment of authorized Medigap benefits be made to _____, or any of its individual providers for any services provided to me by any of its individual providers. I authorize any holder of Medicare information about me to release to my Medigap Insurer (named below) any information needed to determine these benefits payable for related services."

_____ _____
Medicare Patient Signature Medicare Number

Name of Medigap Insurance: _____ _____
Date (Must Complete)

Policy Number: _____

Person Holding Medigap Insurance: _____

For Internal Use Only:

Revised 2/18

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

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.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

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AUTHORIZATION

PERMISSION TO RECEIVE PRERECORDED MESSAGES AND/OR TEXT MESSAGES

As a service to our patients, we provide courtesy appointment reminder calls and when we can text messages. We also may place other important calls and send text messages using a prerecorded or automated message. In order to authorize receiving the calls and messages, please fill out the information below and provide the phone number where you wish to receive these messages.

Important note: By providing your **cell phone number** below, you consent to receiving appointment reminder calls, important calls and/or text messages on your cell phone. If you would like us to utilize a different number—please provide that number below *instead of* your cell phone number.

This authorization permits us to leave messages, call or text you on the phone number that you provide below. If you provide your cell phone number, you will receive automated or prerecorded messages on your cell phone. We are required by law to advise you of this.

You do not need to sign this authorization; however, - if you do not sign this authorization, we will not be able to provide you with courtesy reminder calls, text messages or other important calls.

Patient Name: _____

Signature: _____

Signature of Parent or Guardian (if patient is a minor): _____

Phone number authorized by Patient to receive calls and message as set forth above:

Cell Phone Number: _____

Telephone Number: _____

Date: _____

For Internal Use Only:

MONMOUTH COUNTY WELLNESS TRANSPORTATION



Need Help? Call for an assessment of your individual needs: 732-431-7448

PURPOSE

Monmouth County has partnered with EZ Ride to provide essential transportation services for residents who may face challenges accessing necessary wellness resources.

The program was designed to support Monmouth County residents by providing transportation services for essential needs such as doctor's appointments, pharmacy visits, health department events, and access to food shopping and pantries.

Monmouth County
Board of County Commissioners

Thomas A. Arnone, Director
Ross F. Licitra, Deputy Director
Susan M. Kiley
Nick DiRocco
Erik Anderson

GUIDELINES

- ✓ **MUST** have a working cell phone
- ✓ Each person will be allowed to make two round trip rides a week pending approval of need
- ✓ Rides are limited to the resident and one additional person
- ✓ If children require a car seat/booster seat, it is the parent/guardian's responsibility
- ✓ Must be able to get in and out of the vehicle with gentle assistance (no wheelchairs)

732-431-7448 MCTransportCoordinator@co.monmouth.nj.us

TRANSPORTATION RESOURCES



Seniors/Disabled in Monmouth County Resources:
SCAT: 732-431-6480

Seniors/Disabled in Ocean County Resources:
Ocean Ride: 732-736-8989 or 877-929-2082
(S. Ocean county)

Statewide Options:
American Cancer Society's Road to Recovery Program:
800-227-2345

EZ Ride: 201-939-4242, option #4
ezride.org

Go-Go Grandparent: 855-464-6872
Helps you schedule Uber or Lyft
without a smartphone (for a fee).

ModivCare: (individuals with NJ Medicaid)
Schedule a ride: 866-527-9933
Check ride status: 866-527-9934

NJ Transit Access Link: (seniors and disabled)
973-491-4224 to start application
https://accesslink.njtransit.com/

FINANCIAL ASSISTANCE FOR TRANSPORTATION (Based on funding availability

Cancer Care: 800-813-4673,
cancercare.org

Family Reach: 857-233-2764,
familyreach.org

Komen: 877-465-6636,
komen.org

The Leukemia & Lymphoma Society: 877-557-2672,
lls.org