PROVIDENCE MEDICAL CENTER
25 CRAIG PLACE
NORTH PLAINFIELD, NJ 07060
PHONE#908-791-9993
FAX#908-791-9995

Today's Date	

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)				Name Normally Used (Nickname)	
Address		Apt. No.	City	State	Zip
E-mail	Home Phone		Work Phone	Cell Phone	
Social Security No.	Sex	Marital Status	Date of Birth	Driver's License No.	State Issued
Employer Name	Employer City	Employer State	How Did You Hear About Us?		
List anyone you authorize this office to share your medical information with (name and relationship to you)					
Permitted Contact Method(s) (circle all that apply) home phone cell phone work phone mail e-mail			Ok to leave message on answering machine/voicemail? Yes___ No___		

SPOUSE'S INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	Employer name	Work phone	Cell Phone

INSURANCE INFORMATION

Primary Insurance Company Name		Group No.	ID/Certificate No.
Policy Holder's Name/Parent's Name (if patient a child)	D.O.B.	Policy Holder's Social Security No.	
Secondary Insurance Company Name		Group No.	ID/Certificate No.
Policy Holder's Name			

EMERGENCY INFORMATION

Person to Notify in Case of Emergency	Relationship	Home Phone	Cell Phone

INFORMATION FOR THE PATIENT

1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.
2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.

Patient/ Guarantor Signature:

_____ Date:_____

Patient Medical History Form

NAME: _____ AGE: _____ DATE: _____

PHYSICIAN you were seeing previously: _____

Other SPECIALISTS you currently see: _____

_____

MEDICAL PROBLEMS (including present conditions): _____

_____

_____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

_____

_____

_____

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take: _____

_____

ALLERGIES TO MEDICATIONS (including reaction): _____

_____

List SURGERIES you have had (include year, surgeon, and hospital): _____

_____

_____

Describe HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital): _____

_____

_____

Have you had (circle):	migraines	hepatitis	mono	ulcer
bleeding problem	blood clots	head injury	drug addiction	gallstones
tuberculosis	STDs	seizures	memory trouble	arthritis
psoriasis	heart murmur	rheumatic fever	polio	shingles
alcoholism	depression	mental illness	gout	hemorrhoids
hearing trouble	vision trouble	other	_____	_____

Ethnicity (circle): Hispanic or Non-Hispanic **Race:** _____ **Preferred Language(s):** _____

Do you have a Living Will? Yes No If Not, are you interested in having one? Yes No

Do/did you SMOKE? Yes No How much? _____ packs/day # of years _____ Year you QUIT _____

When was the last time you tried to quit? _____ How many times have you tried to quit? _____

How have you been successful in quitting in the past? _____

Do/did you DRINK alcohol? _____ How much? _____ drinks/week # of years _____

Year you QUIT _____ Previous or current problem with alcohol? _____ AA? _____

Do you or have you used (circle): heroin marijuana cocaine methamphetamine chewing tobacco diet pills

Do you have a history of prescription drug abuse or addiction? _____ If yes, which one(s)? _____

_____

Patient Medical History Form

WOMEN

Age at first period _____ Date of last normal period _____ # of pregnancies _____

# of live births _____ # of children living with you _____ # abortions/miscarriages _____

Problems with pregnancies (circle) pre-term labor toxemia diabetes high blood pressure other: _____

Birth control method _____

Date of last Pap _____ Result?_____ Done where?_____

Date of last mammogram _____ Result?_____ Done where? _____

Do you have (circle):

irregular periods	bad menstrual cramps	heavy periods	abnormal mammogram	abnormal Pap smear
pelvic pain	infertility	sexual difficulty	hot flashes	vaginal dryness
vaginal discharge	vaginal odor	vaginal itching	PMS	breast changes

ALL

Who in your *family* has/had (circle if cause of death and write age of death)

Heart disease _____ genetic disorder _____

Diabetes _____ cancer (what type?)_____

Thyroid disease _____ alcoholism _____

Mental illness _____ arthritis _____

Glaucoma _____ asthma _____

Allergies _____ stomach problems _____

Tuberculosis _____ high blood pressure _____

List any other diseases that run in your family and specify your relationship to each family member listed. _____

_____

When was your last:

Tetanus shot _____ flu shot _____ pneumonia vaccine _____ hepatitis vaccine _____

TB test _____ colonoscopy _____ chest x-ray _____ EKG _____

Who lives with you? _____

Do you have any children? _____ If yes, list their names, ages, and any major medical problems _____

_____

_____

Where do/did you work? _____ What line of work are you in?_____

What is the last grade in school you finished? _____

Anything else you would like us to know? _____

_____

Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care. **PROVIDENCE MEDICAL CTR** offer low cost for uninsured patients and this payment is required at the time service rendered.

We may charge an upfront **$25.00 administrative fee** for completing forms such as disability or insurance and medical records requests. Please be aware that these services may require up to seven to ten days to complete.

If an account is not paid in full within 90 days, a **25% collection processing fee** will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks will no longer be permitted as payment.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time **PROVIDENCEMEDICALCENTER** also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current **no-show fee is $25.00** and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

BY SIGNING BELOW I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES.
I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- **Patient Rights Regarding Medical Records**
- **Patient Financial Responsibility including collections, no-show policy**
- **Confidentiality and Privacy of Medical Records**

_____ _____

Patient Signature Date

_____

Patient Printed Name

RELEASE TO:
PROVIDENCE MEDICAL CTR
25 CRAIG PLACE
NORTH PLAINFIELD NJ 07060
908-791-9993
908-791-9995

Patient Name_____ **D.O.B**_____ **Today's Date**_____

Doctor Name_____

Doctor Addres_____

Phone#_____ **Fax#**_____

3. **INFORMATION TO BE RELEASED:** (Check all applicable)
   ☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports
   ☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records ☐ Other: _____

SPECIAL AUTHORIZATION: Check applicable box (boxes) and sign immediately below.

By signing below, I am authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR parts 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR parts 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict

4. **RECORDS FROM THE TIME PERIOD:** / / through / /____

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)
   ☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
   ☐ Personal ☐ Workers' Compensation Claim ☐ Other: _____

6. I understand that this authorization shall be valid for five years. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

Patient/Guardian Signature: _____ Date: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

For office use only:

MR# Date Initials of Staff Member

PROVIDENCE MEDICAL CENTER
25 CRAIG PLACE
NORTH PLAINFIELD, NJ 07060
PHONE#908-791-9993
FAX#908-791-9995

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY USE AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices describes how we may use and disclosed your protected health information (PHI) to carry out treatment payment or health care operations (TPO) and for other purposes that are permitted or required by law also describes your rights to access and control your protected health information." Protected health information" or feature physical or mental health or condition and related health care services.

1.Uses and Disclosure of Protected Health Information.

Uses and Disclosure of protected health information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for purposed of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any use required by law.

Treatment: WE will use and disclosed your protected health information to provide and coordinate or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary; to a home health agency that provides care to you. For example your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example: Obtaining approval for a hospital stay may require that you're relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: WE may use or disclosed, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment the activities employee review activities, training of medical students licensing, and conducting or arranging for other business activities for example: we may disclosed your protected health information to medical school students that seen patients in our office. In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicated your physician. We may use or disclosed your protected health information, as necessary, to contact to remind you of your appointment.

We may use disclose your protected health information in the following situations

Without your authorization. These situations include: as Required By Law Public

Health issues as required by law communicable diseases: Health Oversight: Abused or Neglect! Food and Drug Administration requirements: Legal proceedings: Law Enforcement: Coroners Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates Required Uses and Disclosures: Under the law we must make disclosure to you and investigate or determine our compliance with the requirements of Section 500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

YOUR RIGHTS:

Following is statement of your rights with respect to protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of or use in a civil criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to

Use or disclosed any part of your protected health information for the purposes of treatment, payment or healthcare

Operations. You may also request that any part of your protected health information not be disclosed to family members

Or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

Your request must state the specific restriction request and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative mean or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request even if you have agreed to accept this notice alternatively I.E. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. We will not retaliate against to you for a complaint.

This notice was published and become effective on/or before April 14, 2003

We required by law to maintain the privacy of and provide individual with this notice of our legal duties and privacy practices with respect to protect to health information. If you have any objections to this form please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this notice of our privacy practices:

Print Name_____ Signature_____ Date_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐