

ADULT REGISTRATION FORM: Please complete the entire registration form.

Physician you are here to see: _____

Patient's Name: _____ **Home Phone#:** _____
 First Middle Last

Work phone #: _____

Street Address: _____
City: _____ State: _____ Zip Code: _____ **Cell Phone #:** _____

Patient Social Security#: _____ Patient's Sex: Male Female

Patient Date of Birth: _____ Patient Marital Status: M S D W

Employer: _____ Occupation: _____ Address: _____

Email address: _____

Spouse's Full Name: _____ Cell/Work #: _____
Emergency Contact: _____ Home/Cell #: _____ Relationship: _____

Primary Care Doctor: _____ Phone: _____ Address: _____

Doctor who Referred you (if different from primary): _____ Phone: _____ Address: _____

Pharmacy Name: _____ Town: _____ Phone#: _____

INSURANCE INFORMATION (Must be completed in full so that we may submit to your insurance for reimbursement.)

Primary Insurance: _____

Policyholder's name (insured's name): _____ Date of Birth: _____

Sex: Male Female Social Security #: _____ Employer: _____

Patient's relationship to insured (please circle): Self Spouse Child Other/Dependent

Group Number: _____ Policy Number: _____

Secondary Insurance: _____

Policyholder's name (insured's name): _____ Date of Birth: _____

Sex: Male Female Social Security #: _____ Employer: _____

Patient's relationship to insured (please circle): Self Spouse Child Other/Dependent

Group Number: _____ Policy Number: _____

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Garden State Urology for any service furnished to me by GSU's physicians. I authorize Garden State Urology to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due the physician. These amounts could include annual deductibles, co-payments, charges denied as not covered by Medicare or my insurance program, and charges denied for services determined as not medically necessary. I further understand that if GSU incurs any fees associated with collecting reimbursement on my account, I will be responsible for paying those fees.

Signature: _____

Date: _____



Acknowledgement of Receipt

By signing below, I acknowledge that I have received a copy of my physician's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians and staff.

Print Name of Patient or Patient's Personal Representative

Signature of Patient or Patient's Personal Representative

Description of Personal Representative's Authority

Date

If you have any questions about this notice or would like further information, please contact the Privacy Officer at Garden State Urology, LLC, Jeanmarie Falco.

For office use only: If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.

Consent to Discuss Health Care

Patient Name: _____

Today's Date: _____

Date of Birth: _____

I authorize _____
to discuss my health care information with the individuals listed below.

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

I give permission to leave my health care information at the following telephone number(s).

Home: _____

Cellular: _____

Work: _____

Other: _____

Signature of Patient, Parent or Legal Guardian

Printed Name

TODAYS DATE _____

ADULT HISTORY FORM

Patient Name: _____ DOB: _____
 Primary Care Physician Name: _____ Phone: _____
 Other Treating Physician Name: _____ Phone: _____
 Pharmacy Name: _____ Phone: _____
 Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Reason for today's visit (New Patients ONLY) _____

Allergies: Please list any drug allergies (including latex and shellfish, if applicable.) Please circle NONE if you do not have any known allergies.
 _____ **NONE**

Medications: Please list all the medications you are currently taking (including OTC medications such as aspirin), dosage and frequency. For example: *Aspirin 325mg daily.*

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you are unable to fit all medications on the above list, please attach an additional page

Past Surgical History: Please list all surgeries. Include approximate dates, if possible.

Procedure: _____ Date: _____ Procedure: _____ Date: _____
 Procedure: _____ Date: _____ Procedure: _____ Date: _____

If you are unable to fit all your procedures/surgeries in the above space, please utilize the back of the page

Past Medical History: Do you have or have you had any of the following medical conditions?

Diabetes	Type 1	Type 2	NO	Heart Disease	YES	NO	Arthritis	YES	NO	
Asthma		YES	NO	Thyroid Disease	Hyper	Hypo	NO	Indigestion	YES	NO
High Blood Pressure		YES	NO	Cancer		YES	NO	Other:	_____	
Kidney Stones		YES	NO	If YES please specify:				_____		

Race (Optional): (Requested by the state of New Jersey for the Cancer Registry)

Caucasian
 African American
 American Indian
 Asian Indian/Pakistani
 Hispanic
 Asian
 Other _____

Family History: Do you have a *family* history of any of the following?

Prostate Cancer YES NO Bladder Cancer YES NO Kidney Cancer YES NO

Please list all serious illnesses in your *family* and indicate the relationship to you:

Social History:

Occupation: _____ Marital Status: _____ # of Children: _____

Do you currently smoke? YES NO Did you ever smoke? YES NO

How many packs per day? _____ When did you quit? _____

Do you drink alcohol? YES NO How many drinks per week? _____

Review of Systems: Do you now or have you had any problems related to the follow systems. **Please circle any that apply. If none apply, please circle None.**

Constitutional :	None	Fever	Chills	Other: _____	
Neurological :	None	Tremors	Dizzy spells	Other: _____	
Hematologic/ Lymphatic :	None	Clotting problems	Swollen glands	Blood transfusion	Other: _____
Musculoskeletal :	None	Joint pain	Neck pain	Other: _____	
Gastrointestinal :	None	Abdominal pain	Nausea/ Vomiting	Other: _____	
Psychological :	None	Depression	Psychosis	Other: _____	
Cardiovascular :	None	Chest pain	Heart attack	Heart murmur	Other: _____
Endocrine :	None	Excessive thirst	Tired/ Sluggish	Diabetes mellitus	Other: _____
Respiratory :	None	Emphysema	Shortness of breath	Other: _____	
Integumentary/ Skin :	None	Skin rash	Persistent itch	Other: _____	
Genitourinary :	None	Urinary tract infection	Blood in urine	Kidney stone	Other: _____

Physician Reviewed/Date: _____ Physician Reviewed/Date: _____ Physician Reviewed/Date: _____

Patient Comments: Please comment on any issues/problems not covered in the above questions.

Patient Signature: _____ Date: _____

**Morris Urology,
a division of Garden State Urology, LLC**

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AUTHORIZATION / REFERRAL POLICY

Many insurance companies have strict guidelines and policies with respect to authorizations and referrals for radiology and lab procedures. Because these policies change on a regular basis, it is the responsibility of the patient to know what information is needed and what guidelines must be met according to his or her insurance company's policies in order to have a radiology or lab procedure. In addition, it is your responsibility to have an understanding of your responsibilities under your insurance contract in respect to referral and pre-authorization requirements as well as your deductible, co-pay and coverage limits.

I understand that I, the patient, am responsible for any payment related to any procedure for which I did not properly obtain a referral, or any procedure that I did not have properly authorized or pre-certified. I also understand that obtaining a proper referral, authorization or precertification is not a guaranty of payment by the insurance company and I am financially responsible for payment of all services not covered by my insurance company.

PRINT PATIENT'S NAME

SIGNATURE

DATE



PATIENT NAME: _____ DATE OF BIRTH: _____

ACKNOWLEDGEMENT FORM FOR THE FINANCIAL INFORMATION DOCUMENT

Attached is Garden State Urology Financial Information Document. This document explains the following information:

- In-network financial responsibility
- Out-of-network financial responsibility
- Self Pay / no insurance
- Medicaid/Charity Care
- Collections
- Precertification/authorization

Please take a few moments to read the document and save it with your medical records for future reference.

If you have any questions or concerns after reading the document, please ask to speak to a Financial Counselor.

In order to document for our records that you received this document we require all patients/guarantors to sign below acknowledging receipt of the document.

I acknowledge receipt of Garden State Urology's Financial Information Sheet that explains the information as outlined above.

Patient/Guarantor Signature _____ Date: _____

For patients with Blue Shield or Horizon Insurance who are seeing an out of network physician:

Unfortunately, these insurance carriers will not send payment directly to an out of network physician. All payments/ explanations of benefits are sent to the patient/guardian.

When you receive an explanation of benefit/payment for a service rendered by Garden State Urology contact the Billing Department IMMEDIATELY.

DO NOT WAIT until you receive a statement or phone call from us.

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of the Payment Summary Sheet, please document the date and time the notice was presented to patient and sign below.

Date: _____ Time: _____ Employee Name: _____

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