HOLY NAME PULMONARY ASSOCIATES DIVISION A – ENGLEWOOD, NORTH BERGEN

200 Grand Avenue, #102 Englewood, N.J. 07631 I 8305 Bergenline Avenue #A North Bergen, N.J. 07047

PATIENT NAME: _____
FIRST NAME MIDDLE INITIAL LAST NAME

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

SEX: M❑ F❑ **EMAIL ADDRESS:** _____

CELL PHONE:_____ **HOME PHONE:**_____ WORK PHONE:_____

PREFERRED CONTACT METHOD: CELL PHONE ❑ HOME PHONE ❑ WORK PHONE ❑ EMAIL ADDRESS ❑

DOB:_____ **SS#:**_____ **MARITAL STATUS:** S❑ M❑ D❑ W❑

NAME OF SPOUSE:_____ DO YOU RESIDE IN A SKILLED NURSING FACILITY? YES❑ NO❑

EMPLOYER: _____ EMPLOYER ADDRESS:_____

EMERGENCY INFORMATION

CONTACT PERSON:_____ RELATIONSHIP TO PATIENT:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____

REFERRING PHYSICIAN/FRIEND:_____

IF FULL-TIME STUDENT INDICATE SCHOOL CURRENTLY ATTENDING: _____

PRIMARY INSURANCE:_____

POLICY #:_____ GROUP #:_____

ADDRESS:_____ EFFECTIVE DATE:_____

RELATIONSHIP TO INSURED: _____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____SS#_____DOB_____

SECONDARY INSURANCE:_____

POLICY #:_____ GROUP #:_____

ADDRESS: _____EFFECTIVE DATE:_____

RELATIONSHIP TO INSURED: _____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____SS#_____DOB_____

ASSIGNMENT OF BENEFITS: MY SIGNATURE BELOW INDICATES MY CONSENT FOR TREATMENT AND CONFIRMS MY UNDERSTANDING THAT ALL NON-COVERED ITEMS, CO-PAYMENTS AND DEDUCTIBLES ARE MY RESPONSIBILITY AND THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIMS THAT WAS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY INSURANCE COMPANY. IF I AM UNCOVERED BY ANY INSURANCE, I AGREE TO PAY THE SELF-PAY FEE FOR THE SERVICES I RECEIVE.

SIGNED:_____ **DATE:**_____

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND THE CENTER FOR MEDICARE AND MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNED: _____**DATE:**_____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PROVIDER OF SERVICE AND (OR) SUPPLIER FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER OF SERVICE AND (OR) SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICARE INFORMATION ABOUT ME TO RELEASE TO:

MEDIGAP INSURANCE:_____ **HIC#**_____

ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED:_____ **DATE:**_____

HOLY NAME PULMONARY ASSOCIATES, PC

DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE
PULMONARY DISEASE, *CRITICAL CARE MEDICINE AND ↑SLEEP MEDICINE

Gregory G. Magee, M.D., F.C.C.P. * ↑
Selwyn E. Levine, M.D., F.C.C.P.*
Theophanis A. Pavlou, M.D., F.C.C.P.* ↑
Victor Gorloff, M.D., F.C.C.P.*
Paul S. Han, M.D., F.C.C.P. * ↑
Harris B. Tesher, M.D.

200 Grand Avenue, Suite 102
Englewood, New Jersey 07631
Tel: (201) 871-3636
Fax (201) 871-2286

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	**Date of Birth:**	**Home Phone:** **Office Phone:**
Patient Address:		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New Jersey State Law and the Privacy Rule of the Health Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. I have the right to revoke this authorization at any time by writing to **HOLY NAME PULMONARY ASSOCIATES** at the address listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

3. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

4. Name and address of the health provider or entity to release this information:

HOLY NAME PULMONARY ASSOCIATES

5. Name and address of health provider or other person(s) to whom this information will be sent:

6. Specific information to be released:
- ☐ Biopsy report(s) dated: _____
- ☐ Lab report(s) dated: _____
- ☐ Records and reports from _____to_____
- ☑ All records and reports
- ☐ Other (specify): _____

7. Reason for release of information:
- ☐ At request to individual
- ☐ Other: _____

8. Date or event on which this authorization will expire:
- ☐ _____**OR**
- ☐ INDEFINITE unless revoked or terminated by the patient or the patient's authorized repetitive.

9. If not the patient, name of person signing form:

10. Authority to sign on behalf of the patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of Patient or Representative Authorized By Law: _____ Date: _____

Witness: _____

NOTE: THIS AUTHORARIZATION IS **NOT** INTENDED TO AUTHORIZE DISCLOSURE OF INFORMATION RELATING TO ALCOHOL AND DRUG ABUSE, MENTAL HEALTH TREATMENT. AND CONFIDENTIAL HIV RELATED INFORMATION.

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FINANCIAL POLICY

We are committed to providing you with the best possible care and your understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees and policies.

Due to rapid changes taking place in the health insurance industry, it is imperative that you are aware of the benefits and requirements of your insurance plan. There is no way we can possibly know, or keep up to the date with each programs provision.

It is your responsibility to know and advice us of your plans requirements in advance, each and every time we provide service. Please be advised that if we have not been informed of your programs requirements and we provide a physician or laboratory service, you will be responsible for the fees. We will do our best to comply with your insurance requirements. Patients must inform us of changes in information and insurance plans prior to being seen. There will be a $25.00 charge for incorrect information.

Participating Plans: Copays are due at time of service. $50.00 surcharge if not paid.

Non-Participating/Out of Network Services: Payment in full is expected at time of service, unless arrangements have been made in advance with the office manager.

Referrals: If your plan requires a referral from your PCP it is your responsibility to present the referral prior to the service, or you may be responsible for the payment in full.

Laboratory Service: Patients must inform the nurse prior to blood drawing, which laboratory is participating with your insurance.

You are responsible for your annual deductible and co-insurance of 20% / 30% ect. We accept CASH, CHECK, VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS.

Cancellation policy: 24hrs notice is required or a fee of $50.00 will be charged.

I acknowledge the original copy of the information.

Signature: _____Date: _____

Please Print Your Name: _____

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UPDATED PATIENT MEDICAL HISTORY

Patient Name: _____ Age: _____ DOB: _____
Address: _____
_____
Occupation: _____
Marital Status: _____
Spouse's Name: _____
Mother's Name: _____
Father's Name: _____

Primary MD: _____
Referred By: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Emergency Contact Phone: _____

ALLERGIES TO MEDICATIONS, DYES OR OTHER SUBSTANCES? ____ NO ___ YES Latex Allergy? ___ NO ____YES
(If YES, please list name of medication and type of reaction)

_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS
(Please circle "Y" if you have had problems with or are presently complaining of any of the following. If not, please circle "N'.)

1. High blood pressure	Y N	10. Constipation	Y N	19. Hepatitis/jaundice	Y N	28. Anemia	Y N
2. Diabetes	Y N	11. Diarrhea	Y N	20. Thyroid Disease	Y N	29. Alcohol Abuse	Y N
3. Cancer	Y N	12. Blood in stool	Y N	21. Headache	Y N	30. Drug Abuse	Y N
4. Heart disease	Y N	13. Ulcers	Y N	22. Kidney disease	Y N	31. Eating Disorder	Y N
5. Chest pain/ tightness	Y N	14. Abdominal discomfort	Y N	23. Difficulty urinating	Y N	32. Eyes	Y N
6. Frequent urination	Y N	15. Change in weight	Y N	24. Blood disorders	Y N	33. Ears nose mouth throat	Y N
7. Rheumatic fever	Y N	16. Hemorrhoids	Y N	25. Venereal diseases	Y N	34. Musculoskeletal	Y N
8. Asthma	Y N	17. Gall bladder disease	Y N	26. Anxiety	Y N	35. Skin	Y N
9. Change in bowel habits	Y N	18. Colitis	Y N	27. Depression	Y N	36. Other	Y N

NEW SURGERIES SINCE LAST VISIT:

Surgery	New Hospitalizations Since Last Visit
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

When was your last:
Pap Smear? _____ Breast Exam? _____ Colonoscopy? _____
Mammogram? _____ Cholesterol Check? _____ Bone Density Test? _____

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FAMILY HISTORY

(Has any member of your family ever had the following:)

Illness			Which family member?	Age when diagnosed
Cancer:	[ ] No	[ ] Yes (describe type) _____		
Breast Cancer:	[ ] No	[ ] Yes		
Ovarian Cancer:	[ ] No	[ ] Yes		
Uterine Cancer:	[ ] No	[ ] Yes		
Colon Cancer:	[ ] No	[ ] Yes		
High Blood Pressure:	[ ] No	[ ] Yes		
Heart Disease:	[ ] No	[ ] Yes		
Diabetes:	[ ] No	[ ] Yes		
Stroke:	[ ] No	[ ] Yes		
Bleeding Diseases:	[ ] No	[ ] Yes		
Other:				

Mother: _____

Father: _____

Siblings: _____

Ancestry: [ ] Jewish [ ] Black [ ] Mediterranean [ ] Other _____

PRESCRIPTION MEDICATIONS / OVER-THE-COUNTER MEDICATIONS / VITAMINS

(Please list any prescription medication you take on a regular basis:)

Drug Name	Dose	Drug Name	Dose

PREVENTION

Do you smoke cigarettes?	[ ] No	[ ] Yes	If yes, packs per day:	
Do you drink alcoholic beverages?	[ ] No	[ ] Yes	If yes, drinks per week:	
Do you drink coffee or tea?	[ ] No	[ ] Yes	If yes, cups per day:	
Do you use recreational drugs (marijuana, cocaine, crack, etc.)?	[ ] No	[ ] Yes	If yes, list type and frequency:	
Have you ever engaged in any activity which has put you at risk of getting AIDS?	[ ] No	[ ] Yes	If yes, explain:	
Do you wish to be tested for AIDS?	[ ] No	[ ] Yes		
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	[ ] No	[ ] Yes		
Do you ever feel afraid of your partner?	[ ] No	[ ] Yes		

M.D. ONLY:

DOCTOR'S SIGNATURE: _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____