PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Legal First Name: _____MI: ___ **Legal Last Name**: _____

First Name Used: _____ **Pronouns Preferred**: □ he/him/his □ she/her/hers □ they/them/their

Date of Birth: _____ **Assigned Sex at Birth:** □ Male □ Female □ Choose not to disclose

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

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Primary Language: _____ Race: _____ Ethnicity: _____

_____ _____ ____ _____

Address City State Zip Code

_____ _____ _____ _____

Home phone Cell phone Work phone Email

Preferred method of contact (circle one): Home Phone Cell Phone Work Phone Email

Would you like access to the patient Portal? Y N **May we text you to confirm an appointment?** Y N

How did you hear about us? ☐Advertising ☐Already a Patient ☐Hospital ☐Insurance Company

☐Primary Care Physician ☐Specialist Physician Referring Physician's Name: _____

☐Proximity to Home/Work ☐Website ☐Word of Mouth ☐Other: _____
Please specify

PATIENT INSURANCE:

Insurance Information: Are you the Primary Cardholder: Y N
If No: Name of Cardholder:_____ Relationship:_____ Date of Birth: _____

Do you have a Secondary Insurance: Y N

Name of Cardholder: _____ Relationship:_____ Date of Birth: _____

EMERGENCY CONTACT:

Contact Name: _____ Contact Phone _____

Relationship to Patient: _____ Contact Cell Phone: _____

REFERRING PROVIDER:

Name: _____ Phone: _____

Address:_____

PHARMACY:

Name: _____ Phone: _____

Address:_____

Policy Number: _____ Phone: _____ Fax: _____

PRIMARY CARE PROVIDER:

Name: _____

Phone: _____

Address: _____

LAB PREFERENCE:

Name: _____

Phone: _____

Address: _____

Patient Signature:_____**Date/Time:** _____

*Valley Medical Group is the "trading as" name for Valley Physician Services, PC, Valley Medical Services, PC and Valley Physician Services, NY PC

PATIENT REGISTRATION FORM
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WORKERS COMPENSATION

Is this a Workers Compensation visit? Y N

Your social security # _____ Date of Injury:_____

Description of Injury_____

Employer Name:_____ Phone:_____ Fax:_____

Address:_____

Supervisor Name:_____

Has treatment for today's injury been authorized? Y N If Yes, by whom? _____

Workers Comp Insurance Carrier Name:_____ Contact:_____

W/C Carrier Address:_____

W/C Carrier Phone:_____ W/C Carrier Fax:_____ W/C Claim #_____

Patient Signature:_____Date/Time: _____

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GENERAL CONSENT FOR TREATMENT

1. **CONSENT TO CARE:** I, _____, hereby consent to treatment by the Valley Medical Group (VMG)* and its physicians, staff and/or agents. I understand that my treatment may include testing (for example, x-rays and blood tests), routine care and procedures (for example injections), and evaluation (for example, interviews and physical exams). This general consent does not include consent for invasive procedures (for example, surgery), which require a separate consent process. I understand that the practice of medicine is not an exact science and no guarantees have been made to me about the outcome of my care and treatment. I acknowledge VMG's authority to dispose of specimens taken for laboratory or pathology examination according to its usual procedures.

2. **IMAGES:** I consent to the use of photography or videotaping relating to my medical condition. I understand that any images may be used for my treatment. At no time will my identity or any information linked to my identity be disclosed without my authorization. VMG will protect the confidentiality of my images in accordance with all applicable federal and state privacy laws.

3. **RELEASE OF INFORMATION:** I understand and agree that VMG may receive, have access to, use and disclose my medical and billing information as described in this Consent and the Valley Notice of Privacy Practices. This includes, as applicable, my diagnosis, prognosis, treatment received, diagnostic tests, images and procedures performed, medication history, and other information about my medical care (my "medical information") which may be maintained now or in the future.

   I understand that my medical information, which may be shared under this Consent, may also include sensitive information regarding my past, present and future behavioral and mental health, HIV/AIDS related information, sexually transmitted diseases, tuberculosis, genetic information, including genetic test results, drug or alcohol related illness, or emancipated care I may receive as a minor, unless a separate written consent from this form would be required by applicable law. I understand and agree that this information may be accessed, used and disclosed to carry out treatment, payment or health care operations, and other purposes permitted or required by law, including coordination of care. VMG may release my information to or receive my information for these purposes from my former, current or future health care providers, my insurance companies/payors, including Medicare or Medicaid, or any other person or entity that may be responsible for coordinating my health care or paying for payment any portion of my bill for services. I acknowledge that this Consent serves as notice to me of the recipients who may have access to, use and disclose my medical information.

   I understand and agree that certain uses and disclosures of my medical and billing information may be facilitated through entities such as Jersey Health Connect, NJHIN, and their participants (collectively, "Health Information Exchange (HIEs)"). I understand that the Valley Notice of Privacy Practices sets forth additional information about these HIEs, including how I can opt-out of participating in such HIEs.

4. **FINANCIAL AGREEMENT:** I understand and agree that I am financially responsible to pay for any services I receive in accordance with the regular rates and terms of VMG. I agree to make prompt payment to VMG for any and all charges not paid for by my health insurer or payor, to the fullest extent permitted by law. I understand that my health insurer or payor may require that I obtain pre-certification and/or pre-authorization for the services provided to me, and that I am responsible for any charges for health care services that are not pre-certified and/or pre-authorized. I acknowledge that it is my responsibility to understand my insurance coverage requirements, benefits and limitations.

5. **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:** I acknowledge receipt of the Valley Notice of Privacy Practices and was given the opportunity to ask questions and voice concerns. I hereby consent to the uses and disclosure set forth in the Valley Notice of Privacy Practices. I also understand that this consent is revocable at any time by writing to the Valley Privacy Officer as identified in the Valley Notice of Privacy Practices, except to the extent that action has already been taken in reliance on my consent. This consent will remain in effect for a reason time in order to accomplish the purpose for which it has been given.

   I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS GENERAL CONSENT FOR TREATMENT, AND THAT ANY QUESTIONS THAT I HAD ABOUT IT HAVE BEEN ANSWERED TO MY SATISFACTION BY THE STAFF OF THIS FACILITY.

_____ _____

Patient or Authorized Representative Signature | Date and Time

_____ _____

Name of Person Signing | Relationship to Patient

The patient is unable to consent because:

_____

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Valley Medical Group
Valley Health System

AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH OTHERS AND/OR LEAVE TELEPHONE MESSAGES

The purpose of this document is to inform us if we have your permission to:

- Relay information to other people regarding your care and treatment.
- Leave information about your care and treatment on your telephone answering machine.
- Call you at work, and/or on your cell phone or other telephone number.

Patient Name:_____ **Date of Birth**:_____

When our physicians or office staff need to speak with you about your healthcare, we generally place a telephone call and ask to speak with you, our patient, first. Some examples of when we may need to call you are: to schedule/change/cancel an appointment; to see how you are feeling after a visit to us; with follow-up instructions after a visit; and/or to provide laboratory, radiology, or other diagnostic test results, etc.

- PREFERRED METHOD FOR OUR FOLLOW-UP COMMUNICATIONS WITH YOU:

☐ Home Phone _____ ☐ Cell Phone _____ ☐ Work Phone _____

If you are unavailable when we telephone you,

- May we leave a detailed message about your care and treatment on your answering machine? ☐ Yes ☐ No

- Is there another person that we have permission to speak with regarding your health care? If "Yes", please specify who:

Name	Relationship	Phone #	Type of Information
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Name of Person Signing Relationship to Patient

Valley Medical Group will abide by the guidelines given in this document unless you instruct us differently.

Valley Medical Group
Valley Health System

PATIENT RESPONSIBILITIES AND STATEMENT OF UNDERSTANDING

In the current healthcare environment, it is increasingly difficult for medical providers to be paid for their services. Dealing with insurance companies is also becoming more confusing to our patients. As a result, we would like to clarify your responsibilities as a Valley Medical Group patient.

Insurance Coverage

- Your insurance policy is a contract between you and your insurance company, not your provider.
- Changes to your insurance coverage must be communicated to our office at the time of service upon check-in.
- Your insurance company may require you to choose a primary care physician in order to receive "in network benefits". If you have chosen a Valley Medical Group physician as your PCP and his or her name does not appear on your insurance card, you must verify that your insurance company has the correct information before services are rendered.
- If your claim is processed incorrectly by your insurer, you give Valley Medical Group permission to appeal the claim on your behalf by your signature below.
- If your insurance plan requires a PCP and the Valley Medical Group physician is not your PCP, you may be responsible for deductibles, co-insurance, and other non-covered services.
- If your plan requires referrals from your Valley Medical Group PCP to specialists, it is your responsibility to obtain the referral from our office prior to your appointment with the specialists. Please be aware that non-emergent referrals can take up to two weeks to process. In addition, referrals will **NOT** be dated retroactively.

Financial Obligations

1. Co-payments are due at the time of service.
2. Valley Medical Group will bill participating insurance companies after verifying coverage. If claims are not paid, Valley Medical Group will bill you for services rendered.
3. Payment for non-covered services, deductibles, and co-insurance amounts are due within thirty (30) days of receipt of invoice.
4. If insurance payments are paid to you in error instead of Valley Medical Group, the payment must be forwarded to us. You may issue a personal check to Valley Medical Group. Be sure to include a copy of your insurance company's documentation or explanation of benefits.
5. If you do not have insurance that Valley Medical Group participates with, you are responsible for payment in full for today's services.
6. Processing fees may be imposed for non-payment of out-of-pocket expenses referenced in #1 and #5 above, and for checks returned by the bank for non-payment.
7. Valley Medical Group bills an additional fee for weekend and holiday visits.
8. If requested, you are responsible for providing your insurance company with any other insurance coverage, details of an injury, dependent student information, and other non-medical information. Failure to comply with an insurance company request for information will result in your being responsible for payment.

I HAVE READ AND UNDERSTAND THE INFORMATION AND MY RESPONSIBLITIES AS STATED ABOVE:

Patient/Guardian:_____ Date: _____

Witness:_____Date: _____

A copy of this form is available upon request.

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Valley Medical Group
Valley Health System

Date: _____

E-Prescribing/Medication History Consent Form

Patient Name: _____ Date of Birth: _____

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Valley Medical Group* can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Valley Medical Group to enroll me in the e-Prescribe Program. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Witness to Signature(s) Patient's or Authorized Representative's Signature

_____

Relationship to Patient

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