MDPartners
ENGLEWOOD HOSPITAL AND MEDICAL CENTER

Patient Information Form

TODAYS DATE / /

LAST NAME | MI | FIRST NAME | GENDER ☐ Male ☐ Female ☐ Transgender ☐ Other

ADDRESS | CITY | STATE | ZIP CODE

MARITAL STATUS ☐ Married ☐ Divorced ☐ Single ☐ Widowed | DATE OF BIRTH / / | EMAIL | SSN # - -

HOME PHONE ( ) | CELL PHONE ( ) | WORK PHONE ( )

May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

Are you part of the Bloodless Medicine Program? ☐ YES ☐ NO

Do you have a Living Will/Advance Directive? ☐ YES ☐ NO

RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ White

ETHNICITY ☐ Hispanic or Latin ☐ Non Hispanic or Latin ☐ Prefer not to answer

PRIMARY LANGUAGE ☐ Chinese ☐ English ☐ Farsi ☐ French ☐ Greek ☐ Hindi ☐ Indian ☐ Italian ☐ Japanese ☐ Korean ☐ Russian ☐ Spanish ☐ Other

DO YOU NEED A TRANSLATOR? ☐ YES ☐ NO

PHARMACY NAME | PHONE ( )

PHARMACY ADDRESS | CITY | STATE | ZIP CODE

EMERGENCY CONTACT #1 | RELATIONSHIP | EMERGENCY CONTACT PHONE ( )

EMERGENCY CONTACT #2 | RELATIONSHIP | EMERGENCY CONTACT PHONE ( )

Which provider do you see to meet most of your healthcare needs?

PRIMARY CARE PROVIDER | PHONE ( )

PRIMARY CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

REFERRING CARE PROVIDER | PHONE ( )

REFERRING CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

OTHER CARE PROVIDER | PHONE ( )

OTHER CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

OTHER CARE PROVIDER | PHONE ( )

OTHER CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

(continued on next side)

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EMPLOYMENT INFORMATION

EMPLOYER NAME			OCCUPATION/POSITION	
EMPLOYMENT STATUS	☐ Employed Full-time	☐ Self-employed	☐ On active military duty	☐ Other
	☐ Employed Part-Time	☐ Retired	☐ Reserves	

INSURANCE/PAYMENT INFORMATION

PRIMARY INSURANCE

Which insurance should be billed first?

SUBSCRIBER NAME			IN WHOSE NAME IS YOUR HEALTH INSURANCE POLICY?
SUBSCRIBER SSN # - -	SUBSCRIBER DATE OF BIRTH / /		RELATIONSHIP TO SUBSCRIBER

SUBSCRIBER EMPLOYER			
SUBSCRIBER EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER GENDER ☐ Male ☐ Female ☐ Transgender ☐ Other			

PRIMARY INSURANCE COMPANY	POLICY #	GROUP #	
INSURANCE COMPANY ADDRES	CITY	STATE	ZIP CODE
EMERGENCY CONTACT PHONE # ( )			

ADDITIONAL INSURANCE

Which insurance should be billed second? This may not apply to you.

SUBSCRIBER NAME			IN WHOSE NAME IS YOUR HEALTH INSURANCE POLICY?
SUBSCRIBER SSN # - -	SUBSCRIBER DATE OF BIRTH / /		RELATIONSHIP TO SUBSCRIBER
SUBSCRIBER EMPLOYER			
SUBSCRIBER EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER GENDER ☐ Male ☐ Female ☐ Transgender ☐ Other			
OTHER INSURANCE COMPANY	POLICY #	GROUP #	

ACKNOWLEDGEMENT/AUTHORIZATION

I CERTIFY THAT ALL INFORMATION I PROVIDED ABOVE IS ACCURATE AND TRUE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR ANY SERVICES FURNISHED TO ME BY THIS PHYSICIAN GROUP. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I AUTHORIZE THE RELEASE OF MY INFORMATION CONCERNING MY HEALTHCARE TO MY INSURANCE COMPANY FOR THE PURPOSE OF REVIEWING AND PROCESSING MEDICAL CLAIMS FOR PAYMENT.

SIGNATURE	RELATIONSHIP TO PATIENT	DATE / /

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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION:
Patient Name: _____

Address (number and street) _____

City, State, Zip Code _____

Telephone _____ Date of Birth _____

I hereby authorize and request MDPartners to:

☐ Release information to ☐ Obtain information from

Name/Facility: _____

Address: _____

City, State, Zip Code: _____

FOR THE PURPOSE OF: _____

INFORMATION TO BE RELEASED/OBTAINED

Please specify visit date(s):

_____

_____

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type:

_____AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection

_____Psychiatric Care

_____Genetic Information

_____Treatment for alcohol and/or drug abuse

_____Sexually Transmitted Disease(s)

_____Tuberculosis

I authorize the above person/organization and/or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in this authorization. I further agree to release the facility 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 thereon. I understand that this authorization will expire on _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

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

_____ _____

Signature of Patient or Legal Representative — Date

_____

If signed by Legal Representative, Relationship to Patient

MDPartners
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CONSENT FOR TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

1. **CONSENT FOR TREATMENT**
   The undersigned consents to any x-rays, laboratory or other medical procedures or examination rendered to me under the general and specific instructions of my physician(s). I acknowledge that no guarantees have been made to me as to the result of treatment/ examination in MDPartners. I also consent to the testing of my blood for Human Immunodeficiency Viruses (HIV) and/or other blood borne pathogens, in the event that any individual at an MDPartners practice is accidentally exposed to my blood or body fluids, or my physician believes such testing is medically indicated. Results of such testing will be reported to me, noted on my medical record and reported to the State Department of Health as required by law.
2. **RELEASE OF INFORMATION**
   MDPartners is hereby authorized to release any/all of my medical records to the person(s) liable for my financial obligations resulting from services and to use data from my medical record for quality, epidemiology and education studies to which no identifying information will be made public. I authorize MDPartners to download my historical medication information from Sure Scripts.
3. **ASSIGNMENT OF INSURANCE BENEFITS**
   In the event the patient is entitled to physician benefits of any type arising out of any policy of insurance coverage from the patient or any other party liable for the patient, said benefits are hereby assigned to MDPartners and/or treating physician. In the event the patient's insurer denies medical benefits, coverage, or payment, consent is hereby authorized to allow MDPartners and/or treating physician to appeal such decisions on the patient's behalf.
4. **MEDICARE BENEFITS (IF APPLICABLE)**
   I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I assign the benefits payable for services to MDPartners or the physician furnishing the services and authorize MDPartners or the treating physician to submit a claim to Medicare for payment.
5. **MEDICAID**
   I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for practice services to MDPartners and/or treating physician. I authorize MDPartners or the physician to submit a claim to Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.
6. **OTHER PHYSICIAN SERVICES (OUTSIDE OF OUR PRACTICE)**
   In the event the patient is entitled to benefits of any type arising out of any policy of insurance covering the patient, that said benefits are also hereby assigned to any other physicians (outside of our practice) providing services to you at our request. I understand that it is the responsibility of the patient to obtain information from his/her insurance company to determine if the above mentioned physicians are participating in the patient's insurance plan. Participation by MDPartners in any given insurance plan does not indicate participation by the other physicians outside of this Practice. I understand that I am responsible to the other physicians' practices for any charges not covered by my insurance plan.
7. **FINANCIAL AGREEMENT**
   I agree, whether signing as agent or patient, that in consideration of the services rendered to the patient, I am hereby individually obligated to make payment to MDPartners in accordance with the regular rates and terms of MDPartners. I understand that I am responsible to MDPartners for any amounts billed to and not covered by any insurance carrier(s), including any amounts denied by the insurance carrier for no pre-certification or referral. Should the account be referred for collection after a default, I agree to pay costs of collection, including reasonable attorney's fee. All delinquent accounts bear interest at legal rates.

The undersigned certifies that he/she has read and understands the foregoing, receiving a copy thereof and as a patient or the patient's agent, authorized to execute the above, accepts its terms.

_____ _____ _____

Patient Signature/Authorized Agent | Date | Print Name Patient Signature/Authorized Agent

I acknowledge that I have been provided with a copy of MDPartners Privacy Notice.

_____ _____

Patient Signature/Authorized Agent | Date

MDPartners
ENGLEWOOD HOSPITAL AND MEDICAL CENTER

DESIGNATION OF RELATIVES, FRIENDS, AND CAREGIVERS TO RECEIVE NECESSARY TREATMENT-RELATED INFORMATION

Patient Name: _____ **Date:** _____

Patient DOB: _____

I agree that MD Partners may disclose certain portions of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care.

MD Partners will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Signature of Patient/Guardian: _____ **Date:** _____

☐ I choose not to designate any individual at this time.

☐ I designate the following contacts listed below as persons involved with my health care or payment relating to my health care for MD Partners to make the limited disclosures described above.

I understand that I am not required to list anyone, and can change this list at any time in writing.

Contact Name: _____ **Contact's DOB (required):** _____

Relationship: _____

Contact Name: _____ **Contact's DOB (required):** _____

Relationship: _____

Contact Name: _____ **Contact's DOB (required):** _____

Relationship: _____

MDPartners
ENGLEWOOD HOSPITAL
AND MEDICAL CENTER

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.
PLEASE REVIEW IT CAREFULLY.

MD Partners, a multi-specialty practice operating in various locations throughout Northern, NJ and Rockland County, NY, is dedicated to protecting your privacy, including the protected health information about you that we generate and maintain. This Notice describes how we may use and share protected health information, our legal obligations related to the use and sharing of this information, and your rights related to the protected health information about you. As required by law, we must maintain the privacy of protected health information, provide you with this Notice of our legal duties and privacy practices with respect to such information, and abide by the terms of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your health information to provide you with treatment and health care services. For example, we may disclose information about you to doctors, nurses, technicians, students, or other personnel involved in your care. We may also share this information about you with other agencies or facilities in order to provide the different things you need, such as prescriptions, lab work, and/or continuing medical care after you leave our practice. Sharing your information for this purpose gives your providers the information they need to provide you with appropriate care.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care, such as an ambulance company. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send an invoice disclosing your health information to your insurance company or to a benefit payer that is responsible for all or part of your medical bill. If federal or state law requires us to obtain a written release from you prior to disclosing health information for payment purposes, we will ask you to sign a release.

Health Care Operations: We may use and disclose your health information for our health care operations. For example, your health information may be used by the members of the medical staff to evaluate the performance of our health care professionals, assess patients' quality of care and case outcomes, and seek areas of improvement within our practice. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.

Appointment Reminders: We may contact you to remind you of an appointment with a provider.

Treatment Alternatives: We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to your family, friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Research: We may use or disclose your health information for research purposes, subject to the requirements of applicable law. All research projects are subject to a special approval process, which establishes protocols to ensure that your health information will continue to be protected. When required, we will obtain a written authorization from you prior to using your health information for research.

Marketing Activities: We may contact you as part of our marketing activities, as permitted by applicable law.

Required by Law: We may use and disclose your health information as required by law. For example, we may disclose health information for mandated patient registries, communicable disease reporting, and for judicial and administrative proceedings, including disclosures in response to a court order.

Law Enforcement: We may release your health information to assist law enforcement officials with their law enforcement duties. Examples include responding to a court order, subpoena, warrant, summons, or similar process; identifying or locating a suspect, fugitive, or missing person; and reporting criminal conduct on our premises.

To Avert a Serious Threat to Health or Safety: As permitted by applicable law and standards of ethical conduct, we may use and disclose health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Disaster-Relief Efforts: When permitted by law, we may coordinate our uses and disclosures of health information with public or private entities assisting in a disaster-relief effort. If you do not want us to disclose your health information for this purpose, you must communicate this to your caregiver so that we do not disclose this information unless done so in order to properly respond to the emergency.

Organ and Tissue Donation: If you are an organ donor, we may release your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the Armed Forces, domestic or foreign, we may release your health information to military command authorities as authorized or required by law.

Worker's Compensation: We may release your health information for programs that provide benefits for work-related injuries or illnesses.

Public Health Activities: We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report births and deaths;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight Activities: We may disclose health information to federal or state agencies that oversee our activities, including licensing, auditing, and accrediting agencies.

Coroners, Medical Examiners, and Funeral Directors: We may disclose health information to coroners, medical examiners, and funeral directors as necessary for them to carry out their duties.

National Security and Intelligence Activities: We may release your health information to authorized federal officials for intelligence, counterintelligence, or other national security activities that are authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so that they may provide protection to the President or other authorized persons or foreign heads of state or to conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your health information to the correctional institution or to law enforcement officials so that duties can be carried out under the law.

Other Uses of Your Health Information: Other uses and disclosures of health information not covered by this Notice or by the laws that apply to us will be made only with your permission in a written authorization, including certain marketing activities, sale of health information, and disclosure of psychotherapy notes with some exceptions. You have the right to revoke your authorization at any time, provided that the revocation is in writing, except to the extent that we have already taken action in reliance on your authorization.

HEALTH INFORMATION EXCHANGE (HIE)

We participate in an electronic health information exchange network (HIE) called "Jersey Health Connect". Generally, an HIE is an organization that health care providers participate in to exchange patient information in order to facilitate health care, to avoid duplication of services (such as lab tests), and to reduce the likelihood that medical errors will occur. Jersey Health Connect allows participating providers to exchange such information through a secure network, thus giving your participating providers immediate electronic access to your pertinent health information that is necessary for treatment, payment, and health care operations.

If you do not wish to have your information included in the Jersey Health Connect HIE, you may opt out. Unless you opt out, your information will be available through the Jersey Health Connect HIE network to your authorized participating providers in accordance with this Notice and applicable law. For instance, if you receive a blood test from one authorized participating provider and you are later treated by a second authorized participating provider, the two providers can share your test results electronically through Jersey Health Connect's secure network. If you choose to opt out of Jersey Health Connect, your information will continue to be accessed, used, and disclosed, in accordance with this Notice; however, we will not share your information through the HIE.

You can obtain additional information about the Jersey Health Connect HIE by visiting http://www.jerseyhealthconnect.org/. We will provide you with an informational brochure about Jersey Health Connect upon request.

HIE Opt Out:

If you do not wish to allow otherwise authorized doctors, nurses, and other clinicians involved in your care to electronically share your health information with one another through Jersey Health Connect as explained in this Notice, you may complete, sign, and submit the *Jersey Health Connect Opt-Out Form* as instructed on that form, and we will honor your opt-out selection. The *Jersey Health Connect Opt-Out Form* can be obtained directly from any of your providers participating in Jersey Health Connect, or you can download the form from www.jerseyhealthconnect.org/patients/opt-out. Any exception that denies an individual from opting out of having their information transmitted through the Jersey Health Connect HIE, shall be fully supported under federal and state law.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy: With certain exceptions, you have the right to inspect and to receive a copy of your health records. You have the right to obtain, upon request, a copy of your health information in an electronic format if we maintain your health information electronically (in our computers). You may also request that we transmit a copy of your health information to another company or person you have designated. However, this right is subject to a few exceptions, including psychotherapy notes, information collected for certain legal proceedings, and any medical information restricted by law. In order to inspect and copy your health information, you must submit your request in writing to MD Partners' Privacy Officer. If you request a copy of your health information, we may charge you a fee for the cost of copying and mailing your records, as

well as for other costs associated with your request. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Right to Request a Restriction: You have the right to request a restriction or limitation on the health information we use and disclose about you for treatment, payment, and health care operations. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full. To request a restriction, you must make your request in writing to MD Partners' Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health matters by alternative means or at alternative locations. To make such a request, you must submit your request in writing to MD Partners' Privacy Officer.

Right to Request an Amendment: You have the right to request an amendment to your health information. In order to request an amendment to your health information, you must submit your request in writing to MD Partners' Privacy Officer, along with a description of the reason for your request. If we agree to your request, we will amend your record(s) and notify you of such. We have the right to deny your request for amendment. If we deny your request for an amendment, we will provide you with a written explanation of why we denied the request and to explain your rights.

Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by us to individuals or entities other than you, in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to MD Partners' Privacy Officer. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the cost of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you have previously agreed to electronically receive this Notice. You can always request a written copy of our most current version of this Notice from MD Partners' Privacy Officer.

CHANGE TO THIS NOTICE

We must comply with the provisions of this Notice as currently in effect, although we reserve the right to change the terms of this Notice from time to time and to make the revised Notice effective for all health information we maintain. This Notice will contain the effective date on the last page. If we amend this Notice, we will provide the revised version on our website, and we will provide you with a copy of the Notice that is currently in effect, upon your request.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of Health & Human Services. You may contact MD Partners at (201) 894-3000 and ask to speak to the Privacy Officer for additional information pertaining to a complaint. We will not take any retaliatory action against you for filing a complaint.

CONTACT PERSON

If you have any questions or would like further information about this Notice, please contact MD Partners at (201) 894-3000 and ask to speak to the Privacy Officer.

This Notice is effective March 1, 2018, and replaces all earlier versions.