Sea Girt Medical Associates
Patient Registration Form

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ / _____ /_____

SSN _____ - _____ - _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

E-mail address _____

Occupation (If retired, state former occupation) _____ Employer Name _____

Employer Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Phone Number (_____) _____ - _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient (Check one): ☐ Spouse ☐ Parent ☐ Sibling ☐ Child ☐ Other _____

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

Guarantor Name _____ Date of Birth: _____ / _____ /_____

SSN _____ - _____ - _____ Sex: ☐ M ☐ F Relationship to patient: ☐ Parent ☐ Spouse ☐ Other _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Employer Name _____

Employer Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance name		Insurance name	
Claims Address		Claims Address	
City, State, Zip		City, State, Zip	
Employer Group Insurance? ☐ Yes ☐ No Employer Name:		Employer Group Insurance? ☐ Yes ☐ No Employer Name:	
Subscriber Name	Sex: ☐ M ☐ F	Subscriber Name	Sex: ☐ M ☐ F
Subscriber ID	Group No.	Subscriber ID	Group No.
Subscriber Date of Birth	Effective Date	Subscriber Date of Birth	Effective Date
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____		Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____	

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize to release to the insurance companies/carriers above any medical or other information required for processing insurance claims. I, Guarantor, hereby acknowledge and accept responsibility for payment in full for all services rendered to me by Sea Girt Medical Associates.

_____ _____ _____

Signature of Adult Patient Guarantor Signature (and relationship) Date

SEA GIRT MEDICAL ASSOCIATES, P.C.
OFFICE FINANCIAL POLICY

Sea Girt Medical Associates' goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our financial policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions please do not hesitate to ask a member of our staff.

1. Upon arrival, please register with the front desk and present your current insurance card(s) at every visit. If we are your primary care physician, make sure our name or phone number appears on your card. If we are not your designated PCP at the time of the visit, you will be financially responsible for the charges.
2. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see a specialist, if pre-authorization is required for a procedure and what services are covered.
3. According to your insurance plan, you are responsible for any and all copayments, deductibles, and coinsurances.
4. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
5. If you have no insurance, payment in full is due at the time of the visit.
6. **Copays are due at the time of service, in accordance with your insurance plan. A $15.00 service fee will be charged in addition to your copay, if the copay is not paid at the time of visit.**
7. Patient balances are billed immediately upon receipt of your insurance plans explanation of benefits. Your remittance is due within15 business days of your receipt of your bill. A finance charge of 1.7% will be added monthly to any unpaid balance.
8. Balances over 60 days will be turned over to a collection agency. Should your account be referred to collections, you will be subject to a fee of **$50.00 or 20%**, whichever is greater.
9. We require 24 hours notice for canceling any appointment, or a **$25.00** no-show fee will apply.
10. A **$25.00** fee will be charged for any checked returned for insufficient funds, plus any bank fees incurred.
11. We charge **$1.00** per page for copying of Medical Records.
12. If you/your child have disability forms, school forms, camp forms, sports forms, etc. to be completed, there is a **$10.00** charge per form. Payment is due when the forms are dropped off. We have a one week turn around time to complete these forms. Immunization records are required.
13. 72 hours advance notice is needed for all non-emergent referrals. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary physician must approve referrals before being issued.
14. Before making an **annual physical** appointment, check with your insurance company to verify they will cover a healthy visit. Not all plans cover annual healthy physicals. It is **your** responsibility to know **your** insurance plan benefits. If it is not covered, you will be responsible for payment.

I have read and understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name (Print) _____

_____ _____

Signature of Patient, Parent or Guardian Date

Sea Girt Medical Associates, P.C.
235 Route 71 Manasquan, NJ 08736
Phone: 732-223-4300
Fax: 732-223-5273

Authorization for Records Release

As a Patient-Centered Medical Home, we are dedicated to providing our patients with comprehensive, personalized, coordinated care. Therefore, it is important that we are connected to any specialists or other physicians responsible for your care. By signing below, you are providing consent for our practice to request courtesy copies of your medical records.

I, _____, hereby authorize Sea Girt Medical Associates to request courtesy copies of my medical records from other physicians responsible for my care, including:

- Lab work results
- Colonoscopy, sigmoidoscopy, and endoscopy reports
- Consult and progress notes
- Vaccination records
- Radiology/imaging reports (X-ray, CT scan, MRI, Mammography, bone density scan, etc.)

Furthermore, I understand that while my primary care physician may receive courtesy copies of my medical records, it remains the ordering physician's responsibility to review, monitor, and arrange follow-up on any test results and diagnoses from testing he or she ordered.

Patient Name (Print) _____

Patient Name (Signature) _____ Date _____

Sea Girt Medical Associates
Health History Form

Today's Date: _____ Preferred Language: _____

Name: _____ Date of Birth: _____

Email address: _____ Home Phone: _____

Local Pharmacy: _____ City: _____ Cell Phone: _____

Mail Away Pharmacy: _____ Work Phone: _____

Do you have a living will? ☐ No ☐ Yes Are you hearing or visually impaired? (Circle): **Hearing Visual**

Please list all current medications (including supplements/over-the-counter), dose, and frequency (e.g. lipitor, 20 mg, 2/day, melatonin 3mg 1/day, etc):

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Please list all medical problems you have been diagnosed with (e.g. diabetes, hypertension, depression):

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Please list any surgeries you've had and the year the surgery was done (e.g. tonsils, 2003):

1. _____ 3. _____ 6. _____
2. _____ 4. _____ 7. _____

Have you been hospitalized in the last year? ☐ No ☐ Yes – explain: _____

_____

Allergies

Do you have any drug or other allergies? ☐ No ☐ Yes – to what? _____

Social History

What is your occupation? (If retired, please state former occupation)_____

Where do you work? _____Who do you live with? _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Exercise ☐ No ☐ Yes ☐ Aerobics ☐ Weights # days/week _____ Duration _____ min

Drug Use ☐ Never ☐ Yes (Please explain): _____

Alcohol Use ☐ None ☐ In recovery since: _____ ☐ Yes -– Drinks per week: _____

Tobacco Use* ☐ Never ☐ Current ☐ Quit – when?_____

***If you currently smoke, are you interested in quitting?** ☐No ☐ Yes

Health Maintenance – Please write date of last:

	Recommendation *(may vary depending on age/risk factors)*	**Date**	**Performing physician and/or facility:**	**Check if none:**
Colonoscopy	Every 5-10 years for **everyone** age 50+			☐
PSA	Yearly for **men** age 50+			☐
Mammogram	Yearly for all **women** age 40+			☐
Pap smear	Yearly for all **women** age 21+			☐
Bone density scan	Every 2 years for postmenopausal **women**			☐

Immunization History:

Influenza	Yearly for **everyone** age 50+			☐
Pneumonia	**Everyone** age 65+, earlier w/ certain illnesses			☐
Shingles	Indicated for **everyone** age 50+			☐
Tetanus				☐

Patient Name:_____ **Date:**_____

Family History

Please list immediate family health problems **(limited to parents, siblings, and children)**. Include current age or age at death and health/mental problems, such as cancers, hypertension, stroke, diabetes, cholesterol, osteoporosis, depression, substance abuse disorder, etc.

Relative	Alive	Deceased	Age or Age at Death	Health/Mental Problems
Mother	☐	☐		
Father	☐	☐		
Brother/Sister	☐	☐		
Brother/Sister	☐	☐		
Brother/Sister	☐	☐		
Brother/Sister	☐	☐		
Brother/Sister	☐	☐		
_____	☐	☐		
_____	☐	☐		
_____	☐	☐		
_____	☐	☐		
_____	☐	☐		
_____	☐	☐		

Does your *family have a history of:**
**Limited to parents, siblings, and children*

			Family member(s):
Breast cancer	☐ No	☐ Yes	_____
Colon cancer or polyps	☐ No	☐ Yes	_____
Gynecological cancer	☐ No	☐ Yes	_____
Prostate cancer	☐ No	☐ Yes	_____
Skin cancer	☐ No	☐ Yes	_____

Patients with diabetes, please complete:

Name of endocrinologist: _____
Date of last visit: _____
Name of podiatrist: _____
Date of last visit: _____
Name of ophthalmologist: _____
Date of last visit: _____

Do you have any of the following symptoms?

- ☐ Bee sting allergy
- ☐ Latex allergy
- ☐ Reoccuring fevers
- ☐ Unexplained weight loss
- ☐ Change in skin color
- ☐ New or changing skin spots
- ☐ Non-healing sores
- ☐ Obstructed swallowing
- ☐ Change in voice
- ☐ Recent change in vision
- ☐ Recent change in hearing
- ☐ Neck mass
- ☐ Lymph gland swelling
- ☐ Chronic cough
- ☐ Sleep apnea
- ☐ Shortness of breath
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Ankle swelling
- ☐ Exertional chest pain
- ☐ Palpitations
- ☐ Heartburn
- ☐ Chronic diarrhea
- ☐ Chronic constipation
- ☐ Blood in your stool
- ☐ Black or tarry stools
- ☐ Lactose intolerance
- ☐ Incontinence
- ☐ Erectile dysfunction
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Abnormal menstruation
- ☐ Scoliosis
- ☐ Sciatica
- ☐ Broken bones
- ☐ Dizziness
- ☐ Slurred speech
- ☐ Anxiety
- ☐ Depression
- ☐ Previous psychiatric care
- ☐ Suicidal thoughts
- ☐ History of trauma
- ☐ Change in height
- ☐ Hot or cold intolerance
- ☐ Reoccuring nose bleeds

☐ **Please check, if none of the above.**

Please explain any **positive** responses:

_____
_____
_____
_____
_____
_____

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Recommendations for Routine Well Care

To Our Valued Patient,

The doctors of Sea Girt Medical Associates understand the importance of routine health maintenance. We also realize that while many patients are seen regularly for "sick visits" or for management of ongoing disorders, well-care can sometimes be overlooked. We believe that a patient's health is not our responsibility alone but a shared responsibility between the doctor and patient.

In an effort to help assure that your routine healthcare is not neglected, we want to remind you that **annual physical exams** are your best assurance that age appropriate screening tests and procedures are done on time. They also offer an opportunity to pick up important physical findings for which you may have no symptoms.

While not all patients wish to pursue well care, those of you who do are strongly urged to set aside time to schedule an annual physical exam. Annual physicals need to be done when you feel well, with very little, if any, "new business" or concerns. There is simply no way to cover current health recommendations for well-care during a sick visit or at a time when you have new symptoms or complaints. While we respect your right to decline any or all current health recommendations, we hope that you do so with a clear understanding of the pros and cons of your decision.

Routine well care, that is recommended for patients who feel completely well, includes but is not limited to:

- Colonoscopy for colon cancer screening
- Prostate cancer screening
- Breast cancer screening and yearly Pap smear
- Review of your personal and family health histories
- Smoking Cessation
- Vaccinations including pneumonia, flu, tetanus, hepatitis, etc.
- Bone density testing for osteoporosis
- Cholesterol testing
- Blood sugar testing for diabetes
- Thyroid testing
- Testicular cancer screening
- High blood pressure screening
- Other recommendations based on your findings

_____ _____

Patient Signature Date

Sea Girt Medical Associates, P.C.
235 Route 71 Manasquan, NJ 08736
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (Name) _____ (Date of Birth) _____, have received a copy of Sea Girt Medical Associates' Notice of Privacy Practices.

Please list any other parties (e.g., spouse, sibling, child) with whom we may share your health information (test results and treatment):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ None. Selecting this option means that we will only communicate with you regarding your health information.

What is the best way to contact you with test results, treatment, and diagnosis information?

☐ **Cell phone (_____) _____ - _____**
May we leave a voicemail at this number containing health information? Yes No

☐ **Home phone (_____) _____ - _____**
May we leave a voicemail at this number containing health information? Yes No

☐ **Work phone (_____) _____ - _____**
May we leave a voicemail at this number containing health information? Yes No

☐ **Secure e-mail communication (via patient portal):**
Please provide e-mail: _____
Note: If you do not yet have a portal account, you will receive an e-mail invitation to join.

Please choose your e-mail preferences below:

☐ We may NOT send messages regarding lab results to your portal

☐ We may send messages regarding lab results via secure e-mail to your portal

IMPORTANT: By selecting this option, please be aware we will not be contacting you by phone with your lab results. Only in the case of critical, time-sensitive results will we notify you by phone. Normal results and/or results with non-emergent changes in your care will only be reported by secure web message.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/01/02 and will remain in effect until we place it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changed are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we make the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provided providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professions, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization, to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocations will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reasons except to those described in this Notice.

To Your Family and Friends: We must disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail, messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the rights to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information.) You may obtain a form to request access by contacting our office. You will be charged a reasonable fee for expenses. You may also request access by sending us a letter. If you request copies, you will be charged $10 for the first page and $1 for each following page plus postage.

Restrictions: You have the right to request that we place additional restrictions on our use or disclose of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing) and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of health information or to have us communicate with you by alternative means for at alternative locations, you may complain to use using the contact information above. You may also submit a written complain to the U.S. Department of Health and Human Services. We will provide HHS address on request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.