Saint Clare's Health

GARDEN STATE UROLOGY

Hospital Outpatient Center for Urologic Services

Dear New Patient:

Welcome to Garden State Urology, a division of Saint Clare's Health. Our physicians and staff are dedicated to providing state of the art urological care in a friendly, caring environment. To make your first visit as smooth as possible, we ask that the following forms be completed and sent to us at least **1 day prior to your appointment in order to avoid wait times**:

- **Patient History Form** –We recommend that you have your medication bottles handy when completing this form so the information is accurate.
- **Registration Form** completed with signed Financial Agreement
- Provide a copy of your **insurance card** – front AND back (make sure ID #s are legible)

We have established a private/secure email and fax number for you to use:

EMAIL - gsuscreg@gsunj.com
FAX - **973-627-1095**

Do **NOT** mail the forms! If you are unable to email or fax the forms, simply bring them with you to your appointment.

Please remember to arrive 30 minutes prior to your scheduled appointment with a print out of your completed documents so that your information can be entered into your electronic medical record or your appointment may be delayed until the proper documents are obtained:

- Bring the completed forms with you in case there is a problem with the processing of your forms. **We do not want you to have to complete the forms again.**
- Registration and History forms
- Photo ID (driver's license, passport or visa)
- **Referral, if it is required by your insurance**. Please make sure that you bring that document with you to your appointment. If you do not bring this information you will be held responsible for the charges occurred on that day
- **The consult/referral form** included in this packet is necessary regardless of your insurance requirements. If the referring physician did NOT give you a referral document, please ask them to complete the enclosed CONSULT REFERRAL FORM **prior** to your scheduled appointment. If your physician did give you a consult referral or prescription stating the reason for the visit then you do not have to complete the attached form. Please have it faxed or emailed to our office, or bring it with you the day of the visit. If you were not referred by another physician or are not presently under the care of a physician that you would like us to correspond with, this document is not necessary.
- **Insurance card(s)**
- **Lab results**, especially blood work and urine cultures any other tests or medical results that pertain to your visit.
- **Radiology testing** (reports and films/CD) *It is your responsibility to bring these items to your appointment. You cannot rely on the facility to deliver them.

If you need to reschedule your appointment or have any questions please call our office at (973) 927-5788 so that we may give that time to another person in need and arrange a more convenient time for you.

Sincerely,

The Scheduling Staff

ADULT REGISTRATION FORM: Please complete the entire registration form.

PATIENT'S LAST NAME	
PATIENT'S FIRST NAME	
PATIENT'S DATE OF BIRTH	
PATIENT'S SEX	
PATIENT'S ADDRESS	
APT., SUITE OR FLOOR	
CITY, STATE & ZIP CODE	
PATIENT'S PHONE #	
EMAIL ADDRESS	
RELIGION	
MARITAL STATUS	
RACE	
PRIMARY LANGUAGE	
PRIMARY CARE DOCTOR & PHONE NUMBER	
REFERRING PROVIDER & PHONE NUMBER	
PHARMACY NAME , TOWN, PHONE NUMBER	
ORGAN DONOR?	PLEASE SEI
ADVANCE DIRECTIVE/LIVING WILL	PLEASE SEI
POWER OF ATTORNEY/DPA	PLEASE SEI
EMERGENCY CONTACT NAME	
RELATION TO PATIENT	
EMERGENCY CONTACT PHONE #	
PATIENT'S EMPLOYER/OCCUPATION	
EMPLOYMENT STATUS	PLEASE SELECT
GUARANTOR NAME	
RELATION TO PATIENT	
GUARANTOR'S DATE OF BIRTH	
GUARANTOR'S ADDRESS	

CITY, STATE, ZIP CODE	
GUARANTOR'S SOCIAL SECURITY NUMBER	
GUARANTOR'S EMPLOYER	
GUARANTOR'S EMPLOYER ADDRESS	
GUARANTOR'S OCCUPATION	
GURANTOR'S EMPLOYER PHONE #	
PRIMARY INSURANCE	
INSURANCE NAME, ADDRESS, AND PHONE NUMBER	
POLICY NUMBER	
GROUP NUMBER	
SUBSCRIBER NAME	
RELATION TO PATIENT	
SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S ADDRESS	
CITY, STATE, ZIP CODE	
SUBSCRIBER'S PHONE #	
SUBSCRIBER'S EMPLOYER	
SUBSCRIBER'S ADDRESS	
SUBSCRIBER'S EMPLOYMENT STATUS	PLEASE SELECT
SUBSCRIBER'S EMPLOYER PHONE #	
SECONDARY INSURANCE	
INSURANCE NAME, ADDRESS, AND PHONE NUMBER	
POLICY NUMBER	
GROUP NUMBER	
SUBSCRIBER NAME	
RELATION TO PATIENT	
SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S ADDRESS	
CITY, STATE, ZIP CODE	

SUBSCRIBER'S PHONE #	
SUBSCRIBER'S EMPLOYER	
SUBSCRIBER'S ADDRESS	
SUBSCRIBER'S EMPLOYMENT STATUS	PLEASE SELECT
SUBSCRIBER'S EMPLOYER PHONE #	
SUBSCRIBER'S OCCUPATION	

Saint Clare's Health

GARDEN STATE UROLOGY

Hospital Outpatient Center for Urologic Services

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**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take a daily Aspirin? Yes ☐ **No** ☐

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

DATE OF LAST FLU IMMUNIZATION:_____ DATE OF LAST PNEUMONIA IMMUNIZATION_____

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****

Colonoscopy Date:_____ **Do you have a pacemaker?** ☐ **Yes** ☐ **No**

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

Diabetes ☐ Type 1 ☐ Type 2 ☐ NO

Asthma ☐ YES ☐ NO

High Blood Pressure ☐ YES ☐ NO

Kidney Stones ☐ YES ☐ NO

Heart Disease ☐ YES ☐ NO

Thyroid Disease ☐ Hype ☐ Hypo ☐ NO

Cancer ☐ YES ☐ NO
If YES please specify:

Arthritis ☐ YES ☐ NO

Indigestion ☐ YES ☐ NO

Other:_____
_____

When were you first diagnosed with: DIABETES?_____HIGH BLOOD PRESSURE?_____HEART DISEASE?_____

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

☐ Caucasian ☐ African American ☐ American Indian ☐ Asian Indian/Pakistani

☐ Hispanic ☐ Asian ☐ Other_____

Height:_____ **Weight:_____**

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:_____

Saint Clare's Health

GARDEN STATE UROLOGY

Hospital Outpatient Center for Urologic Services

Consult Request Form

Today's consultation with Dr. _____ is a

request for consultation for _____

(Patient name/DOB)

DX. _____.

YES NO Requesting advice/opinion with treatment and continued co-management.

YES NO Requesting advice/opinion.

Please complete this form and fax it to: 973-927-6831 _____

A copy of this request should be filed in the medical record of both the originating physician and the consulting physician.

_____

Referring Physician Signature

_____

Date

25 POCONO RD, DENVILLE, NJ 07834 PHONE (973) 927-5788 FAX (973) 927-6831

Acknowledgement of Receipt

By signing below, I acknowledge that I have received a copy of the 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

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:_____Telephone #:_____Relationship: _____

Name:_____Telephone #:_____Relationship:_____

Name:_____Telephone #:_____Relationship:_____

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

Work:_____ Other:_____

I consent for Garden State Urology to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology as a reminder of a previously booked appointment date and time._____ (initial)
Opt out from receiving text messages :_____(initial)

_____

Signature of Patient, Parent or Legal Guardian

_____

Printed Name

RACE AND ETHNICITY PATIENT SELF-IDENTIFICATION

Please mark one selection in the Ethnicity Box plus up to five selections in the Race box.

Please choose one Ethnicity category in this box.

☐ **(1) HISPANIC OR LATINO** -A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American , or other Spanish culture or origin.

☐ **(2) NON-HISPANIC OR LATINO** - Any possible options not covered in the above origin.

☐ **(3) UNKNOWN** - Patient who cannot or refuse to declare above category.

Please choose up to five Race categories in this box.

☐ **(1) AMERICAN INDIAN OR ALASKA NATIVE** - A person having origins in or who identifies with any of the original peoples of North and South America, and who maintains cultural identification through tribal affiliation or community recognition.

☐ **(2) ASIAN** - A person having origins in or who identifies with Asian Indian, Bangladeshi, Bhutanese, Burmese, Cambodian, Chinese, Filipino, Hmong, Indonesian, lwo Jiman, Japanese, Korean, Laotian, Madagascar, Malaysian, Maldivian, Nepalese, Okinawan, Pakistani, Singaporean, Sri Lankan, Taiwanese, Thai, and Vietnamese.

☐ **(3) BLACK OR AFRICAN AMERICAN** - A person having origins in or who identifies with any of the black racial groups including Botswanan, Ethiopian, Liberian, Namibian, Nigerian, Zairean, Barbadian, Bahamian, Dominican, Haitian, Jamaican, Tobagoan, Trinidadian, and West Indian.

☐ **(4) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER -A** person having origins in or who identifies with the following groups: Native Hawaiian, Carolinian, Chamorro, Chuukese (Trukese), Fijian, Guamanian, Kiribati, Kosraean, Mariana Islander, Marshailese, Melanesian, Micronesian, Mariana Islander, New Hebrides, Palauan, Papua New Guinean, Pohnpeian, Polynesian, Saipanese, Samoan, Solomon Islander , Tahitian, Tokelauan, Tongan, and Yapese.

☐ **(5) WHITE** - A person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East. This may include the following groups: Armenian, English, French , German, Irish, Italian, Polish, Scottish, Middle Eastern, North African, Assyrian, Egyptian, Iranian, Iraqi, Lebanese, Palestinian, Syrian, Afghanistani, lsraeili, and Arab.

☐ **(6) OTHER** - Any possible options not covered in the above categories. This category includes patients who cite more than one race.

☐ **(7) UNKNOWN** - If the patient's race is not recorded in the patient's medical record, the race should be reported as "Unknown ." This category includes patients who cannot or refuse to declare race.

_____

Patient/Guardian Signature

CONDITIONS OF ADMISSION

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including which may include, but are not limited to, laboratory emergency treatment or services and procedures, x-ray examinations, medical or surgical treatment or procedures, telehealth services, anesthesia, or hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon.

2. NURSING CARE: The hospital provides only general-duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse it is agreed that such must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that the patient is not provided with such additional care.

3. PERSONAL VALUABLES: It is understood and agreed that the hospital maintain a fireproof safe for the safe keeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, eye glasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices or other articles of unusual value and small size, unless placed there in, and shall not be liable for loss or damage to any other personal property, unless checked in the hospital safe and a receipt is issued to me. Property checked in the safe will not be surrendered without Hospital's receipt.

4. CONSENT TO PHOTOGRAPH: Photographs may be recorded to document the patient's progress of care and shall be part of the patient's medical records or physician's office medical record. I consent to this and the use of the same for scientific, education or research purposes if approved. The hospital/physician will retain rights to the as well as to the medical records. Photographs may also be taken for the purpose of patient identification.

5. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS: All physicians and surgeons furnishing services to the patients, including the radiologist, pathologist, anesthesiologist and the like are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the physician.

6. EMERGENCY OR LABORING PATIENTS: In accordance with Federal law, I understand my right to receive an appropriate medical screening examination performed by a doctor, or other qualified medical professional, to determine whether I am suffering from an emergency medical condition and, if such a condition exists, stabilizing treatment within the capabilities of the hospital's staff and facilities, even if I cannot pay for these services, do not have medical insurance or I am not entitled to Medicaid. If I deliver an infant(s) while a patient of this hospital, I agree that these same Conditions of Admission apply to the infant(s).

7. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL: The undersigned irrevocably assigns and hereby authorizes, whether he/she signs as agent or as patient, direct payment to the hospital of all insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's actual

charges. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she isfinancially responsible for allowed charges not paid pursuant to this assignment. In the event the undersigned's insurance company or health plan makes payment directly to the undersigned for services provided by the hospital, the undersigned shall remit such payment to the hospital within 15 days of his/her receipt of such payment.

8. **RELEASE OF INFORMATION:** The hospital will obtain the patient's consent and authorization to release medical information, other than basic information, concerning the patient, except in those circumstances when the hospital is permitted or required by law to release information. The undersigned has consented to the release of medical information to entities that provide care in post-acute setting. In accordance with the Safe Medical

Device Act of 1990, the undersigned agrees that in the event a permanent medical device is implanted the hospital is hereby authorized to notify the manufacturer of the patient's name, address, telephone number, and social security number (if available) as well as other information about the implantation. I authorize a copy of my record to be sent to my family physician or physician of referral at time of discharge.

Physician Name/Address_____

_____

I authorize release of information regarding the birth of my child, as applicable.

☐ Yes ☐ No Initial _____

The hospital is authorized, without further action by or on behalf of the patient to disclose all or any part of the patient's record to any entity which is or may be liable to the hospital, patient or any entity affiliated with patient for all or part of the hospital's or hospital-based physicians' charges for the patient's services (including, without limitation, hospital or medical service companies, insurance companies, workers' compensation carriers, welfare funds, patient's employer, or medical utilization review organization designed by the forgoing).

9. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL-BASED PHYSICIANS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to any hospital-based physician of any insurance or health plan benefits otherwise payable to or on behalf of the patient for professional services rendered during this hospitalization of for outpatient service, including emergency services if rendered, at a rate not to exceed such physician's regular charges. It is agreed that payment to such physician pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligation under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment to the extent permitted by state and federal law.

10. HOW YOUR BILL IS DETERMINED: Hospital charges include a basic daily rate, which covers your room, nursing care and food service, or outpatient/emergency services. Additional charges are made for special services ordered by your doctor. Operating room, surgical supplies, medications, treatments, tests, oxygen, x-rays and physical therapy are some examples of such services. Physician charges are billed separately. In addition to receiving bills for services rendered by the hospital and your personal physician, you will receive separate bills from hospital-based physicians who participate in your care. These physicians may represent any of the following areas: anesthesiology' radiology, pathology, nuclear medicine, cardio diagnostics, and the like.

11. FINANCIAL AGREEMENT: Not withstanding section (6), (Emergency or Laboring Patients), I further

understand that I am responsible to the hospital and physician(s) for all reasonable charges, listed in the hospital charge description master and if applicable the hospital's charity care and discount payment policies and state and federal law incurred by me and not paid by third party benefits. In the event that said bill, or any part thereof, is deemed delinquent by the hospital, I understand that I will be responsible for collection expenses as well as reasonable attorney's fees and court costs if a suit in instituted. All delinquent accounts shall bear interest in the maximum rate allowed by law. In the event that hospital is not paid by third parties within three (3) months from the date of billing for payment, I will promptly make arrangements to pay the outstanding account. I authorize the hospital, or collection agency or other entity contracting with the hospital to obtain credit report about me from the national credit bureaus in connection with payment of my account NON-COVERED CHARGES -in the event that insurance does not cover particular procedures, medications, and/ or services, the undersigned hereby agrees to be personally responsible for payment of such charges, if not prohibited by law.

12.MEDICARE INSURANCE, BENEFITS AND EXCLUSIONS: If the patient is a Medicare beneficiary or will apply for Medicare benefits, the undersigned certifies that the information given about the patient is correct. It is also agreed and understood that we may release certain medical information about the patient to the Social Security Administration and/or its intermediaries and/or its carriers for this or a related Medicare claim. The undersigned requests that payment of authorized benefits be made on the patient's behalf. Some services may not be covered by Medicare, such as the following: 1) Worker's Compensation, 2) Dental, 3) Cosmetic Surgery,
4) Custodial Care, 5) personal comfort Items, and/or any services determined to be unnecessary or unreasonable by Medicare. If the patient is not on file with the Social Security Administration, the usual billing procedures will be used independent of the data access

13. IF YOU DO NOT HAVE INSURANCE: You may be eligible for the Charity Care and Discounted Payment Program. Please contact the business office.

14.WAIVER OF LIABILITY- I understand that some or all of these services may not be covered by Medicare and that I am financially responsible if these services are denied.

15. FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE: I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 6) and Assignment of Health Plan Benefits (Paragraphs 7 and 8) set forth above.

Date/Time	Financially Responsible Party	Witness

Translator: I **have <u>accurately and completely read the forgoing</u> document to**

_____

(name of the patient/person legally authorized to give consent)

in_____

(the patient's or patient's representative's primary language.)

He/she understood all the terms and conditions and acknowledges his/her agreement thereto by signing this document in my presence.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the

NJ Saint Clare's	Patient ID
CONDITIONS OF ADMISSION	

patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

1. I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS OF SERVICE, WHICH BECOME EFFECTIVE AT THETIME SERVICE IS RENDERED.

PATIENT/PARENT/CONSERVATOR/GUARDIAN

POLICY HOLDER OR FINANCIALLY RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT

WITNESS

SIGNATURE OF TRANSLATOR

DATE OF SIGNING

TIME OF SIGNING

Patient unable to sign: ☐

EDUCATION MATERIALS:

All patients will receive the following:

- Patient's Rights and Patient's Responsibilities
- Notice of Privacy Practices
- Patient Guide

Inpatients - Please review for education on the following:

- Your Right to Make Decisions About Your Medical Treatment
- An Important Message from Medicare (Medicare/HMO Medicare Only)
- Understanding Your Pain
- Patient Safety
- Smoking Cessation Information
- Pneumococcal Vaccine Information (Publication date 04/25/2015)
- Influenza Vaccine Information (During the Current Flu Season) (Publication date 08/07/2015)

HEALTHCARE DIRECTIVE

Do you have a Healthcare Directive or a Living Will? ..... ☐ YES ☐ NO

Have you provided us with a copy? ☐ Yes ☐ No

1. If no, then note healthcare wishes below: _____

_____

I permit _____ to be involved in the care, treatment and service decisions during this hospital stay.

By signing below, I acknowledge that I have been provided the required **Educational Materials** and **Healthcare Directive** information.

_____ _____

Signature of Patient / Patient's Representative Date/ Time

_____ _____

If other than patient, include relationship. Witness

FOR STAFF USE ONLY:

If you are unable to provide any of the above information to the patient because of an emergency treatment situation, describe below the good faith efforts that you made to provide such information to the patient:

_____

_____

_____ _____

Employee Signature Date/ Time

SAINT CLARE'S HEALTH SYSTEM

HEALTH DATA EXCHANGE

PATIENT NAME:_____ **ACCOUNT NUMBER:**_____

Jersey Health Connect Health Information Organization (HIO)

Saint Clare's Health System has partnered with the Jersey Health Connect HIO to take part in the New Jersey Health Information Exchange (HIE) pursuant to federal requirements. The purpose of an HIE is to allow physicians and healthcare providers and facilities from across the state to share their patients' health information electronically for improving the quality of health care services provided. The goals for using an HIE are to have timely information about the patient's medical condition, reduce medical and medication errors, and reduce or eliminate duplicate tests and unnecessary costs. Patients can access the HIE to obtain their health information and become a more active, informed participant in their overall health care. New Jersey laws and federal regulations have strict privacy and security requirements that HIE participants must comply with in order to protect patient privacy and confidentiality.

Patient information contained and shared in the HIE may include office, hospital, and other health care treatment and services including sensitive information such as the diagnosis or suspected diagnosis of HIV/AIDS, sexually transmitted diseases, mental health and drug and alcohol treatment, genetic testing, genetic information, services paid for out-of-pocket in full, care or services received as an emancipated minor under state law, and any other health information for which the law requires prior written consent. *Information relating to mental health facility admissions and visits and all health information for patients aged 12 to 17 years will not be shared through the HIE.*

The patient's health information will automatically be available to the HIE participants. However the patient may choose to opt out of the HIE at anytime by contacting Jersey Health Connect directly by toll-free number (855) 624-6542 or via the Internet at http://www.jerseyhealthconnect.org. If the patient chooses to opt out of the HIE, their health information will only be available for access by those physicians and entities directly affiliated with Saint Clare's Health System.

Information Exchange Acknowledgment

By signing below I acknowledge that I understand Saint Clare's Health System will share my health information, through the Jersey Health Connect HIE, with all individuals and entities that are authorized to access such information for purposes related to my treatment and care. I understand this includes the protected health information described above. I also acknowledge that I am entitled to opt-out of this electronic health exchange by contacting Jersey Health Connect directly. I understand that I may choose to opt-out at a later date by contacting Jersey Health Connect however information may have been previously submitted and viewed by my healthcare providers prior to the opt-out date.

_____ _____

Patient or Legal Representative Signature | Printed Name & Authority of Legal Representative (If Applicable)

Pharmacy Health Information Exchange (E-Prescribe) Consent

Saint Clare's Health System has the ability to obtain a patient's prescription medication history information electronically through a pharmacy health information exchange. Healthcare providers such as physicians, pharmacies, and insurance companies participate in this exchange in order to improve the administration of care and facilitate the billing process.

I do ☐ do not ☐ consent to having my drug benefit coverage and medication history electronically accessed and retrieved from the national electronic prescribing network.

_____ _____

Patient or Legal Representative Signature | Printed Name & Authority of Legal Representative (If Applicable)

_____ _____ _____

Witness Signature | Date | Time

Using the patient's primary language (if other than English), _____ the interpreter acknowledges the patient understands and agrees with the above statements.

_____ _____

Interpreter Signature | Interpreter Printed Name