Primary Care Partners
Affiliated with
Atlantic Health System

Adult Registration Form

☐ New Patient ☐ Edit Information
Today's Date: _____

Please complete this form in order to ensure proper billing of your services. **Please Print.**

Patient Information- *Please provide Photo ID*

Patient Last Name: _____ Social Security Number: _____

First Name: _____ MI _____ Date of Birth: _____

Alias/Preferred Name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Life Partner ☐ Significant Other ☐ Other

Sex: ☐ M ☐ F ☐ Nonbinary ☐ Other ☐ Unknown ☐ X

Sex Assigned at Birth: ☐ M ☐ F ☐ Uncertain ☐ Unknown ☐ Choose not to disclose ☐ Not Recorded on Birth Certificate

Gender Identity: ☐ M ☐ F ☐ Other ☐ Transgender Female/Male-to-Female ☐ Transgender Male/Female-to-Male ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Sexual Orientation: ☐ Bisexual ☐ Choose not to disclose ☐ Don't know ☐ Lesbian or Gay ☐ Something Else ☐ Straight (Not Lesbian or Gay

Hearing Impaired? ☐ YES ☐ NO Comments: _____
Vision Impaired? ☐ YES ☐ NO Comments: _____

Ethnicity: (Data is used for statistical reporting.)
☐ Central/S Am ☐ Cuban ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Mexican ☐ Puerto Rican ☐ Rather Not Say ☐ Other _____
Religion: _____

Race: (Data is used for statistical reporting.)
☐ American Indian ☐ Asian ☐ African American ☐ White
☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Rather Not Say

Patient's Contact Information

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ Alt Phone ☐ Letter ☐ Email

Automated Reminder Calls/Text about Appointment ☐ YES ☐ NO

Home Phone: (_____) _____
Cell Phone: (_____) _____
Work Phone: (_____) _____
Alt Phone: (_____) _____

E-Mail: _____ ☐ No Email

Patient's Primary Address

Address: _____ City, State, Zip: _____

County: _____ Country: _____

Patient's Employment Information

Emp. Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other _____

Employer: _____
Address: _____
City, State, Zip: _____
County: _____ Country: _____

Patient's Emergency Contact

Emergency Contact Name.: _____ Home Phone: (_____) _____

Patient's Relationship to Emerg. Cont.: _____ Cell Phone: (_____) _____

Pharmacy Name, Address & Phone #: _____

INSURANCE INFORMATION – *Please provide copies of all cards*

(A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRRIER: _____ Telephone #: (_____) _____

Address: _____ ID/Cert #: _____

Group/Plan #: _____ Effective Date: _____ Subscriber's Name: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F ☐ Other Relationship to Patient: _____

SECONDARY CARRIER: _____ Telephone #: (_____) _____

Address: _____ ID/Cert #: _____

Group/Plan #: _____ Effective Date: _____ Subscriber's Name: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F ☐ Other Relationship to Patient: _____

Guarantor Information *(Guarantor is the person financially responsible for this patient's bill.)*

Please complete if guarantor is other than self

Guarantor: _____ Patient's Relationship to Guarantor: _____

Addr: _____ Social Security Number: _____

City, State, Zip: _____ Date of Birth: _____

County: _____ Country: _____ Sex: ☐ M ☐ F ☐ Other

Home Phone: (_____) _____ Cell Phone: (_____) _____

(Billing company utilizes TEXTING)

Guarantor's Employer: _____ Work Phone: (_____) _____

Address: _____

City, State, Zip: _____

Assignment of Benefits/Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Primary Care Partners Payment Policy and Notice of Privacy Practices for more information)

Signature_____ Print Name_____ Date_____

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	☐ YES ☐ NO	Has treatment been authorized by the V.A.?	☐ YES ☐ NO
Do you or your spouse have other insurance?	☐ YES ☐ NO	Are you covered under the Black Lung Program?	☐ YES ☐ NO
Are you disabled or have end stage renal disease?	☐ YES ☐ NO	Is there Medigap coverage secondary to Medicare?	☐ YES ☐ NO
Is illness/injury the result of an auto accident?	☐ YES ☐ NO	Is there insurance coverage primary to Medicare?	☐ YES ☐ NO
		Is there employer supplemental coverage secondary to Medicare?	☐ YES ☐ NO

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services

Signature_____ Print Name_____ Date_____

Atlantic Health System | CentraState Healthcare System
ATLANTIC HEALTH SYSTEM PARTNER

DT7013

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, INCLUDING ADMISSION AND MEDICAL TREATMENT AUTHORIZATION

This form cannot be modified. Any handwritten changes to this form shall not be legally binding or enforceable.

GENERAL CONSENT, AUTHORIZATION, PATIENT RIGHTS AND RESPONSIBILITIES, PATIENT CONTACT

I authorize Atlantic Health System (which includes CentraState, Chilton, Hackettstown, Morristown, Newton and Overlook Medical Centers, collectively referred to as "Hospital"), Atlantic Medical Group ("AMG"), Atlantic Affiliates, Hospital staff, AMG staff and the physician(s) participating in my care to render hospital and medical care for my condition, which may include routine diagnostic procedures and such other medical treatment as may be deemed advisable by the physician(s) participating in my care. This may or may not include admission to the Hospital. I acknowledge that no guarantees have been made to me about the outcome of my medical care and treatment. I understand and acknowledge that the majority of the physicians at the Hospital are members of the Voluntary Medical Staff and are not employees or agents of the Hospital, but are either independent contractors or independent practitioners who have been granted the privilege of using the Hospital's facilities for the care and treatment of their patients. This includes, but is not limited to, Emergency Department physicians, anesthesiologists, cardiologists, neonatologists, obstetricians, pathologists, radiologists, surgeons, the on call physician, telehealth providers, and other consultants who may treat me. I understand that telehealth involves the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services. I consent to treatment and care by Hospital affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through telehealth. I understand that physicians in training, medical and nursing students, and paramedical personnel may observe and participate in my care under the supervision of the Hospital or AMG staff and my physician(s). I authorize the Hospital to arrange for the disposition of all specimens and tissues. These consents and authorizations shall also apply to the admission and medical treatment of a newborn infant who is delivered by me during my hospitalization. I understand that it may be necessary for my healthcare provider(s) to take photographs, films, recordings and/or other like images and that the presence of a vendor representative may be required for medical, educational and/or continuity of care purposes.

☐ **I hereby acknowledge receipt of a Statement of Patient Rights and Responsibilities.** I understand that professional personnel are available to explain the Statement upon request.

The Hospital maintains a current list of patients and their location in the hospital. ☐ **I hereby permit my location to be provided to friends, family and/or visitors.**

I authorize Hospital, AMG and Atlantic Affiliates, all clinical providers who have provided care to me, and their authorized agents, including but not limited to any billing services, collection agencies, attorneys or other agents who may work on their behalf, to contact me via electronic mail, text and/or telephone on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology. ☐ **I hereby authorize such contact at this time.**

FINANCIAL ARRANGEMENTS

I understand the Hospital charges do not include the fees of my treating physician or the fees for services provided by other Voluntary Medical Staff who may treat me. I understand that I am financially responsible for the payment of my physician fees and my hospital bill; these fees may not be covered by my insurance plan. I authorize payment of medical insurance benefits (including managed care, Medicare and Medicaid, when applicable) directly to the Hospital and/or any physician(s) participating in my care. I understand that some insurance and managed care entities require pre-approval of certain hospitalizations, procedures and surgeries, and it may be my responsibility to obtain appropriate pre-approvals. If I am receiving hospital billed services, a copy of "An Important Message from Medicare" or "An Important Message from TRICARE", as applicable, and "Notice of Charity Care and Reduced Charge Charity Care" have been made available to me. I understand my rights as outlined in the document(s) I have received. A deposit may be requested. If I am a Medicaid beneficiary, I certify that I am receiving the services covered by this consent and I request that payment for these services be made. **Not applicable to Emergency Department Treatment Authorization.**

PROTECTED HEALTH INFORMATION

I have received a copy of the Notice of Privacy Practices for Protected Health Information (the "Notice"). The Notice provides a complete description of the uses and disclosures of my Personal Protected Health Information ("PHI"). I have had an opportunity to review this information before signing this form. I consent to the Hospital, Atlantic Affiliates, AMG and/or any physician(s) participating in my care releasing my PHI (either in writing or verbally) in order to carry out treatment, payment, or health care operations. This includes any medical information (including drug and alcohol abuse treatment information, psychiatric treatment information, and HIV related information including HIV testing results (if applicable), which may be needed to process claims for medical insurance (or managed care) benefits relative to this hospitalization (including precertification or verification, if necessary), or which may be needed to conduct continued care planning, which may include release of my PHI to home healthcare agencies.

AUTHORIZATION TO DRAW BLOOD

In the event that any individual participating in my care is accidentally exposed to my blood or bodily fluids, I authorize the Hospital to draw my blood and test it for the presence of blood borne pathogens such as the Human Immunodeficiency Virus ("HIV"). I understand that if such testing is necessary the Hospital or my physician will make all reasonable efforts to notify me. I consent to the confidential disclosure of the test results to the authorized medical provider treating the person who has been exposed to my blood or bodily fluids, so that appropriate treatment determinations may be made. I understand that I do not have to agree to testing and/or disclosure of my test results.

____ By initialing here I agree to be tested for blood borne pathogens such as the Human Immunodeficiency Virus ("HIV") and I consent to the disclosure of my blood test results.

VALUABLES

I understand that the Hospital recommends all personal belongings and valuables be sent home with a family member or friend. I assume all risk for loss or damage to any personal belongings retained by me. The Hospital will not replace or reimburse me for any personal belongings which are lost, broken or stolen during my admission.

OUTPATIENT SERVICES IN HOSPITAL SETTING

I understand that I am having care, testing, procedure(s) or treatment that is considered an outpatient procedure in a hospital setting. As such, there may be different requirements for deductibles and/or copays than for a physician office visit. I understand that it is my responsibility to fully understand the requirements of my insurance company or managed care entity and that I am responsible for payment of any copayments, deductibles, and charges as required. If the services rendered qualify me for recurring status, my signature on this consent shall be valid for care rendered throughout this period.

_____ (Initial) I understand that there will be two components to my bill: the professional services provided by my physician and the tests and/or procedures conducted by the Hospital.

_____ _____ _____ (am) (pm)
SIGNATURE OF PATIENT OR PERSON SIGNING / CONSENTING ON BEHALF OF PATIENT — Date — Time

If I am signing / consenting on behalf of the patient, I recognize that signing / consenting on behalf of the patient is not an acceptance of financial responsibility which I would not otherwise have for the services rendered.

_____ _____
PRINTED NAME OF PERSON SIGNING/CONSENTING ON BEHALF OF PATIENT — Relationship

For verbal consents, print full name of employee witness: _____ _____ _____ (am) (pm)
Date — Time

For verbal consents, print full name of employee witness: _____ _____ _____ (am) (pm)
Date — Time

PATIENT UNABLE TO SIGN BECAUSE: _____

Primary Care Partners

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Atlantic Health System

Authorization to Use or Disclosure PHI

Protected Health Information (PHI) Use and/or Disclosure

I do hereby consent to and authorize Primary Care Partners _____ (Name of Care Center to disclose to the person(s) named, information from my medical records relating to my treatment, payment, and healthcare operations as I have indicated below. I Understand that this consent shall operate as a complete release of liability to Primary Care Partners, the Care Center and to its employees for the release of information as specified below.

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

This authorization permits Primary Care Partners, _____ (Name of Care Center) to use and/or share with the individuals noted above any part of my individual, identifiable health information, with the exception of information related to:

☐ **Alcohol & Drug Use** ☐ **Sexual Activity or Sexually Transmitted Disease** ☐ **Pregnancy** ☐ **Other**_____

I have the right to refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, Insurance Payment, or eligibility benefits. When my information is used or shared based on this authorization, the recipient may share it with others and my PHI may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the Care Center has acted upon the authorization. My written revocation must be submitted to the Primary Care Partners Care Center.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize Primary Care Partners to use or disclose my health information in the manner described above.

Patient Signature _____ Date of Birth _____

Patient Printed Name _____ Witness _____

Date: _____

Skylands Pediatrics Vaccine Policy

For the past many years our doctors and nurse practitioners have done our best to support families who are concerned about vaccinating their children. However, recent events have caused us to re-evaluate our policy regarding unvaccinated or under-vaccinated children using our practice for health care. Around the country, the actions of relatively few parents have put many of the most vulnerable at risk. Whooping cough and measles are now in full resurgence. These diseases are life threatening, especially to our youngest patients. In the face of recent outbreaks, we no longer have the option of supporting families who choose not to vaccinate or to delay recommended vaccines. It is our duty to provide the safest environment possible to receive health care.

Effective June 1, 2019, our practice will not accept new families that do not vaccinate their children. Established patients that are behind on their required vaccines will be required to bring their children up to date and will be given one month to comply with our policy after notification.

At Skylands Pediatrics:

- We firmly believe in the safety and effectiveness of vaccines to prevent serious illness.
- We firmly believe that all children should receive all of the recommended vaccines according to the schedule published by the Advisory Committee on Immunization Practices (ACIP) of the US Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP). (http://www.cdc.gov/vaccines/acip) (http://www2.aap.org/immunization/izschedule.html)
- We firmly believe based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities.
- All children must receive all vaccines recommended by the AAP and mandated by the State of NJ and the State of PA.
- **COVID VACCINE: Covid vaccines are not currently mandated by the State of NJ and the State of PA and will not be required until they are mandatory.**
- Children who have not had the MMR vaccine and are over 1 year of age, must have this done at first vaccine visit.
- Children will need to come in at 1-4 week intervals (depending upon how many vaccines they elect to receive at each visit) until they have caught up.
- Parents or caregivers who choose not to comply with Skylands Pediatrics Vaccine Policy, will be given a 1-month grace period after notification in order to find another pediatric practice to care for their child.

We prefer to remain your child's pediatrician and will not dismiss any family who is actively working to properly vaccinate their child.

PLEASE TURN OVER FOR SIGNATURE

Primary Care Partners
Affiliated with
Atlantic Health System
Skylands Pediatrics

Carol E. Calabrese, MD, FAAP
Inna Meskin, MD, FAAP
Alexis Capozzoli, MD, FAAP
Ashwini Achar, MD, MPA
Renee Thomas, APN

I, _____, have received a copy of the

Skylands Pediatrics vaccine policy.

Child/Children's name(s):

_____DOB: _____

_____DOB: _____

_____DOB: _____

Signature Parent/Guardian: _____

Date: _____

Signature of Witness: _____

Date: _____

☐ Will be vaccinating

☐ Will **NOT** be vaccinating

328-A Sparta Avenue Sparta, NJ 07871 Tel 973.729.2197 Fax 973.729.3653
Milford Health & Wellness Center 111 East Catharine Street, Suite 140 Milford, PA 18337 Tel 570.296.2737 Fax 570.296.5126

Primary
Care Partners
Affiliated with
Atlantic Health System

PATIENT/FAMILY CONTACT LIST

Patient's Name: _____ DOB: _____

Contacts

People who have permission to receive detailed information about your care (PHI):

PRIMARY CONTACT

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

SECONDARY CONTACT(S)

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

☐ **I decline to designate a representative at this time.**

Comments/Other Information:

_____

_____

_____

_____

This form is effective upon execution and will remain in effect unless revoked by me.

Patient/Guardian Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____