Patient Registration Form

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: ____________

Patient Information

Patient Last Name: ______________________________

First Name: ______________________ MI: ________

Other Name: ______________________________

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

Addr1: ______________________________

Addr2: ______________________________

City, State, Zip: ______________________________

Preferred Method of Contact: ☐ Alt Phone Number ☐ Email ☐ Letter ☐ Phone Call (Cell) ☐ Phone Call (Home)

Driver's License # ____________________ State ________

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

Language: ☐ English ☐ Spanish ☐ Other ____________

Social Security Number: ______________________________

Date of Birth: ____________________ Sex: ☐ M ☐ F

Race: (please choose one of the following):
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Asian
☐ Patient Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Patient Declined

Home Phone: (________) ______________________________

Alt Phone: (________) ______________________________

Home E-Mail: ______________________________

Cell Phone: (________) ______________________________

Employer: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Work Phone: (________) ______________________________

Insurance Information

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

PRIMARY CARRIER: ______________________________

Address: ______________________________

Group/Plan #: ______________ Effective Date: ____________

Subscriber's DOB: ________ SSN: ____________ Sex: ☐ M ☐ F

Subscriber's Employer: ______________________________

Telephone #: (________) ______________________________

ID/Cert #: ______________________________

Subscriber's Name: ______________________________

Relationship to Patient: ______________________________

SECONDARY CARRIER: ______________________________

Address: ______________________________

Group/Plan #: ______________ Effective Date: ____________

Subscriber's DOB: ________ SSN: ____________ Sex: ☐ M ☐ F

Subscriber's Employer: ______________________________

Telephone #: (________) ______________________________

ID/Cert #: ______________________________

Subscriber's Name: ______________________________

Relationship to Patient: ______________________________

Primary Care Phys.: ______________________________

Address: ______________________________

City, St., Zip: ______________________________

Telephone #: (________) ______________________________

Refer. Phys. (if different): ______________________________

Address: ______________________________

City, St., Zip: ______________________________

Telephone #: (________) ______________________________

Pharmacy Name, Address & Phone #: ______________________________

____

Guarantor Information

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: ______________________

Addr1: ______________________

Addr2: ______________________

City, State, Zip: ______________________

Employer: ______________________

Address: ______________________

Work Phone: (______) ______________________

Driver's License # ______________ State ______

Patient's Relationship to Guarantor: ______________________

Social Security Number: ______________________

Date of Birth: ______________ Sex: ☐ M ☐ F

Home Phone: (______) ______________________

Cell Phone: (______) ______________________

City, State, Zip: ______________________

Guarantor E-Mail: ______________________

Emerg. Cont.: ______________________

Home Phone: (______) ______________________

Alt Phone: (______) ______________________

Patient's Relationship to Emerg. Cont.: ______________________

Cell Phone: (______) ______________________

How did you hear about our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing ☐ Newspaper/Magazine ☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other

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IDX Account #:

Assignment of Benefits / Authorization / Notice of Collection Action

I understand that 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 Advocare Payment Policy and Notice of Privacy Practices for more information.)

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

Vaccine Registry (if applicable)

Please be advised that our office submits confidential data of children and adult vaccinations to your State Immunization Registry per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record or patient's immunization history.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

Patient Name **(Please Print)** ________________ Patient Signature ________________

Guarantor/Parent/Guardian completing this form **(Please Print)** ________________ Date ________

Guarantor/Parent/Guardian Signature ________________ 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? ☐ Y ☐ N

Do you or your spouse have other insurance? ☐ Y ☐ N

Are you disabled or have end stage renal disease? ☐ Y ☐ N

Is illness/injury the result of an auto accident? ☐ Y ☐ N

Did illness/injury occur at work? ☐ Y ☐ N

Has treatment been authorized by the V.A.? ☐ Y ☐ N

Are you covered under the Black Lung Program? ☐ Y ☐ N

Is there Medigap coverage secondary to Medicare? ☐ Y ☐ N

Is there insurance coverage primary to Medicare? ☐ Y ☐ N

Is there employer supplemental coverage secondary to Medicare? ☐ Y ☐ N

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 payable for related services.

Patient Name **(Please Print)** ________________ Patient Signature ________________

Guarantor/Parent/Guardian completing this form **(Please Print)** ________________ Date ________

Guarantor/Parent/Guardian Signature ________________ Date ________

HIPAA Acknowledgement

Notice of Privacy Practices

Printed Name of Patient: ____

Patient Date of Birth: ____

I acknowledge receipt of Advocare's Notice of Privacy Practices.

Signature of Patient/Legal Representative: ______________________________ Date: ______________

****

Office Use:

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Reason: ____

Signature of Advocare Representative: ____

Printed Name: ______________________________ Date: ______________

Consent, Disclosure and Authorization Form

Patient Name: ______________________________ Medical Record #:______________

Address: ______________________________ DOB:______________

As used in this form, the words “I,” “me,” “my” and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize Advocare and all physicians and ancillary medical personnel of Advocare, to perform medical examinations and provide routine medical care for all my visits to Advocare. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of Advocare. Any photographs or other images taken will become part of my medical record. Advocare will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Advocare will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand Advocare’s HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information (“PHI”). I understand that Advocare has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, Advocare will post a new notice in the office. I may contact Advocare at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. I may also access a copy on its website.

Consent To Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize Advocare to use and disclose my health information, which includes all or any part of my medical records, including drug or alcohol treatment information, genetic, genetic counseling and genetic testing information, HIV/AIDS information, and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of Advocare. I understand that, for example, my health information may be used or disclosed by Advocare to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by Advocare; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand Advocare may release my protected health information as required by law or court order.

Patient Name: ______________________________ DOB: ______________________

Disclosures to Authorized Individuals

I understand that Advocare may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name: ______________________________ Relationship: ______________________

Address: ____

Phone: ______________________________ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name: ______________________________ Relationship: ______________________

Address: ____

Phone: ______________________________ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name: ______________________________ Relationship: ______________________

Address: ____

Phone: ______________________________ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name: ______________________________ Relationship: ______________________

Address: ____

Phone: ______________________________ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Contact Information

I understand that if I have checked the box "detailed message," I agree that Advocare may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/financial issues, biopsy or other test results, and any other information regarding care/treatment.

I wish to be contacted in the following manner (Please check all that apply):

☐ Home Telephone: (________) ______________________ ☐ Detailed Message ☐ Call Back Message Only

☐ Work Telephone: (________) ______________________ ☐ Detailed Message ☐ Call Back Message Only

☐ Cell Telephone: (________) ______________________ ☐ Detailed Message ☐ Call Back Message Only

☐ Mail to Home Address: ____

☐ Mail to Work Address: ____

Consent and Authorization

A copy of this consent and authorization may be used in place of the original. I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name ______________________________ Date ______________

Patient Signature ____

Authorized Individual (Parent/Guardian) Name ______________________________

Authorized Individual Signature ______________________________________

Basis of Authority (e.g., parent, guardian): ______________________________

Practice Philosophy

Welcome to Advocare. We are honored that you have chosen us as your health care provider, and together we will work diligently to keep you and your family safe and healthy.

1. Our philosophy is to provide high quality care; to treat our patients with courtesy and respect; to provide our patients with the information needed to make informed decisions; and to answer all questions to the best of our ability.
2. As an informed healthcare consumer, we encourage you to ask questions regarding diagnosis or treatment. You have the right to obtain from your physician complete, current information concerning your diagnosis, treatment and prognosis.
3. It is important that you follow through on our recommendations. This includes scheduling follow-up appointments as requested; administering the medications we prescribe according to our instructions; following up on laboratory or x-ray studies that we order; and scheduling referral appointments with specialists as instructed.
4. We make every effort to ensure that you receive the results of any laboratory or x-ray studies ordered. However, you should always call if you do not receive results in a timely manner.
5. We respect your time and make every effort to minimize waiting time in our office. However, we ask that you understand that there may be occasions when one of our patients needs more of our time than anticipated (such as emergencies and complicated health issues). While this may prolong your wait, please be assured that you would receive the same consideration should the need arise.
6. We ask that you treat our staff with courtesy and respect, be on time for your appointment, and provide advance notice if you are unable to keep an appointment.

Thank you for selecting our office to partner with you in providing high quality health care!

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Payment Policy

Insurance: We participate with most major insurance plans, including Medicare. Knowing what benefits your insurance plan provides for you is your responsibility. Please contact your insurance company with any questions.
IF WE PARTICIPATE WITH YOUR INSURANCE CARRIER, all services provided in our office (unless otherwise indicated) will be submitted to your insurance. All co-payments are due at time of service. Deductibles and coinsurance are your responsibility, and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse. The doctor's fees may be higher than what the insurance carrier reimburses, or it may not be a covered service. Therefore, any balances not covered by insurance become the responsibility of the patient.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE CARRIER OR IF YOU DO NOT HAVE HEALTH INSURANCE, payment in full is expected from you at the time of your visit.

Proof of Insurance: All patients must complete our patient registration form before seeing the doctor. Photo identification and a current valid insurance card are required at every visit to provide proof of insurance. It is your responsibility to verify that the office staff has the most current and correct information regarding your health insurance policy. Failure to provide current information may result in non-coverage for services provided, and the resulting charges will be your responsibility.

Co-payments and Deductibles: In accordance with your insurance plan and services provided, you are responsible for any and all co-payments, deductibles, and coinsurances at the time of service.

Referrals: In accordance with your insurance carrier, it is your responsibility to know if a written referral is required to see a specialist, or for a certain procedure. When a referral is not presented at the time of service to the provider, the patient may be responsible for payment in full at the time of service.

Claims Submission: Submission of claims is a courtesy extended to our patients. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. Your insurance coverage is a contract between you and your insurance carrier. We are not party to that contract.

Non-covered Services: Certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", "cosmetic" or simply "non-covered" by your insurance carrier. You are responsible for payment of these services. In the event your care exceeds a plan limitation, the balance becomes your responsibility.

Non-payment of patient balances: Should your account become delinquent, the patient or guarantor agrees to pay all costs associated with collecting the balance due. This includes, but is not limited to, attorney, collection, and contingent fees.

Non-sufficient funds (NSF)/ Returned Checks: A fee of $35.00 will be charged for all returned checks.

Missed Appointments: Failure to cancel your appointment without 24 hours notice from your scheduled visit may result in a fee of $50.00.

Record Release From

advocare | Arthritis Osteoporosis & Rheumatology Associates

150 Delsea Drive, Suite B · Sewell, NJ 08080 · T 856.302.0500 · F 856.302.0504
2059 Briggs Road, Suite 306 · Mt. Laurel, NJ 08054 · T 856.924.6060 · F 856.924.6061
1001 Laurel Oak Road, Suite D-1 · Voorhees, NJ 08043 · T 856.248.0063 · F 856.248.0067
1051 W Sherman Avenue, Suite 1B · Vineland, NJ 08360 · T 856.457.4490 · F 856.457.4489

Authorization for Medical Record Request

Patient's Name: ___________________________________ **DOB:________**

I Authorize: ____

(Name of Provider making the release)

To disclose the protected health information to:

Advocare Arthritis Osteoporosis & Rheumatology Associates

150 Delsea Drive, Suite B

Sewell, NJ 08080

Phone: 856-302-0500 **Fax: 856-302-0504**

Records requested: ____

Signature of Patient: ______________________________

NAME OF MEDICATION	**DOSAGE OF MEDICATION**	**DIRECTIONS**	**REASON WHY YOU TAKE THIS MEDICATION**

ANY KNOWN ALLERGIES?	

advocare | Arthritis Osteoporosis & Rheumatology Associates
150 Delsea Drive, Suite B · Sewell, NJ 08080 · T 856.302.0500 · F 856.302.0504
2059 Briggs Road, Suite 306 · Mt. Laurel, NJ 08054 · T 856.924.6060 · F 856.924.6061
1001 Laurel Oak Road, Suite D-1 · Voorhees, NJ 08043 · T 856.248.0063 · F 856.248.0067
1051 W Sherman Avenue, Suite 1B · Vineland, NJ 08360 · T 856.457.4490 · F 856.457.4489

We have a waiting list for patients that need to be scheduled. Please be courteous and call us in advance so we may contact a patient waiting to be seen.

Patient must call to cancel their appointment **atleast 72 hours in advance** or you will be charged **a $50.00 no show fee**.

advocare | Arthritis Osteoporosis & Rheumatology Associates

Attention All Patients

Co-Pay must be paid at the time of visit. You will ***not be seen*** if copayment is not paid.

If your insurance requires a referral, it must be presented at time of check in, otherwise you will not be seen.

Insurance card must be presented at every visit.

There is $25.00 fee for any form requiring the Physician's signature. Please allow 7 business days for completion of forms.

YOUR COOPERATION IS GREATLY APPRECIATED!!!

Arthritis Osteoporosis & Rheumatology Associates

Patient Name: ________________________ Date of Birth: _________

Reason for Visit:_______________________

Musculoskeletal Pain: Please circle where your pain is located.

HAND R / L **WRIST R / L** **ELBOW R / L** **SHOULDER R/ L**

FOOT R/L **ANKLE R /L** **KNEE R/ L** **HIP R/ L**

NECK **MID-BACK** **LOWER BACK**

MUSCLE PAIN: **YES OR NO**

INTENSITY: **LEAST 1 2 3 4 5 6 7 8 9 MOST**

DURATION: **DAYS** **WEEKS** **MONTHS** **YEARS**

QUALITY: **DULL** **SHARP** **OTHER:** _____________________________________

RADIATION OF PAIN: **ARMS** **LEGS** **NONE**

MORNING STIFFNESS: **MINUTES** **HOURS** **NONE**

SWELLING IN JOINTS: **YES OR NO**

Over the counter PAIN MEDICATIONS YOU HAVE TRIED IN THE PAST?

TYLENOL **ALEVE** **ADVIL** **OTHER**

PRESCRIPTION MEDICATIONS YOU HAVE TRIED IN THE PAST?

MOTRIN **NAPROXEN** **CELEBREX** **MOBIC** **PREDNISONE**

OTHER: ________________________________

JOINT INJECTIONS IN THE PAST: YES OR NO?

IF THE ANSWER IS YES, PLEASE SPECIFY__________________________

NUMBNESS OR TINGLING: **YES OR NO**

MUSCLE WEAKNESS: **YES OR NO**

PLEASE CIRCLE, IF YOU ARE EXPERIENCING ANY OR THESE SYMPTOMS:

CONTITUTIONAL: Fever, Chills, Fatigue, Change in appetite, Change in weight, Insomnia

HEENT: Dry eyes, Dry mouth, Redness/Pain in eye, Visual Disturbance, Oral Ulcers, Nasal Ulcers

RESPIRATORY: Shortness of breath, Cough, Wheezing, Chest Pain

CARDIOVASCULAR: Exertion chest pain, Leg Swelling, Raynaud's symptoms

GASTROINTESTINAL: Nausea, Vomiting, Swallowing difficulty, GERD, Diarrhea, Constipation, Blood in Stool

SKIN: Rash, Photosensitivity, Hair Loss, Alopecia, Psoriasis

ENDOCRINE/OBGYN: Thyroid hormonal Problem: Yes or No

HEMATOLOGIC: Blood clots, Anemia, Bleeding/clotting disorder

NEUROLOGICAL: Seizure, Headache, Stroke, Numbness or Tingling, Muscle weakness

PSYCHIATRY: Anxiety, Depression, Memory Impairment

Past medical history:

____

____

____

Past surgical history:

____

____

____

Social history:

Smoking:____

Alcohol intake:____________________________________

____

Family history:

____

____

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