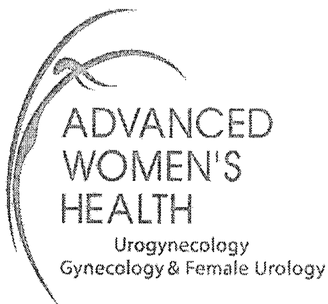

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FAX: 973-512-3161

616 Willow Grove Street
Hackettstown, NJ 07840

First Name ______________________ MI ____ Last Name ______________________

Address ______________________________________ City ______________

State ________ Zip __________ Date of Birth ______________ SSN ________-________-________

Home # ______________ Cell # ______________ Work # ______________

E-mail ______________________________ Marital Status ______________

Occupation ______________________ Employer Name ______________________

Employer Address ______________________________________

Pharmacy ______________________________________
Phone Number City/State

Primary Care Physician ______________________________________
Name Phone Number City/State

Emergency Contact ______________________________ Relationship ______________

Cell # ______________ Work # ______________ Home # ______________

INSURANCE INFORMATION

Primary Insurance

Insurance Name ______________________

Insurance ID ______________________

Group# ______________

Subscriber's Name ______________________

DOB __________ SSN ______-______-______

Relationship to Patient ______________________

Address ______________________

Phone ______________________

Secondary Insurance

Insurance Name ______________________

Insurance ID ______________________

Group# ______________

Subscriber's Name ______________________

DOB __________ SSN ______-______-______

Relationship to Patient ______________________

Address ______________________

Phone ______________________

Patient or Responsible Party Signature: ______________________ Date: ______________

Parent/Guardian, if Patient is Minor: ______________________ Date: ______________

NJU Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Information, Your Rights, Our Responsibilities

Your Information

How We May Use and Disclose Medical Information About You

Treatment
- We can use your health information and share it with other professionals who are treating you.

Payment
- We can use and share your health information to bill and get payment from health plans or other entities.

Health Care Operations
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Health Care Information Organization
- We may elect to use a health information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

Appointment Reminders, Treatment Alternative, Health-Related Benefits and Services
- We may use and disclose medical information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options and health-related benefits and services that may be of interest to you.

Assist with Public Health and Safety issues
- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

For Research
- We can use or share your information for health research

As Required By Law
- We will disclose medical information about you when required to do so by federal, state or local law

Respond to Organ and Tissue Donation Requests
- We can share health information about you with organ procurement organizations

Work with Coroner, Medical Examiner, or Funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies

Address Workers' Compensation, Law Enforcement, and Other Government Requests
- We can use or share health information about you
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Military and Veterans
- If you are a member of the armed forces of the United States or another country, we may release medical information about you as required by military command authorities

Respond to Lawsuits and Legal Actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena

Special Privacy Protections
- If your medical information includes HIV-related information , alcohol or substance abuse, mental health or genetic information, special protections may apply to such information and you can contact us if you have any questions

Other Uses of Medical Information
- Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made with your written authorization , on an NJU authorization form. You may revoke such an authorization by writing us , and such revocation will be effective to the extent that we have not already released the information pursuant to the authorization or otherwise taken action in reliance on the authorization

Fundraising and Other Events
- We may contact you for fundraising efforts, but you can tell us not to contact you again
- We never share your information unless you give us written permission for marketing purposes, sale of your information, and most sharing of psychotherapy notes

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Right to Inspect and Copy
- You can request to see or get an electronic or paper copy of your medical record and other health information we have about you. This right does not include psychotherapy notes, information compiled for use in a legal proceeding, or certain information maintained by laboratories.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Right to Request Amendments
- You can request us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Right to Request Confidential Communications
- You can request us to contact you in a specific way (for example, home or office phone) or to send mail to different address.
- We will say "yes" to all reasonable requests.

Right to Request Restrictions
- You can request us not to use or share certain health information to someone who is involved in your care or the payment of your care, such as a family member or friend.
- If you pay for a service or health care item out-of-pocket in full, you can request us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Right to an Accounting of Disclosures
- You can request for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within the same 12 month period.

Right to a Paper Copy of this Notice
- You can request for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Right to Choose Someone to Act For You
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

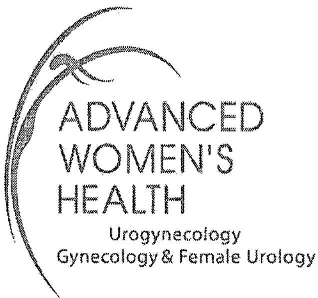
Right to be Notified of a Breach
- In the event of a breach of your Protected Health Information as defined by the Department of Health and Human Services (HHS), you will be notified by us in a manner specified by HHS.

Right to File a Complaint
- You can file a complaint if you feel we have violated your rights by contacting us or the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind**
- **We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office or website**

Updated - 7.2.2018



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MEDICARE FINANCIAL POLICY

It is our sincere desire to provide you with the best possible medical care. This involves mutual understanding among the patients, doctors and the staff. We encourage you, our patient, to discuss any questions you may have regarding our professional fees, this financial policy and your responsibility.

You will be financially responsible for your annual $183 deductible and for coinsurance representing 20% of the allowable Medicare fee for service. We do not waive the annual $183 deductible or coinsurance. Payment in the form of cash, check, Visa, MasterCard is required at the time of services. This is a federal law, with which we must comply.

The Medicare program specifically excludes payment for certain items and/or services. Medical procedure(s) recommended by the doctor that are not covered by Medicare require payment in advance. You will be asked to sign an Advance Beneficiary Notice (ABN) prior to the delivery of a non-covered service.

If you fail to inform this office of your secondary coverage at the time you complete your insurance paperwork, we will not be able to bill your secondary carrier. You will be responsible for any unpaid charges for deductibles and/or co-insurance.

If you neglect to report to Medicare who is primary and who is secondary regarding your coverage, known as "Coordination of Benefits", you will automatically be responsible for all unpaid medical charges filed with Medicare.

All returned checks will be subject to $30.00 return fee.

Name of Beneficiary ______________________________ **Medicare #** ____________________

"I request that payment of authorized Medicare benefits be made on my behalf to Skylands Urology Group, PA for any services furnished to me by my physician. I authorize any holder of medical information about me to be released to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services."

☐ I have been presented with a copy of the Advanced Women's Health of NJ Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law.

Patient Signature ______________________________________ **Date** ______________

Print Patient name ______________________________________

NJU ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practice which provides information about how we may use and disclose protected health information(PHI) about you. The notice details your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or from our website.

Please check the first box below and sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

☐ I acknowledge that I have received a copy of the NJ Urology Notice of Privacy Practices.

☐ We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the patient but it could not be obtained because: ______________________________

Employee Signature/Date: ______________________________ (For Office Use Only)

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so except for necessary instances allowing for disclosure as explained in our Notice of Privacy Practices. Please list below name(s) of the individual(s) (Family, Friends, etc.) with whom we may discuss your care. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

I authorize NJ Urology to disclose my Protected Health Information to these individuals:

Name	Relationship to Patient	Phone Number
1.______	______	______
2.______	______	______
3.______	______	______
4.______	______	______
5.______	______	______

______________________________ ______________
Name of Patient (print) Date of Birth

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Signature of Patient Representative Date
(Required if patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient Print Name

Updated – 7.2.2018

ADVANCED WOMEN'S HEALTH
Urogynecology
Gynecology & Female Urology

MEDICAL HISTORY QUESTIONNAIRE

Name	Date of Birth	Age	Drug Allergies:	Reactions:

Please describe the reason for your visit (chief complaint)

OBSTETRIC HISTORY

Number of Pregnancies:	Vaginal Deliveries:	Cesarean Deliveries:	Largest Baby Weight:

Forceps or Vaccum ☐ Yes ☐ No | Episiotomy ☐ Yes ☐ No | Laceration/Tear ☐ Yes ☐ No

Degree/Details | Other Complications or Prolonged Labor

GYNECOLOGIC HISTORY

Gynecologist Name:

Date of last menstrual period:

Date of last PAP smear: Result:

Date of last mammogram: Result:

Have you ever had a sexually transmitted disease?

Are you using contraception? What type:

Are you sexually active? Describe any problems below:

Do you experience any of the following? (check ones you have)

_____ Bleeding between periods
_____ Heavy menstrual periods
_____ Pain with periods
_____ Bleeding after intercourse
_____ Pain with intercourse
_____ "Falling" of pelvic organs or prolapse

Are you presently taking, or have you taken in the past, hormone replacement therapy? If yes, medication and dose schedule, vaginal/oral:

MEDICAL CONDITIONS AND MEDICATIONS

Please list ALL your medical conditions, the medication(s) you are taking for them (if any), how long you have been on the medication

Medical Condition	Name of Medication	Dosage	How often you take it	How long have you been on the medication
Example - Hypertension	*Tenormin*	*50 mg*	*1 daily*	*2 years*

Reviewed with Patient ____________/____/____
Drs Initials & Date

Name	DOB	Date

PAST SURGICAL AND HOSPITAL HISTORY: ☐ None ☐ Yes, if yes

Please describe your past experience with, **operations**, serious injuries, all and any hospitalizations and related treatments. Please include dates (month/year) of any surgeries.

1.
2.
3.
4.
5.
6.

FAMILY HISTORY

Are there medical events in your family's history, including diseases that may be hereditary or place you at risk?
Please circle **Y** or **N** for each condition (no blanks please ☺)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
Y	N	Asthma	Y	N	Diabetes	Y	N	Stroke
Y	N	Bleeding problems	Y	N	Heart disease	Y	N	Thyroid disease
Y	N	Ovarian Cancer	Y	N	High blood pressure	Y	N	Kidney Stones
Y	N	Breast Cancer	Y	N	Kidney disease	Y	N	Other:
Y	N	Other Cancer (indicate type)						
			Y	N	Adopted			

SOCIAL HISTORY

Marital Status	Drug/Alcohol Use: Yes No	**Current Smoker:** ☐ Yes
Single Married Widowed Separated Divorced	Drinks/week	# of cigarettes/day How many years have you smoked: **Former Smoker** : ☐ Yes When did you quit: # of Cigarettes/day: **Never Smoked:** ☐ Yes

REVIEW OF SYSTEMS

Do you have or have you had any serious or chronic medical conditions?
Please Circle **Y** or **N** or any condition(s) you have had or that you have currently. (no blanks please ☺)

		Yes	No		Yes	No		Yes	No
Constitutional:	Weight change	Y	N	Fatigue	Y	N			
Eyes:	Blurry Vision	Y	N	Dry Eyes	Y	N			
Endocrine:	Excessive Thirst	Y	N	Feelings of being cold	Y	N	Feelings of being hot	Y	N
Respiratory:	Chest Pain	Y	N	Shortness of breath at rest	Y	N	Wheezing	Y	N
Cardiovascular:	Difficulty lying flat	Y	N	Painful breathing with activity	Y	N			
Gastrointestinal:	Nausea/Vomiting	Y	N	Change in bowel habits	Y	N	Bloody Stool	Y	N
Hematologic/Lymphatic:	Easy Bruising	Y	N	Groin Mass	Y	N			
Neurological:	Balance Difficulty	Y	N	Difficulty Speaking	Y	N	Seizures	Y	N
Psychiatric:	Anxiety	Y	N	Depression	Y	N	Neuropathy	Y	N

Other Comments:

Patient Signature ____________________ Date ____________________

Reviewed with Patient ________/______/______
Drs Initials & Date

Risk Assessment for Hereditary Cancer Syndromes

Patient Name: ______________________ Physician: ______________________

Date of Birth: ______________________ Date Completed: ______________________

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes. Share this information with your healthcare professional to help determine your hereditary cancer risk.

BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y N Breast cancer before age 50			
Y N Ovarian cancer			
Y N Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y N Male breast cancer			
Y N Triple negative breast cancer* (ER-, PR-, HER2-pathology)			
Y N Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y N Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			
COLON AND UTERINE CANCER	**SELF**	**FAMILY MEMBER**	**AGE AT DIAGNOSIS**
Y N Uterine (endometrial) cancer before age 50			
Y N Colorectal cancer before age 50			
Y N Ovarian, stomach, kidney/urinary tract, brain or small bowel cancer			
Y N Two or more Lynch syndrome cancers†			
POLYPOSIS SYNDROME	**SELF**	**FAMILY MEMBER**	**AGE AT DIAGNOSIS**
Y N 10 or more cumulative (lifetime) colorectal adenomas (colon polyps) in the family			
MELANOMA	**SELF**	**FAMILY MEMBER**	**AGE AT DIAGNOSIS**
Y N Two or more melanomas in an individual or family			
Y N Melanoma and pancreatic cancer in an individual or family			

Y N Have you or any member of your family ever been tested for hereditary risk of cancer?
If yes, please explain: ______________________

____
Patient's Signature Date

FOR OFFICE USE ONLY
- ☐ Candidate for further risk assessment and/or genetic testing
- ☐ Information given to patient to review
- ☐ Follow-up appointment scheduled Date: ________

☐ Patient offered genetic testing:
☐ Accepted ☐ Declined

____
Healthcare Professional's Signature Date

*For a better understanding of triple negative breast cancer, please ask your healthcare provider.
†Lynch syndrome-related cancers include ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas
Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

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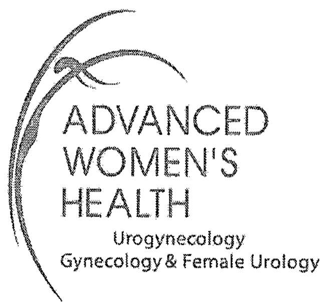

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PHQ-9 Depression Questionnaire

Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total____ =	____	+ ____	+ ____	+ ____
PHQ-9 score ≥ 10: Likely major depression				
Depression score ranges:				
5 to 9: mild				
10 to 14: moderate				
15 to 19: moderately severe				
≥20: severe				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ____	Somewhat difficult ____	Very difficult ____	Extremely difficult ____

NAME: ______________________________ DATE: ____________________