Pulmonary and Intensive Care Specialists of New Jersey

593 Cranbury Road, Suite 1A ● East Brunswick, NJ 08816 | Office (732) 613-8880 Fax (732) 613-0077

Date: _____

Clear Form Fields


Douglas Hutt, M.D.


Andrea Harangozo, M.D.


Donna Klitzman, M.D.


Tricia Gilbert, M.D.


David Fischler, M.D.


Amina Saqib, M.D.

Dear: _____

Welcome to *Pulmonary and Intensive Care Specialists of New Jersey*. We look forward to your visit with Dr. _____ on _____ at _____.

We will provide you with a complete and thorough consultation. However, in order to do so, receiving the following information from you is vital:

1. Please complete the enclosed forms and bring them to your appointment. **IT IS VERY IMPORTANT THESE FORMS ARE COMPLETED BEFORE YOUR VISIT TO OUR OFFICE. DOING SO WILL HELP TO SAVE TIME UPON YOUR ARRIVAL.**

2. X-rays/ Scans: Bring the original X-rays (or CDs/discs) of all studies which relate to your condition along with reports. The films will be reviewed at the time of your visit. Failure to bring the original X-rays may, in some instances, result in the need for a second scheduled visit to review those X-rays.

3. Pathology: If you have had any biopsies or surgery, it is extremely important that we have a copy of the pathology and surgical report(s) of those procedures.

If your insurance requires a referral, we must have your referral form at the time of your visit. Please visit our website at www.picsnj.org to review our financial policy.

IF YOU MUST CANCEL THIS APPOINTMENT, PLEASE CALL US AT LEAST **24 HOURS IN ADVANCE AT 732-613-8880 OR YOU WILL BE CHARGED $50**. WE WILL BE HAPPY TO RESCHEDULE YOUR APPOINTMENT AT ANOTHER CONVENIENT TIME. PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINT-MENT FOR REGISTRATION.

Thank you for choosing *Pulmonary and Intensive Care Specialists of New Jersey*. We look forward to seeing you on the day of your visit.

***

Remember to please bring a valid picture ID, i.e. Driver's License and your insurance cards

***

Directions to Us!

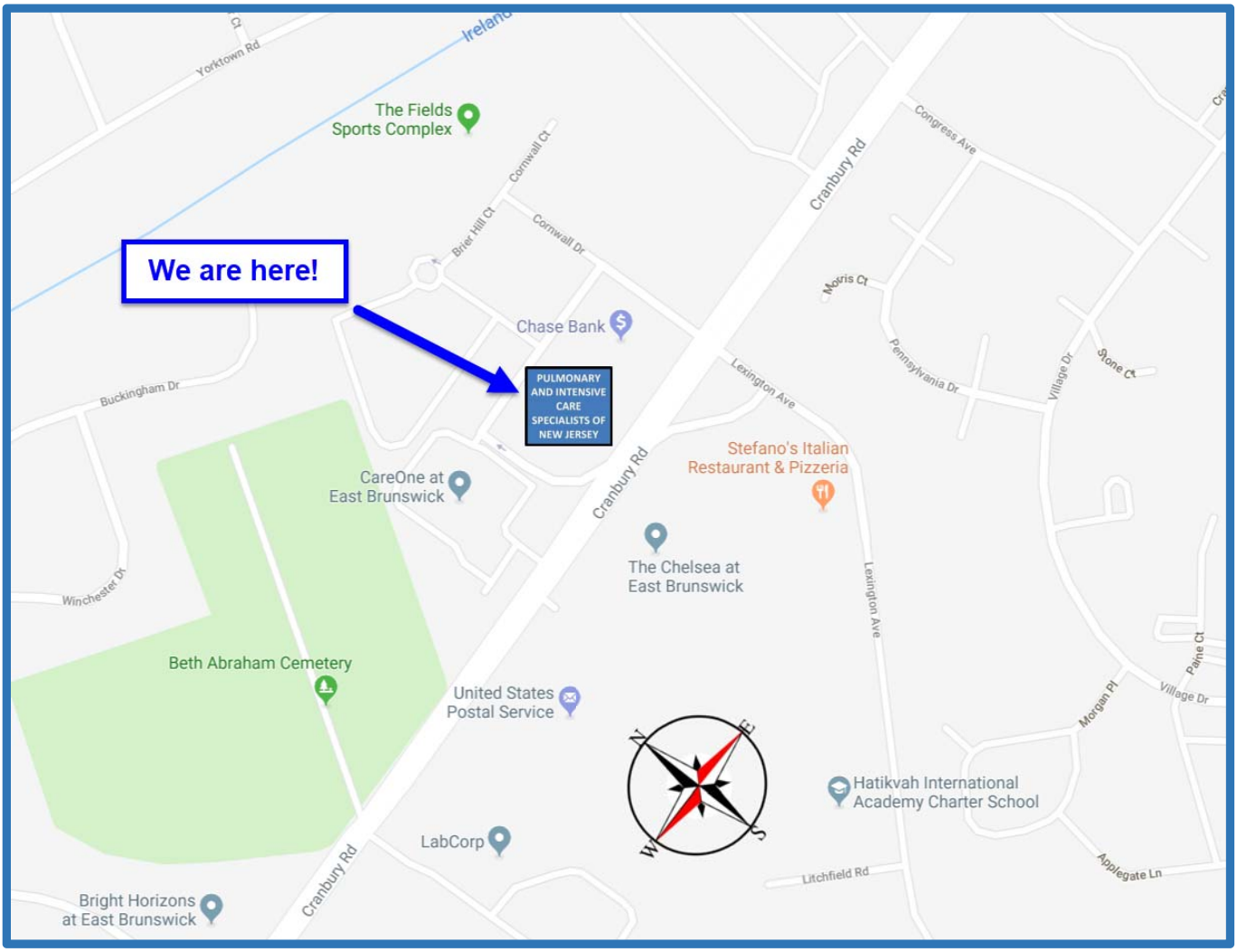
NJ Turnpike North or South: Take exit 9. Follow signs to Route 18 South and follow directions below.

ROUTE 18 SOUTHBOUND: Take the exit for Cranbury/Route 535 South (Cranbury Road.) After the 7th traffic light, take the Lexington Avenue/U and Left Turn exit. Our driveway is half way around the U-turn.

ROUTE 18 NORTHBOUND: Take the Rues Lane jug handle. Cross Route 18. Make a left at the 3rd traffic light onto Cranbury Road. After the 3rd traffic light, take the Lexington Avenue/U and Left Turn exit. Our driveway is half way around the U-turn.

ROUTE 1: Take the Ryders Lane exit towards East Brunswick. At the 7th traffic light, turn right on Cranbury Road. After the 3rd traffic light, take the Lexington Avenue/U and Left Turn exit. Our driveway is half way around the U-turn.

CRANBURY/MONROE and POINTS SOUTH: Take Route 130 North to the exit for Route 535 North (Cranbury Road.) Pass the East Brunswick Post Office on your right. Take the exit for Cornwall Drive/Lexington Avenue/All Turns. At the stop sign, turn left. At the traffic light, turn left. Immediately get into the right lane and take the Lexington Avenue, U and Left Turn exit. Our driveway is half-way around the U-turn.



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Patient Information

Patient Name (first, last) | Social Security No. | Date of Birth | Gender | Marital Status

Home Address | City | State | Zip Code

Preferred Phone | Type | Other Phone 1 | Type | Other Phone 2 | Type

E-Mail Address | Primary Care Physician (PCP) | PCP Phone Number

Emergency Contact Name | Relationship | Phone Number

Preferred Pharmacy | Pharmacy Phone

Ethnicity
☐ Hispanic/Latino ☐ Non-Hispanic

Race
☐ White ☐ African-American/Black
☐ American Indian ☐ Asian
☐ Alaskan Native ☐ Multiracial
☐ Pacific Islander ☐ Unknown

Account Information

Who is responsible for your bill? ☐ Self ☐ Other (If other, please complete information below…)

Guarantor's Name | Relationship to patient

Guarantor's Address (if different from above) | Phone Number

Insurance Information

Primary

Company Name

ID Number | Group Number

Address, City, State, Zip

Phone 1 | Phone 2

Subscriber Name | Date of Birth

Relationship to Patient

Secondary

Company Name

ID Number | Group Number

Address, City, State, Zip

Phone 1 | Phone 2

Subscriber Name | Date of Birth

Relationship to Patient

Assignment of Benefit and Release of Information

I certify that the information provided herein is correct and accurate and hereby authorized PICSNJ to submit claims to Medicare, Medigap, and commercial insurance payers on my behalf. I assign any payment and/or benefit from these payers for these services to PICSNJ. I further authorize the release of any medical records necessary for the adjudication and payment of claims or any authorizations for services or procedures rendered or to be rendered. I understand balances for deductibles, co-insurance, co- payments, and non-covered services are my financial responsibility. If any balances become delinquent and are referred for further collection activity, I may become liable for any cost of collection including collection fees, court fees, and legal fees.

Signature | Date

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Authorization for Treatment

I hereby authorize the release to my stated health care carrier(s) or the Health Care Financing Administration or authorized agents thereof, any information needed for services provided by the **Pulmonary and Intensive Care Specialists of New Jersey**. When assignment has been accepted, I hereby authorize payment to be made directly to **Pulmonary and Intensive Care Specialists of New Jersey**.

Your Protected Health Information (PHI) will be kept confidential in accordance with HIPAA (Health Insurance Portability and Accountability Act) regulations as stated in our 'Notice of Privacy Practices Acknowledgement'.

It is the responsibility of managed care patients who require referral forms from their primary care physicians, to obtain those referral forms. Patients whose insurance plans require such forms and do not obtain them may be responsible for all charges resulting from such visits including charges incurred in the office and from subsequent testing and further referrals.

_____
Signature

_____
Patient's Name

_____
Date

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Health History Questionnaire

Patient Name (first, last) _____ Date of Birth _____ Gender _____ Marital Status _____

Primary Care or Referring Physician _____ Phone Number _____ City _____ Date of Last Physical Exam _____

Reason for Today's Visit

Personal Health History

Childhood Illness(es): ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations & Year: ☐ Influenza _____ ☐ Pneumovax _____ ☐ Prevnar 13 _____

List any medical problems that other doctors have diagnosed

Medical History: Current or Past (check all that apply)

Respiratory
- ☐ Asthma
- ☐ Bronchiectasis
- ☐ COPD
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Pneumonia
- ☐ Pulmonary Fibrosis
- ☐ Collapsed Lung
- ☐ Sarcoidosis
- ☐ Lung Cancer
- ☐ Pleural Effusion
- ☐ Cystic Fibrosis
- ☐ Asbestosis
- ☐ Pulmonary HTN
- ☐ Pulmonary Embolism
- ☐ Lung Nodule
- ☐ BOOP

Other:_____

Eyes
- ☐ Glaucoma
- ☐ Cataracts

Other:_____

Allergy
- ☐ Sinusitis
- ☐ Nasal Polyps
- ☐ Eczema
- ☐ Hives
- ☐ Rash
- ☐ Rhinitis (seasonal)
- ☐ Allergies
- ☐ Food
- ☐ Environment

Other:_____

Sleep
- ☐ Sleep Apnea
- ☐ Insomnia
- ☐ Restless Leg Syndrome
- ☐ Narcolepsy

Other:_____

Cardiac
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Arrhythmia Pacemaker
- ☐ Defibrillator
- ☐ Valve Disorder
- ☐ Congestive Heart Failure

Other:_____

Infectious
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Polio
- ☐ Tuberculosis
- ☐ Positive PPD

Other:_____

Hem/Oncology
- ☐ Anemia
- ☐ Blood Clot
- ☐ Cancer (List Below)

_____

Other:_____

Neurology
- ☐ Stroke
- ☐ TIA
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Myasthenia Gravis
- ☐ Neuropathy
- ☐ ALS
- ☐ Anxiety
- ☐ Depression
- ☐ Psychosis
- ☐ Schizophrenia

Other:_____

Endocrine
- ☐ Diabetes
- ☐ Cholesterol
- ☐ Thyroid, over
- ☐ Thyroid, under

Other:_____

Gastrointestinal
- ☐ Acid Reflux Bleeding
- ☐ Colitis
- ☐ Diverticulosis
- ☐ Hiatal Hernia
- ☐ Irritable Bowel
- ☐ Ulcer
- ☐ Liver Abnormality

Other:_____

Rheumatology
- ☐ Arthritis
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Scleroderma
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Other:_____

GU/Renal
- ☐ Kidney Disorder
- ☐ Dialysis
- ☐ Enlarged Prostate
- ☐ Kidney Stones

Other:_____

Occupational History

Are you or have you been exposed to dust, fumes, chemicals, asbestos, or silica? ☐ Yes ☐ No

List all pets/animals within your home

Surgeries and Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Screenings (most recent)

Mammogram: _____ (year) Pap Smear: _____ (year) PSA: _____ (year) Colonoscopy: _____ (year) Bone Densitometry: _____ (year)

Family Health History

Member	Alive?	Gender	Significant Health Problems
Father	☐	n/a	
Mother	☐	n/a	
Sibling 1	☐		
Sibling 2	☐		
Sibling 3	☐		
Grandmother *Maternal*	☐	n/a	
Grandfather *Maternal*	☐	n/a	
Grandmother *Paternal*	☐	n/a	
Grandfather *Paternal*	☐	n/a	

Review of Systems

Check if you have, or have had, any symptoms n the following areas to a significant degree and briefly explain:

☐ Skin: _____	☐ Chest/Heart: _____	Recent Changes in:
☐ Head/Neck: _____	☐ Back: _____	☐ Weight: _____
☐ Ears: _____	☐ Intestinal: _____	☐ Energy Level: _____
☐ Nose: _____	☐ Bladder: _____	☐ Ability to Sleep: _____
☐ Throat: _____	☐ Bowel: _____	☐ Other: _____
☐ Lungs: _____	☐ Circulation: _____	☐ Other: _____

Medications List

Drug Name	Strength/Dosage	Frequency Taken

Allergies to Medications

Drug Name	Reaction You Had

Health Habits and Personal Safety (all data will be kept strictly confidential)

Exercise	☐ Sedentary (no exercise)
	☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week or more for 30 min.)
Diet	Are you dieting ☐ Yes ☐ No
	If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No
	Do you or have you used weight loss medications or supplements? ☐ Yes ☐ No
	Rank Salt Intake: ☐ High ☐ Medium ☐ Low
	Rank Fat Intake: ☐ High ☐ Medium ☐ Low
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola
	Number of cups/cans per day?_____
Alcohol	Do you drink alcohol? ☐ Yes ☐ No
	If yes, how many drinks per week?
Tobacco	Do you or have you ever smoked? ☐ Yes ☐ No
	☐ Cigarettes; packs per day:_____ ☐ Chew #/day:_____ ☐ Pipe #/day:_____ ☐ Cigars #/day:_____
	Number of years:_____ Year Started:_____ Year Quit:_____
Drugs	Do you or have you ever used recreational or street drugs? ☐ Yes ☐ No
Sex	Are you sexually active? ☐ Yes ☐ No
Personal Safety	Do you live alone? ☐ Yes ☐ No
	Do you have frequent falls? ☐ Yes ☐ No
	Do you have vision or hearing loss? ☐ Yes ☐ No
	Do you have an Advance Directive and/or Living Will? ☐ Yes ☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No

Health Insurance Portability and Accountability (HIPAA) Privacy Authorization for Use and Disclosure of Personal Health Information

This authorization affects your rights in the privacy of your personal healthcare information.
Please read it carefully before signing.

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. section 1320d, et. Seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA")

Pulmonary and Intensive Care Specialists of New Jersey, ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for requested use disclosure.

By signing this authorization you acknowledge and agree that the Covered Entity or its Business Associates may disclose your personal health care information to physicians that are or may be involved in your healthcare and all appropriate healthcare providers, healthcare organizations and when appropriate, insurance companies (usually for billing purposes). This includes records of your care maintained by us, whether created by our employees, your physician, consulting physicians, or others covered by this HIPAA Notice.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under the HIPAA. While Covered Entity has the right to change the terms of its Privacy Notice, copies of the Privacy Notice, as amended, are available from Covered Entity at any of its offices or by sending a written request to **Pulmonary and Intensive Care Specialists of New Jersey** at the address above.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect a copy of your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address above.

This authorization shall expire upon earlier occurrence of:

a) revocation of the authorization:
b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA:
c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity; or
d) six years from the date this authorization was executed.

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By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for disclosure by the recipient and no longer protected under HIPAA.

Acknowledged and agreed to by:

_____ _____

Patient's Signature Date

Family/Persons that may access patient information

Name	Relationship to Patient	Phone Number

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE Health Insurance Portability & Accountability Act of 1996 (''HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers .
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that i may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Acknowledged by:

_____ _____

Signature Date

_____ _____

Patient Name Relationship To Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____ _____ _____

Date Initials Reason

Clear Form Fields