PEDIATRIC REGISTRATION FORM

Patient's Name: ____ Home Phone#:_______________
First Middle Last
Street Address: ______________________________City: _________________State:_______ Zip: _______

Patient's Date of Birth______________________ Patient's Sex: Male Female
Patient's Social Security#: ___________________
Parent Information:
Mother's Name:______________________________ Father's Name: _____________________________
Home Address:_______________________________ Home Address: _____________________________
Mother's Birth Date:___________________________ Father's birth date: __________________________
Employer's Name: ____________________________ Employer's Name:___________________________
Employer's Address:___________________________ Employer's Address:__________________________
Work Number:_______________________________ Work Number: ______________________________
Cell Number: ________________________________ Cell Number: _____________________________
Email Address:_______________________________ Email Address: ____________________________

If parents are divorced or separated is there a court order or other financial arrangement we need to be aware of?
____Name of Step Parent_______________________
Emergency Contact: __________________________Home/Cell#: _______________Relationship: _________
Pediatrician Name: ___________________________________
Address: ___________________________ City___________________ State________ Phone # _____________________
Referring Doctor (if different from Pediatrician) ____
Address: ___________________________ City___________________ State________ Phone #:____________________
Pharmacy Name: _________________________ Town: _________________ Phone #:________________

INSURANCE INFORMATION (Must be completed in full so that we may submit to your insurance for reimbursement.)
Primary Insurance: __________________________________
Policyholder's Information:
Name (insured's name): ___________________________ Date of Birth: ___________________
Sex: Male Female Social Security #:____________________ Employer: ______________________
Patient's relationship to insured (please circle): Child Other/ Dependent
Policy #: ___________________________________ Group #: _______________________________

Secondary Insurance: __________________________________
Policyholder's Information:
Name (insured's name): ___________________________ Date of Birth: ___________________
Sex: Male Female Social Security #:____________________ Employer: ______________________
Patient's relationship to insured (please circle): Child Other/ Dependent
Policy #: ___________________________________ Group #: _______________________________

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Garden State Urology, LLC, for any service furnished to me by GSU's physicians. I authorize Garden State Urology, LLC to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due the physician. These amounts could include annual deductibles, co-payments, charges denied as not covered by Medicare or my insurance program, and charges denied for services determined as not medically necessary.

Signature: ____ Date: __________________

GARDEN STATE UROLOGY
Merging compassion & innovation.

TODAYS DATE_______________

PEDIATRIC HISTORY FORM

Patient Name: ____ DOB: _____________________

Primary Care Physician Name: ______________________________ Phone: ____________________

Other Treating Physician Name: ____________________________ Phone: ____________________

Pharmacy Name: ____ Phone: ___________________

Pharmacy Address:__________________________________City:____________State:_____Zip:_______

Medical reason for today's visit (New Patients ONLY): _______________________________________

Allergies: Please list any allergies your child may have to any medications .Please circle NONE if they do not have any known allergies.

____ **NONE**

Medications: Please list all the medications your child is currently taking, dosage and frequency. For example: *Aspirin 325mg daily.*

Medication	Dosage	Frequency
____	_____________	_____________
____	_____________	_____________
____	_____________	_____________

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****

Past Medical History: Does your child have or had any of the following medical conditions?

Diabetes	Type 1	Type 2	NO	**Kidney Disease**		YES	NO	**Heart Disease**	YES	NO
Asthma		YES	NO	**Thyroid Disease**	Hyper	Hypo	NO	**Other**	Yes	NO
High Blood Pressure		YES	NO	**Cancer** If YES please specify:		YES	NO	If yes, please explain: ______________________ ______________________ ______________________		
Kidney Stones		YES	NO							

When you were pregnant with this child: What was the length of pregnancy? _____________________

Was the pregnancy ? **NORMAL** **ABNORMAL** If abnormal, describe___________________________

IN-Vitro **YES** **NO**

If you had a pregnancy ultrasound, was it **NORMAL** **ABNORMAL**

Revised 1/29/2015

Family History: Do you have a *family* history of any of the following?(grandparents, parents or siblings)

Diabetes	Type 1	Type 2	NO	**Kidney Disease**	YES	NO	**Heart Disease**	YES	NO
Recurrent UTI's		YES	NO	**Hernias**	Yes	NO	**Bedwetting**	YES	NO
High Blood Pressure		YES	NO	**Cancer** If YES please specify:	YES	NO	**Other**	YES	NO
Kidney Stones		YES.	NO				If yes, please explain: _______________________ _______________________		
Bladder Anomolies		YES	NO						
Genital Problem		YES	NO	**Undescended Testis**	YES	NO			

Social History: Who does the child live with?____

Does anyone in the home smoke? Yes No What grade is the patient in?______________

Review of Systems: Is your child experiencing any of the following problems? **Please circle any that apply. If none apply, please circle NONE.**

Constitutional :	None	Fever	Chills	Headache	Other_________________	
Neurological :	None	Tremors	Numbness Tingling	Weakness	Other___________________	
Allergic/ Immunologic :	None	Seasonal Allergies	Drug Allergies	Other:____________________________		
Musculoskeletal :	None	Joint pain	Other:_____________________________			
Gastrointestinal :	None	Abdominal pain	Nausea/ Vomiting	Other:_____________________________		
Cardiovascular :	None	Heart Murmur	Other:____			
Endocrine :	None	Excessive thirst	Other:_______________________________________			
Respiratory :	None	Wheezing	Shortness of breath	Frequent Cough	Other:_______________	
Hematologic/ lymphatic :	None	Swollen Glands	Blood Disorder	Other:_____________________________		
Genitourinary :	None	Painful Urination	Urinary Frequency	Urinary Tract Infection	Blood in Urine	**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:________________

Acknowledgement of Receipt

By signing below, I acknowledge that I have received a copy of my physician's 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

If you have any questions about this notice or would like further information, please contact the Privacy Officer at Garden State Urology, LLC, Jeanmarie Falco.

For office use only: If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.

____

____

____

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:___________________________________ Relationship:__________________________

Name:___________________________________ Relationship:__________________________

Name:___________________________________ Relationship:__________________________

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

Home:___________________________________ Cellular:______________________________

Work:___________________________________ Other:_________________________________

____
Signature of Patient, Parent or Legal Guardian

____
Printed Name

Address: 16 Eden Lane, Whippany, NJ 07981 <> **Phone:** 973.240.2170 <> **Fax:** 973.947.9063

PATIENT NAME: ________________________ DATE OF BIRTH: _________________

ACKNOWLEDGEMENT FORM FOR THE FINANCIAL INFORMATION DOCUMENT

Attached is Garden State Urology Financial Information Document. This document explains the following information:

- In-network financial responsibility
- Out-of-network financial responsibility
- Self Pay / no insurance
- Medicaid/Charity Care
- Collections
- Precertification/authorization

Please take a few moments to read the document and save it with your medical records for future reference.

If you have any questions or concerns after reading the document, please ask to speak to a Financial Counselor.

In order to document for our records that you received this document we require all patients/guarantors to sign below acknowledging receipt of the document.

I acknowledge receipt of Garden State Urology's Financial Information Sheet that explains the information as outlined above.

Patient/Guarantor Signature __________________________ Date:____________________

For patients with Blue Shield or Horizon Insurance who are seeing an out of network physician:

Unfortunately, these insurance carriers will not send payment directly to an out of network physician. All payments/ explanations of benefits are sent to the patient/guardian.

When you receive an explanation of benefit/payment for a service rendered by Garden State Urology contact the Billing Department IMMEDIATELY.

DO NOT WAIT until you receive a statement or phone call from us.

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of the Payment Summary Sheet, please document the date and time the notice was presented to patient and sign below.

Date: ________ Time: __________ Employee Name: ______________________

Notice of Privacy Practices

If you have any questions about this Notice please contact our Privacy Officer, Jeanmarie Falco at the number listed at the end of this notice.

This Notice of Privacy Practices describes how GSU may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Garden State Urology, LLC
16 Eden Lane
Whippany, NJ 07981
Phone: (973) 240-3000 Fax: (973) 947-9055

How we may use and disclose medical information about you:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. We may communicate your information either orally or in writing by mail or facsimile.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. We may use and disclose your protected health information in the

following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations:

- Required By Law
- Public Health
- Communicable Diseases
- Health Oversight
- Abuse or Neglect
- Food and Drug Administration
- Legal Proceedings
- Law Enforcement
- Coroners
- Funeral Directors
- Organ Donation
- Research
- Criminal Activity
- Military Activity
- National Security
- Workers' Compensation
- Inmates and Required Uses
- Disclosures

We may disclose your protected health information to researchers when the research has been approved by an institutional review board and there is an established protocol.

For more information on this please contact the GSU Privacy Officer, Jeanmarie Falco at (973) 240-3000.

You have the right to inspect and copy your protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information

that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form that includes an acknowledgment of this notice of privacy. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this pamphlet. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling (973) 240-3000 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must also be submitted in writing. You will not be penalized for filing a complaint.