



**UROLOGY GROUP OF NEW JERSEY, LLC
PATIENT INFORMATION SHEET**

GENERAL INFORMATION

Patient Name: _____

Date of Birth: _____ **Age:** _____ **SS#:** _____

Gender: **Male** _____ **Female** _____

Street Address: _____

City/State/ZipCode _____

Phone Numbers: **Home** _____ **Work** _____ **Cell** _____

Marital Status (Circle One): **Married** **Widowed** **Divorced** **Single**

Do you have an Advance Directive: **Yes** _____ **No** _____

Parent / Guardian Name (if Minor) _____

Patient's Employer: _____

Employer Address: _____

Spouse's Name (if applicable): _____

Spouse's Address (if different from above): _____

Emergency Contact: _____

Relationship: _____ **Phone:** _____

Pharmacy Name: _____ **Phone #:** _____

Address: _____

PLEASE SEE BACK OF FORM

INSURANCE INFORMATION

Primary Insurance Company: _____

Policy #: _____ **Group #:** _____

Subscriber / Insured's Name: _____ **Date of Birth:** _____

Subscribers SSN #: _____ **Relationship to Insured:** _____

Secondary Insurance Company: _____

Policy #: _____ **Group #:** _____

Subscriber / Insured's Name: _____ **Date of Birth:** _____

Subscribers SSN #: _____ **Relationship to Insured:** _____

PRIMARY & REFERRING PHYSICIAN

Primary Care Physician: _____ **Phone:** _____

Primary Care Physician Address: _____

Referring Physician: _____ **Phone:** _____

Referring Physician Address: _____

WORKERS COMPENSATION INFORMATION (If applicable)

Workers' Compensation Insurance: _____

Claim #: _____ **Phone #:** _____

Signature of Patient

Date

**UROLOGY GROUP OF NEW JERSEY, LLC
(THE "PRACTICE")]**

**Notice of
Disclosure of Health Information to Family and Friends Involved in Your Care and Your
Right to Object**

Communications with Family Members/ Caregivers

In an effort to promote effective communication between the Practice, its patients and family and friends involved in a patient's care or payment of care and in recognition of the important role that family members, friends and others play in a patient's care or payment of care, it is the policy of the Practice to communicate to family members, friends or any other person(s) you may identify, information about you that is directly related to that family member's, friend's or caregiver's involvement in your care or payment of care. Unless you object and direct us otherwise by checking the box below, we will communicate with your family or friends that information about you that is directly related to their involvement in your care or payment for care.

I DO NOT want the Practice communicating any information to my family or friends. By checking this box I understand that I am limiting the Practice's ability to communicate information about me to my spouse, children, significant other or other person(s) who may accompany me to a procedure or call or seek to act on my behalf or who otherwise may be involved in my care or the payment of my care.

By signing below, I acknowledge receiving and reading this Notice.

Print Name

Signature

Date _____

UGNJ
UROLOGY GROUP OF NEW JERSEY, LLC

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I authorize payments and/or insurance benefits to UGNJ for medical services and/or surgical procedures that are payable to me under any government or private plan of health benefits, including Medicare payments, Medigap payments, and any other payments from private or self-insured plans. I certify that the information that I gave to UGNJ is correct. I assign and transfer to UGNJ the right to act in my place to bill and collect for all payments that are payable to me under any government or private plan of health benefits. I understand that I am responsible for any deductible, coinsurance, copayment and non-covered services.

I understand UGNJ is allowed to use and disclose my health information for treatment or payment and I understand this use is allowed by law. I hereby authorize UGNJ to release any such medical information as necessary.

FINANCIAL AGREEMENT

I understand that if UGNJ does not participate with my insurance payer, and I still wish to be seen, I can be seen as a "Self-Pay" patient. I understand that I will be required to pay the total cost of the visit in advance. UGNJ may courtesy file a claim to my non-participating insurance on my behalf or a claim form will be provided to me by the Billing Office.

NON-COVERED SERVICES

I understand that UGNJ's contracts with health care insurance carriers and other payers relate only to items and services which are "covered" by the health benefits carriers and other payers. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health benefits carrier or other payers not to be covered. Examples of services not eligible for payment include, but are not limited to, services which are determined as not medically necessary, non-covered, experimental or not otherwise specified as being covered in the patient's contract or in a benefit summary furnished to the patient beneficiary.

APPOINTMENT CANCELLATION

I understand that if I need to cancel or reschedule my appointment, I need to do so a minimum of twenty-four (24) hours in advance of my scheduled appointment time. Failure to comply may result in an appointment cancellation fee.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of UGNJ's Notice of Privacy Practices, which describes how medical information about me may be used and disclosed and how I can have access to this information.

I have read, understand, and agree to the provisions outlined in the paragraphs above.

SIGNATURE

Print Name: _____

Patient Signature: _____

Date: _____

Practice Partner Patient Id Number: _____

UROLOGY GROUP OF NEW JERSEY
PATIENT NOTIFICATION
DISCLOSURE OF PHYSICIAN OWNERSHIP
And
FACILITY OUT-OF-NETWORK STATUS

Urology Group of New Jersey would like to disclose to our patients that our physicians have a financial interest in the following healthcare facilities:

Florham Park Surgery Center

The Stone Center of New Jersey

Northern Jersey Lithotripsy

Please be advised that the following facility, Florham Park Surgery Center, is an out-of-network facility, healthcare insurance reimbursement will be at the out-of-network benefit level by your healthcare insurance carrier.

You have the right to use a healthcare facility other than those listed above, if you choose. You will not be treated differently by your physician if you choose another healthcare facility.

You may contact your physician or a patient representative if you have any questions or need additional information regarding this form.

I have read and understand this Disclosure of Ownership.

Patient or Responsible Party Signature

Date

Patient Name – Please Print



DISCLOSURE FORM

In-Office Ancillary Services (Computer Tomography (CT))

Dear Patient:

In the event that you may need to have a CT scan, we want to inform you of the following:

Federal law requires physicians who refer patients to certain healthcare services in which they have a significant financial interest to inform patients in writing at the time of the referral that the patient may obtain the services for which he or she is being referred from a supplier other than the physician making such referral.

Urology Group of New Jersey, LLC (UGNJ), which is the medical practice of which your treating urologist is a member, provides CT (Computed Tomography) services at its 375 Mt. Pleasant Avenue in West Orange, New Jersey, location.

You may, of course, seek CT services at another provider. For your information, the following is a list of diagnostic radiology providers who provide CT services in this area:

1. Saint Barnabas Ambulatory Care Center
2. Montclair Radiology
3. Imaging Center at Morristown
4. Denville Diagnostics

By signing this disclosure, you or your legal representative acknowledge that: (1) you have been informed by UGNJ that you may obtain CT services from a supplier other than UGNJ; and (2) UGNJ has provided you with a list of several other suppliers of CT services in the area.

Patient Signature:

Witness:

Printed Name:

Printed Name:

Date:

Date:

_____, 20____

_____, 20____

PAST MEDICAL HISTORY: (Please Circle All That Apply)

Urology: Bladder Cancer, BPH, Erectile Dysfunction, Interstitial Cystitis, Kidney Cancer, Kidney Infection, Kidney Stones, Prostate Cancer, Prostatitis, Testicular Cancer, Urethral Stricture, Kidney Stone disease, Other.

Eyes: Glaucoma, Blindness, Other.

ENT: Deafness, Allergies, Throat Cancer, Other.

Cardiovascular: Arrhythmia, Congestive Heart Failure, Elevated Cholesterol, Hypertension, Heart Attack, Coronary Artery Disease, Valve Disease, Peripheral Vascular Disease, Other
Anticoagulant Use: Aspirin, Plavix, Coumadin, Vitamin E

Respiratory: Emphysema, Pneumonia, Asthma, COPD, Bronchitis, Lung Cancer, Other.

Gastrointestinal: Hiatal Hernia, Pancreatitis, Peptic Ulcer Disease, Reflux Disease, Inflammatory Bowel Disease, (*Crohn's Disease/Ulcerative Colitis*), Diverticulitis, Colon Cancer,

Renal: Renal Insufficiency, Renal failure, Polycystic Kidney Disease, Other.

Gynecologic: Endometriosis, Pregnancies (#)____, Menopause, Ovarian Cancer, Uterine Cancer, Cervical Cancer, Breast Cancer, Other.

Orthopedic: Herniated disk, Arthritis, Osteoporosis, Other.

Neurologic: Migraine Headaches, Multiple Sclerosis, Epilepsy, Brain Tumor, Other.

Endocrine: Hyperparathyroidism, Diabetes Mellitus, Hyperthyroidism, Hypothyroidism, Gout, Other.

Skin: Melanoma, Non-Melanoma Skin Cancer, Other.

Hematology: Anemia, Deep Venous Thrombosis, Sickle Cell Disease/Trait, Lymphoma, Leukemia, Other.

Psychiatric: Anxiety, Depression, Schizophrenia, Other.

PAST SURGICAL HISTORY: (Please Circle All That Apply)

Urology: Circumcision, ESWL, Laser Stone treatment (Kidney, Ureter, Bladder), Percutaneous Nephrolithotomy, R/L Orchiectomy, Laser Treatment of Prostate, Radical Retropubic Prostatectomy, Robotic Prostatectomy, Testicular Torsion, Resection of Bladder Tumor, Urethroplasty, R/L Varicocelelectomy, TURP, R/L Nephrectomy (Open/Laparoscopy), Other.

Eyes: Cataracts, Other.

ENT: Tonsils and Adenoidectomy, Sinus Surgery, Other.

Respiratory: Lung Resection for Cancer, Other.

Heart Surgery: Heart Bypass, Pacemaker Placement, Valve Replacement, Other.

General Surgical: Gastric Bypass Surgery, Peptic Ulcer Repair, Cholecystectomy, Appendectomy, Colon Resection, Hernia Repair (Side and Type _____), Other

Gastrointestinal: Hiatal Hernia, Pancreatitis, Peptic Ulcer Disease, Reflux Disease, Inflammatory Bowel Disease, (*Crohn's Disease/Ulcerative Colitis*), Diverticulitis, Colon Cancer,

Gynecologic: Hysterectomy, C-Section, Bladder Suspension, Sling, Other.

Orthopedic: Arthroscopy, Laminectomy, Foot Surgery, Hip Surgery, Knee Surgery, Other.

Neurologic: Brain Surgery, Other.

Endocrine: Parathyroidectomy, Thyroidectomy, Other.

REVIEW OF SYSTEMS: (Please Circle All That Apply)

Urinary: None, Urgency, Urine Retention, Painful Urination, Urinary Frequency, Blood in the Urine, Incontinence of Urine, Other.

Constitutional: None. Headache, Fever, Chills, Other.

Eyes: None, Blurred Vision, Double Vision, Eye Pain, Other.

Ears/Nose/Throat/Mouth: None, Ear Infections, Sore Throat, Sores, Sinus Problems, Other.

Cardiovascular: None, Chest Pain, Heart Murmur, High Blood Pressure, Varicose Veins, Other.

Respiratory: None, Wheezes, Frequent Cough, Shortness of Breath, Other.

Gastrointestinal: None, Abdominal Pain, Nausea, Vomiting, Indigestion/Heartburn, Other.

Neurological: None, Tremors, Dizzy Spells, Numbness, Tingling, Other.

Hematologic/Lymphatic: None, Swollen Glands, Blood Clotting Problems, Other.

Allergic/Immunological: None, Hay Fever, Drug Allergies, Other.

Endocrine: None, Excessive Thirst, Too Hot, Too Cold, Tired, Sluggish, Other.

Musculoskeletal: None, Joint Pain, Back Pain, Neck Pain, Other.

Psychological: None, Depressed, Suicidal, Other.

Gynecological (Women only): None, Menopause, Pregnant, Possibly Pregnant, Other.

Skin: None, Rash, Hives, Persistent Itch, Boils, Other.