Hackensack Meridian *Health*
Mountainside Medical Group
Pascack Valley Medical Group

Patient Registration

Please review and confirm information. If information is missing please furnish)

Date: _____ **Patient Number:** _____

Name: _____ **DOB:** _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____ **Home:** _____ **Preferred:** ☐

Marital Status: _____ **Cell:** _____ **Preferred:** ☐

Sex: _____ **Work:** _____ **Preferred:** ☐

Please select one

SS: _____ ☐ **Permission to text appointment reminders**

Race: ☐ **White** ☐ **Asian** ☐ **American Indian** ☐ **African American** ☐ **Other** ☐ **Refuse**

Ethnicity: ☐ **White** ☐ **Hispanic** ☐ **Non-Hispanic** ☐ **Refuse**

Primary Language: ☐ **English** ☐ **Spanish** ☐ **Other** ☐ **Refuse**

Primary Pharmacy: _____ **Phone:** _____

Street: _____ **City:** _____ **State:** _____

Secondary Pharmacy: _____ **Phone:** _____

Street: _____ **City:** _____ **State:** _____

Emergency Contact: _____ **Patient's Relation to contact:** _____ **Phone:** _____

Patient's Care Team

(please furnish all current providers being seen within and out of this practice)

Physician's Name	Specialty or Condition Being Treated	Phone	Address
	Primary Care		

Hackensack Meridian *Health*

Employment Information

Employer: _____ **Phone:** _____

Street: _____ **City:** _____ **State:** _____ **ZIP:** _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Number: _____ **Group Number:** _____

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Subscriber: _____ **Phone:** _____ **DOB:** _____

Street: _____ **Relationship to patient:** _____

City: _____ **State:** _____ **Zip:** _____

Does your current policy require a referral? ☐ Yes ☐ No

Secondary Insurance: _____

Policy Number: _____ **Group Number:** _____

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Subscriber: _____ **Phone:** _____ **DOB:** _____

Street: _____ **Relationship to patient:** _____

City: _____ **State:** _____ **Zip:** _____

Does your current policy require a referral? ☐ Yes ☐ No

Hackensack Meridian *Health*

Assignment of Benefits Authorization

I request that payment of authorized benefits be made to MPV New Jersey MD Services, PC for any service furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration ad its agents any information to determine these benefits payable for related services. This authorization may be canceled on my request any time.

Signature _____

Financial Policy

Thank you for choosing us for your medical care. The following is a statement of our Financial Policy which we ask you read and sign prior to any treatment.

All patients must complete our general information form and Medical History form before seeing the doctor. If you belong to an insurance or managed care plan, please let us know beforehand.

- We Accept cash, checks and credit cards.
- If you belong to an HMO or PPO that requires a co-payment, you will be asked to pay this prior to your seeing the doctor.

Regarding Medical Insurance…

Your health insurance policy is a contract between you and your insurance company. Any disputes regarding medical coverage should be addressed directly to them.

- ♦ If you belong to an HMO, PPO, or any other managed care plan in which we participate, we will automatically file your insurance claim for you. You are responsible for obtaining any required authorizations, pre certifications, and/or referrals prior to you visit.
- ♦ If a treatment or procedure is performed here and is deemed not payable by your insurance company (e.g. annual physicals, preventive immunizations, etc), you will be held responsible for payment in full.
- ♦ If you are a Medicare beneficiary, we will file your claim directly with Medicare for you, If you have secondary insurance, we will balance bill them for the portion Medicare does not pay, However, you will remain responsible for the annual deductible as well as any remaining co-payments. If you have a third insurance, you will be responsible for filing your own claims with them.

Patients Signature: _____ **Date:** _____

Print Name:

Hackensack Meridian *Health*
Mountainside Medical Group
Pascack Valley Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY OF PRACTICES

I, , have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

For Office Use Only

Patient's Number: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency prevented us from obtaining acknowledgement
☐ Other (Please Specify) _____

****You May Refuse to Sign This Acknowledgement****

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE NOTICE)

Name: _____ **DOB**: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name	Relationship	DOB	Phone Number

☐ Information is not to be released to anyone

This **Release Of Information** will remain in effect until terminated by me in writing

By signing this form you are acknowledging the release of information to all partners of Hackensack UMC Medical center, except our Gynecology office. You will be required to sign a second release form when seeing our gynecologists.

Signature: _____ Date: _____

Witness: _____ Date: _____

Hackensack Meridian *Health*
Mountainside Medical Group
Pascack Valley Medical Group

Depression Screening Assessment Tool

Patient Name: Patient Number:
DOB: Today's Date:

When thinking about the following situations, please choose your response based on your experience over the last 2 weeks. Please circle the duration for each question. Please return your completed form to a member of our staff.

How often have you been bothered by any of the following problems?	Not at all	Several days	More than half of the days	Nearly every day
1. Little or no pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or feeling like you have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading, or watching television	0	1	2	3
8. Moving or speaking slowly (noticed by yourself or others) or the opposite (being fidgety, restless, or in constant motion)	0	1	2	3
9. Thoughts you would rather be dead, or thoughts of hurting yourself or others	0	1	2	3
Total for each column:	0			

Clinical staff to combine the 3 scores above for total score	TOTAL SCORE:

Providers: Score of 9 or greater indicates a positive screen

10. If you indicated you are suffering from any problem above, how difficult has it been for you to go to work, take care of things at home, or get along with others? **Circle the level on the right*	1. Not at all difficult 2. Somewhat difficult 3. Very difficult 4. Extremely difficult

Health Care Provider Signature: _____

Hackensack Meridian *Health*
Mountainside Medical Group
Pascack Valley Medical Group

Patient Information (Please Print):

First Name:	Middle Initial:	Last Name: **Tabakovic**
Name at Time of Treatment (if different):		
Date of Birth:	Phone:	Email:
Address:		

Which records do you need?

Date(s) of service: __/__/____ through __/__/____

Physician's Name and Address: _____

_____

Where do you want the information sent to?

Recipient Name:		
Street Address:	Phone:	Fax:
City:	State:	Zip:

Please print your name and sign below:

Name of Patient or Personal Representative	**Relationship**
Signature	**Date/Time**

Please return completed form to:

Fax: 201-967-0340 Mail: MPV New Jersey MD Services, PC 250 Old Hook Road Westwood, NJ 07675 Attention: Medical Records Department	Questions? Call us at 201-468-5580 There may be charges associated with production of your medical record.

Hackensack
Meridian *Health*
Mountainside Medical Group
Pascack Valley Medical Group

Financial Responsibility Agreement

Date:
Patient Name:
DOB:

I am aware that I will be seen for my annual wellness visit. If any of the below mentioned issues are addressed during my wellness visit, my provider will document and bill an additional charge to my insurance plan for a medical visit. I understand and agree that I will be financially responsible for any balance identified by my insurance plan.

- New acute condition
- A worsening chronic condition
- A diagnostic test ordered
- A treatment changed

I understand and agree that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical service(s), preventative exam/physical, lab or diagnostic testing, or any other screening service ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility to know if my insurance has any Deductible, Co-Payment, Co-Insurance, Out-of-Network, Usual and Customary Limit or any other type of benefit limitation for the services I receive, and I agree to make full payment.

Signature:	Date:
Print Responsible Party Name:	

Hackensack Meridian *Health*
Mountainside Medical Group
Pascack Valley Medical Group

Fall Efficacy Scale

PLEASE ONLY COMPLETE IF YOU ARE 65 YEARS OLD OR OLDER

Name:
Date
DOB:

Provider:

On a scale from 1 to 10 with 1 *being very confident* and 10 *being not confident at all*, how confident are you that you do the following activities without falling?

Activity	**Score** 1= very confident 10= not confident at all
Take a bath or shower	
Reach into cabinets or closets	
Walk around the house	
Prepare meals not requiring carrying heavy or hot objects	
Get in and out of bed	
Answer the door or telephone	
Get in and out of a chair	
Getting dressed and undressed	
Personal grooming (i.e. washing your face)	
Getting on and off the toilet	
Total Score:	

A total score of greater than 70 indicates that the person has a fear of falling.

Have you had a fall I the last 12 months? Yes _____ No _____
If you answered yes, how many times? _____

Was an injury sustained? Yes _____ No _____

Provider Signature: _____

Source: Tinetti, M., Richman, D., Powell, L (1990). Falls Efficacy as a measure of fear of falling. Journal of Gerontology. 45;239