



JOHN C. SCOLAMIERO, M.D.
Medical Director
Internal Medicine

A.J. SCOLAMIERO, M.D.
Associate Medical Director
Family Practice

PATIENT REGISTRATION SHEET

MR#: _____
RAD#: _____

HOME PHONE #:

WORK PHONE #:

CELL #:

EMAIL:

PLEASE FILL OUT COMPLETELY AND SIGN

DATE:						
LAST NAME		FIRST NAME		MI	SEX	SOCIAL SECURITY #:
DATE OF BIRTH	AGE	MARITAL STATUS SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			EMPLOYED <input type="checkbox"/> STUDENT <input type="checkbox"/> RETIRED <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/>	
HOME ADDRESS		CITY			STATE	ZIP CODE
NOTIFY IN CASE OF EMERGENCY		PHONE #:		RELATIONSHIP		
RACE: <input type="checkbox"/> WHITE/CAUCASAN <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> OTHER _____ <input type="checkbox"/> DECLINES TO ANSWER						
ETHNICITY: <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> NON HISPANIC/LATINO <input type="checkbox"/> DECLINES TO ANSWER			PREFERRED LANGUAGE: <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> ITALIAN <input type="checkbox"/> RUSSIAN <input type="checkbox"/> GERMAN <input type="checkbox"/> FRENCH <input type="checkbox"/> OTHER _____ <input type="checkbox"/> DECLINES TO ANSWER			

PATIENT OR GUARDIAN'S SIGNATURE AUTHORIZES THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNED: _____

DATE: _____



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PATIENT INSURANCE ADVISORY
PLEASE FILL OUT COMPLETELY AND SIGN

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY	ID#:	GROUP#:	
POLICY HOLDER'S NAME	DATE OF BIRTH	SEX	PHONE # (IF DIFFERENT FROM ABOVE)
ADDRESS (IF DIFFERENT FROM ABOVE)			
RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/>		EMPLOYER	
SECONDARY INSURANCE	ID#:	GROUP#:	
POLICY HOLDER'S NAME	DATE OF BIRTH	SEX	PHONE # (IF DIFFERENT FROM ABOVE)
ADDRESS (IF DIFFERENT FROM ABOVE)			
RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/>		EMPLOYER	

Please be advised that due to significant changes in insurance plans you must provide this office with a current insurance card at each visit. Plans change frequently and coverage varies by plan, which is why we need to verify your insurance EACH & EVERY time you come in.

Please understand that you, the patient, are responsible for providing the office with any updated insurance information you receive that may affect your coverage. Failure to provide a valid insurance card each time you come for a visit, or if we are unable to verify your insurance coverage at the time of your visit may necessitate this office to bill you directly for all charges incurred.

I, the undersigned, agree to provide a valid and current insurance card at each visit. I understand that if my insurance information is not up to date or my coverage can't be verified that I will be responsible for the cost of all charges incurred.

Patient's Signature

Date: _____

MED-CARE HIPAA FORM
245 PARK AVENUE, E. RUTHERFORD, NJ 07073
150 FAIRFIELD ROAD, FAIRFIELD, NJ 07004

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PRIVACY POLICY

Your Rights With Respect to Your Personal Health Information

Under **HIPAA**, you have certain rights with respect to your personal health information. You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures:* (a) to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

You have the right to review our notice before signing this consent. By signing this form, you consent to our use and disclosure of protected healthcare information about you for treatment, payment and healthcare operations. You have the right to revoke consent, in writing, signed by you. However, such a revocation shall not affect disclosures we have already made in reliance on your prior consent. Med-Care provides this form to comply with the Health Insurance Portability Accountability Act of 1996 (HIPAA).

CONSENT TO RELEASE INFORMATION

By signing this form, I permit Med-Care to release any medical information to physicians involved in my care. I consent that Med-Care may call my house or other designated location and leave a message on my voice mail or in person in reference to an appointment, reminders and insurance items. In addition, Med-Care may mail to my home patient statements and medical results.

I designate the following representative(s) who the provider can communicate with on my behalf. If I do not designate anyone, the doctor will be unable to speak to anyone in my family regarding my medical condition.

NAME	RELATIONSHIP
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NAME	RELATIONSHIP
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PATIENT OR LEGAL GUARDIAN _____

(PLEASE PRINT)

PATIENT OR LEGAL GUARDIAN _____

(SIGNATURE)

(DATE)