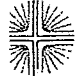


LOURDES MEDICAL ASSOCIA[illegible]

REGISTRATION FORM

PLEASE MAKE SURE COPIES OF INSURANCE CARDS & REFERRALS ARE ATTACHED!

Last Name:	First Name:	Middle Name:

Address: City: State: Zip:	Contact information: ☐ Home Phone:________ ☐ Cell Phone:________ *Check preferred communication*
Email Address:	

Date of Birth:	Social Security:	Sex:	Marital Status: ( )Married ( ) Single ( ) Widowed ( )Divorced ( ) Separated ( ) Life Partner

Race:	Ethnicity:	Preferred Language:
( ) Asian ( ) Filipino ( ) Black or African American ( ) White ( ) Other________	( ) Central American ( ) Hispanic or Latino/Spanish ( ) Mexican ( ) Cuban ( ) Dominican ( ) Puerto Rican ( ) South American ( ) Not Hispanic or Latino ( ) Spaniard	( ) English ( ) Spanish; Castilian ( ) Other________

Employer Name:	Telephone #:	Employer Address: City: State: Zip:

Allergies?

Do you have a legal guardian? ☐ Yes ☐ No Name: Contact #:

Do you have an Advance Directive?	Primary Care Physician:

Emergency Contact Name and Address:	Relationship:	Emergency Contact Phone #:

PRIMARY INSURANCE: (please attach copies of cards and necessary referrals)	Insurance Phone #:	POLICY ID#:
Address: City: State: Zip:		GROUP #:

Subscriber Name:	Sex:	DOB:	Subscriber Employer:	Telephone #:
Address: City: State: Zip:			Employer Address: City: State: Zip:	

Subscriber Relation to Patient:	Employment status:	Subscriber Social Security #:
( )Self ( )Spouse ( ) Father ( ) Mother ( )Life Partner	( )Full time ( )Part Time ( )Not Employed ( ) Unknown ( ) Self Employed ( )Retired ( )Active Military Duty	

SECONDARY INSURANCE:	Insurance Phone #:	POLICY ID#:
Address: City: State: Zip:		GROUP #:

Subscriber Name:	Sex:	DOB:	Subscriber Name:	Sex:
Address: City: State: Zip:			Employer Address: City: State: Zip:	

Subscriber Relation to Patient:	Employment status:	Subscriber Social Security #:
( )Self ( )Spouse ( ) Father ( ) Mother ( )Life Partner	( )Full time ( )Part Time ( )Not Employed ( ) Unknown ( ) Self Employed ( )Retired ( )Active Military Duty	

I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits or payments from insurance company for physician services to be made directly to Lourdes Medical Associates and/or OLOLMC for the services rendered. I permit a copy of this authorization to be used in place of the original. I understand I am financially responsible for any balance not covered by my insurance.

I understand the cost of administrative forms is not covered under my insurance and I agree to be responsible for these charges.x________ INITIAL

I understand that I will be responsible for a $25 fee for non-cancellation of a scheduled appointment. x________ INITIAL

Signature: x________________ Date:____/____/____

Revised 8/2/2011

Professional Orthopaedics **Medical History**

Patient Name: ______________________ Current Problem: ______________________

How long have you had this problem? __________________ Or from what specific date? __________

How did your injury occur? ______________________________ **Work related?** ☐ **Yes** ☐ **No**

Describe your pain: (circle all that apply) dull / aching / throbbing / cramping / stinging / tingling / sharp /tender / sore / constant

On a scale of 1-10 with 10 being the most sever, please circle the number best describing your pain. 1 2 3 4 5 6 7 8 9 10

What helps to alleviate your pain? ____

Have you had any of the following for this problem? (circle all that apply) X rays / MRI / CT scan / EMG / Ultrasound / blood work

Where were the studies/labs performed? ______________________________ When? __________

PAST MEDICAL HISTORY (check all that apply)

☐ Diabetes	☐ Blood in Stool	☐ Nausea/Vomiting	☐ STD
☐ Drug Abuse	☐ Hay Fever	☐ Pacemaker	☐ Major Infection
☐ Change in bowel habits	☐ High Cholesterol	☐ Depression	☐ Cancer:
☐ Back Pain	☐ Kidney Disease	☐ Headache	Please specify: __________
☐ Heart Disease	☐ Asthma	☐ Shortness of breath	______________
☐ Alcohol Abuse	☐ Epilepsy	☐ Gout	☐ Other __________
☐ Blood Clot	☐ Stroke	☐ Bleeding Disorder	______________
☐ Hypertension	☐ Thyroid Problems	☐ Ulcers	______________
☐ Liver	☐ Arthritis	☐ Tick Bite/Lyme Disease	

Please list your current medications and / or supplements: ______________________________

____

Allergies: ______________________ Previous Surgeries and Dates: ______________________

______________________ ______________________

☐ Penicillin ☐ Latex ☐ Iodine ☐ Shellfish

____

Height ________ **Weight** ________

SOCIAL HISTORY

Tobacco Use? ☐ Yes ☐ No If yes, how much? __________ For how long? __________

Alcohol Use? ☐ Yes ☐ No If yes, how much? __________ For how long? __________

Pregnant or Possibility of pregnancy?

☐ **Yes** ☐ **No**

FAMILY HISTORY

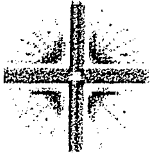
Are there any diseases that run in your family? (i.e. diabetes, cancers, heart disease, ect)______________________

____

PRIMARY CARE PHYSICIAN______________________________ **PHONE**______________

ADDRESS ____

CITY ______________________ **STATE** __________ **ZIP CODE**__________



Lourdes Medical Associates

AUTHORIZATION AND CARE/RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

CONSENT TO TREAT

The term "health care provider(s)" in this document means Lourdes Medical Associates (LMA), its agent and employees, members of the medical staff, their agents and employees, and other health care practitioners who provide care to patients.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for care including future treatment. I understand that this information serves as:

1. Basis for planning my treatment and care
2. Information used to file my claim with the insurance company (procedure and diagnosis)
3. Means by which a third-party payer can verify that billed services were actually provided
4. A tool for routine health care operations including assessing quality and reviewing competency of your staff and/or other health care providers

I understand that I have been provided with the Notice of Information Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf. Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing, and procedures as are deemed necessary in the course of my care.

RELEASE OF INFORMATION

Information about me necessary to substantiate my insurance claims may be released by the health care provider involved in my care.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health care providers are not paid after reasonable notice, that account shall be deemed delinquent and a service charge shall be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized medical benefits be made either to me or on my behalf to Lourdes Medical Associates for any services furnished me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on item 9 of the CMS-1500 claim form or elsewhere on the approved claim form or electronically submitted claim, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

____

SIGNATURE DATE

____

WITNESS TITLE DATE

Lourdes Medical Associates

GENERAL AUTHORIZATION TO USE SCLOSE HEALTHCARE INFORMATIO

Patient Name:________________________ Date of Birth:________________

Phone # :________________________ SS #: XXX-XX-____________

1. I authorize the use or disclosure of the above-named individual's health information as described below:

2. The following individual or organization(s) are authorized to make the disclosure:

RANCOCAS ORTHOPAEDICS

3. The type of information to be used or disclosed is as follows: (check appropriate boxes and include other information where indicated)

Dates of Service(s):________________________

- ☐ Face Sheet/Registration
- ☐ History & Physical
- ☐ Progress Notes
- ☐ EKG Results
- X OTHER (please specify): All Existing Medical Records
- ☐ Medication List
- ☐ Lab Results
- ☐ Xray Results
- ☐ Immunization Records

4. I understand that if my record contains sensitive information such as mental health information, drug and alcohol abuse information or HIV related information, separate authorizations will be required.

5. The information identified above may be used by or disclosed to the following individual or organization(s):

Name: Professional Orthopaedics at Lourdes Medical Associates
Dr. David Eakin
Dr. Efrain Paz, Jr

6. The information for which I am authorizing disclosure will be used for the following purpose:

☐ Sharing with other healthcare professionals as needed ☐ Other: Continuation of Medical Care and/or Evaluation

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. Unless I specify differently, this authorization will expire six (6) months from the date signed below.

9. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

________________________ X________________

gnature of Patient or legal representative (list relationship to patient) Date

________________________ ________________

gnature of Witness Date

tient/legal representative identification verified? o YES o NO

Patient Acknowledgement of Receipt of Lourdes Medical Associates Notice of Privacy Practices (HIPAA)

Patient Name ***(please print)*****:** ______________________________

Patient Address ***(please print)*****:** ______________________________

Physician Name ***(please print)*****:** ______________________________

By signing below, I acknowledge that I have reviewed the Lourdes Medical Associates' Notice of Privacy Practices. This notice describes how medical information about me may be used and disclosed, and how I can get access to this information.

In addition, I give permission for this office to discuss my medical records with other doctor's offices, specialists, hospitals, and radiology facilities. I also give permission for the following person(s) to receive medical information on my behalf (*please check one*):

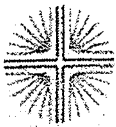
☐ No one else

☐ ______________________ (Name) ______________________ (Relationship)

Patient/Guardian Signature:
(If Guardian, state relationship to patient) ______________________________

Date: ______________________________

☐ 2009 ____________	☐ 2012 ____________	☐ 2015 ____________
☐ 2010 ____________	☐ 2013 ____________	☐ 2016 ____________
☐ 2011 ____________	☐ 2014 ____________	☐ 2017 ____________



LOURDES
HEALTH MANAGEMENT SERVICES ORGANIZATION

2103 Burlington Mt Holly Rd, Burlington, NJ 08016
Phone: 609-747-9200   Fax: 609-747-1408

MEDICAL RECORD REQUEST

Patient's Name: ____________________ Date of Birth: ____________________

Previous Name: ____________________ Social Security #: ____________________

I request and authorize ______________________________________ to

release healthcare information of the patient named above to:

Name: Professional Orthopaedics at Lourdes Medical Associates

Address: 2103 Burlington Mt Holly Road

City: Burlington   State: NJ   Zip Code: 08016

Type of information/documentation you wish to have released:

☐ Face Sheet/Registration

☐ History and Physical

☐ EKG Results

☐ Medication List

☐ Lab/X-rays/Slides/CDs

☐ Face Sheet/Registration

☐ Progress Note/s (Dates of Service) ____________

☐ Other: ______________________________

____

☐ All healthcare information

****Reason for Request:* ☐ *On-going care*   ☐ *Transfer care*   ☐ *Other:* ____________________

I understand that if my record contains sensitive information such as mental health information, drug and alcohol abuse information or HIV related information, separate authorizations will be required.

____

I understand that I have the right to revoke this authorization at any time and that if I revoke this authorization, I must do so in writing and present my written revocation t Lourdes Medical Associate. I understand that my revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance carrier as the law provides my insurer the right to contest a claim under my policy.

Unless I specify otherwise, this authorization will expire in six (6) months form the date signed below. I understand that it is not necessary for me to sign this form in order to receive health care treatment.

______________________________________ Date Signed: ____________________

Signature of Patient or Legal Representative (list relationship to patient)