

North Jersey Center for Urologic Care, P.A.

A Division of Urology Group of New Jersey, LLC

16 Pocono Road, Suite 114

Denville, NJ 07834

(Tel) 973-586-3056 (Fax) 973-625-0116

www.njcuc.com

PATIENT INFORMATION

Patient Name: _____ Sex: M / F

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

Street Address: _____

City/State/Zip Code: _____

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

Marital Status (Circle One): Married Widowed Divorced Single

.....
Parent / Guardian Name (If Minor): _____

Patient's Employer: _____

Employer's Address: _____

Spouse's Name (if applicable): _____

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

Emergency Contact: _____

Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Policy #: _____ Group #: _____

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

Subscriber's SSN#: _____ Relationship to Insured: _____



Secondary Insurance Company: _____

Policy #: _____ Group #: _____

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

Subscriber's 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)

Worker's Compensation Insurance: _____

Claim #: _____ Phone #: _____

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Urology Group of New Jersey, LLC Insurance Authorization and Assignment

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: _____

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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.

SIGNATURE

Print Name: _____

Patient Signature: _____

Date: _____

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Patient Health History

Name: _____ Date of Birth: _____

Past Urology History:

- | | |
|--|--|
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Interstitial Cystitis |
| <input type="checkbox"/> Enlarged Prostate (BPH) | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> UTI's |
| <input type="checkbox"/> Kidney Cancer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> |

Past Medical History:

Past Surgical History:

Past Family History:

Allergies:

- No Known Drug Allergies

Social History:

- Do you drink alcohol? Yes No
Do you smoke? Yes No If yes, how many cigarettes / day? _____

Review of Systems:

- | | | | |
|--|-------|---|-------|
| Constitutional: fever, headache, chills | Y / N | Eyes: blurred vision, double vision, pain | Y / N |
| Allergy: hay fever, allergies | Y / N | Neurologic: tremors, dizziness, numbness | Y / N |
| Endocrine: thirst, fatigue, hot / cold | Y / N | GI: abd. pain, nausea, indigestion | Y / N |
| Cardiovascular: chest pain, hypertension | Y / N | Skin: rash, itching | Y / N |
| Musculoskeletal: joint pain, neck or back pain | Y / N | ENT: sinus or ear infection, sore throat | Y / N |
| GU: retention, dysuria, frequency | Y / N | Respiratory: wheezing, cough, short of breath | Y / N |

Additional Information:

Patient Signature _____ Today's Date: _____

Physician Signature _____ Today's Date: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed the online version of
Urology Group of New Jersey, LLC (DBA: NJCUC) Notice of Privacy Practices.

Patient's Signature

Date