☐ CHANGE OF ADDRESS ☐ **DR. NAZHA** ☐ **DR. DALZELL** ☐ **DR. WANG** ☐ **DR. STOYKO** ☐ NEW PATIENT

☐ CHANGE OF INSURANCE ☐ OTHER

NAZHA CANCER CENTER
REGISTRATION-PLEASE FILL OUT COMPLETELY

FULL NAME_____ MALE_____FEMALE_____ RETIRED ___
ADDRESS_____ EMPLOYER _____
_____ _____
SKILLED NURSING HOME_____ _____
HOME PHONE_____ WORK PHONE_____
CELL PHONE _____ SOCIAL SECURITY#_____
DATE OF BIRTH_____ ( )SINGLE ( )MARRIED ( )OTHER
EMAIL ADDRESS:_____
REFERRING PHYSICIAN_____PRIMARY PHYSICIAN_____
PHARMACY NAME AND PHONE #_____
PERSON WHO MAY BE CONTACTED REGARDING YOUR CONDITION:
NAME: _____TELE # _____
OTHER CONTACT NAME: _____TELE # _____

INSURANCE INFORMATION

WE WILL BE SUBMITTING TO YOUR INSURANCE CARRIER(S) AND NEED A COPY OF YOUR ID CARD

INSURANCE #1_____ INSURANCE #2_____
ID #_____ ID #_____
EFFECTIVE DATE_____ EFFECTIVE DATE_____
GROUP NAME & #_____ GROUP NAME & #_____
INSURED'S NAME_____ INSURED'S NAME_____
INSURED'S DATE OF BIRTH_____ INSURED'S DATE OF BIRTH_____
INSURED'S EMPLOYER_____ INSURED'S EMPLOYER_____

ASSIGNMENT AND RELEASE

I. THE UNDERSIGNED, CERTIFY THAT I (OR MY DEPENDANT) HAVE INSURANCE COVERAGE WITH THE CARRIER(S) LISTED ABOVE AND ASSIGN DIRECTLY TO NAZHA CANCER CENTER. ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

PRINT NAME_____ MEDICARE #_____
SIGNATURE_____ DATE_____

I REQUEST THAT PAYMENT OF AUTHORIZED SECONDARY INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO NAZHA CANCER CENTER. FOR ANY MEDICAL SERVICES FURNISHED ME BY NAZHA CANCER CENTER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY SECONDARY INSURER ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

I hereby give Nazha Cancer Center permission to use and disclose all protected health information for treatment, payment, or health care operations.

_____
SIGNATURE

MEDICAL HISTORY

NAME:_____ AGE:_____DATE:_____

PRIMARY DOCTOR:_____ LAST VISIT:_____

WHAT IS THE REASON FOR TODAY'S VISIT?_____

DO **YOU** HAVE OR HAVE **YOU** HAD ANY OF THE FOLLOWING PROBLEMS (CHECK ALL THAT APPLY AND YEAR)

___ DIABETES	___ HEART CONDITION	___ HIGH BLOOD PRESSURE
___ HEART MURMUR	___ HEART ATTACK	___ LUNG PROBLEMS
___ ASTHMA	___ EMPHYSEMA	___ KIDNEY PROBLEMS/INFECTIONS
___ ABNORMAL BLEEDING TIME	___ CELLULITIS	___ HEPATITIS
___ KIDNEY STONES	___ SEIZURES/EPILEPSY	___MIGRAINES
___ LIVER DISEASE	___ GALL BLADDER PROBLEMS	___ BLOOD CLOTS (PHLEBITIS)
___ GASTROENTERITIS	___ COLITIS HISTORY	___ ULCER DISEASE
___ PNEUMONIA	___ THYROID PROBLEMS	___ LEUKEMIA
___ RHEUMATIC FEVER	___ HAY FEVER	
___ CANCER	___ AIDS	

___ OTHER PROBLEMS:_____

DO **YOU** HAVE ANY OF THE FOLLOWING **ALLERGIES** (CHECK ALL THAT APPLY) :

___ PENICILLIN ___NOVACAINE ___ ASPIRIN ___ ADHESIVE TAPE ___ HAY FEVER ___ MOTRIN OR NSAID'S
___ OTHER ALLERGIES:_____

MEDICATIONS YOU ARE PRESENTLY TAKING (NAME, DOSAGE AND TIMES PER DAY; IF NONE STATE **NONE**)

SURGICAL HISTORY:LIST TYPE OF SURGERY AND YEAR PERFORMED (INCLUDING INPATIENT, OUTPATIENT, AND ANY HOSPITALIZATIONS):

PERSONAL HABITS: (DO YOU NOW OR HAVE YOU EVER)

SMOKE? YES/NO PACKS PER DAY?___ NUMBER YEARS _____ WHEN STOPPED? _____
DRINK? YES/NO BEER ___ MIXED DRINKS___ HOW OFTEN? _____ WHEN STOPPED? _____
BLOOD TRANSFUSIONS? YES/NO WHEN? _____REASON_____

FAMILY HISTORY: THIS INCLUDES **ONLY** IMMEDIATE FAMILY MEMBERS-MOTHER, FATHER, SISTER, BROTHER, AUNTS OR UNCLES (PLACE A CHECK NEXT TO ALL THAT APPLY)

___ HIGH BLOOD PRESSURE	___ HEART DISEASE	___ HEART ATTACKS	___BLEEDING PROBLEMS
___ STROKE	___ PNEUMONIA	___ ASTHMA	___ EMPHYSEMA
___ TUBERCULOSIS	___ MIGRAINES	___ PHLEBITIS	___ CELLULITIS
___ LIVER DISEASE	___ HEPATITIS	___ AIDS	___ CANCER
___ THYROID DISEASE	___ LEUKEMIA	___ ARTHRITIS	

WHO **REFERRED** YOU TO THE OFFICE TODAY?_____

ADDITIONAL COMMENTS:_____

Review of Systems

Name:_____

Do you now or have you had any problems related to the following systems? Circle Yes or No

Please explain any Yes answers in space provided

Constitutional Symptoms			**Integumentary**		
Fever	Y	N	Skin rash	Y	N
Chills	Y	N	Boils	Y	N
Headache	Y	N	Persistent Itch	Y	N
Other_____			Other_____		
Eyes			**Musculoskeletal**		
Blurred vision	Y	N	Joint Pain	Y	N
Double Vision	Y	N	Neck Pain	Y	N
Pain	Y	N	Back Pain	Y	N
Other_____			Other_____		
Allergic/Immunologic			**Ear/Nose/Throat/Mouth**		
Hay Fever	Y	N	Ear Infection	Y	N
Drug Allergies	Y	N	Sore Throat	Y	N
Other_____			Sinus Problems	Y	N
			Other_____		
Neurological					
Tremors	Y	N	**Genitourinary**		
Dizzy Spells	Y	N	Urine Retention	Y	N
Numbness/tingling	Y	N	Painful Urination	Y	N
Other_____			Urinary Frequency	Y	N
			Other_____		
Endocrine					
Excessive Thirst	Y	N	**Respiratory**		
Too Hot/Cold	Y	N	Wheezing	Y	N
Tired/Sluggish	Y	N	Frequent Cough	Y	N
Other_____			Shortness of Breath	Y	N
			Other_____		
Gastrointestinal					
Abdominal Pain	Y	N	**Hematologic/Lymphatic**		
Nausea/Vomiting	Y	N	Swollen Glands	Y	N
Indigestion/Heartburn	Y	N	Blood Clotting Problem	Y	N
Other_____			Other_____		
Cardiovascular			**Psychological**		
Chest Pain	Y	N	Are you generally satisfied with your life?	Y	N
Varicose Veins	Y	N	Do you feel severely depressed?	Y	N
High Blood Pressure	Y	N	Have you considered suicide?	Y	N
Other_____			Other_____		

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 – 9	3
10+	4 or 5

Physician:_____ **Date:**_____ /_____/____

NAZHA CANCER CENTER
OUR FINANCIAL POLICY

Thank you for choosing Nazha Cancer Center as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read, and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE, if you do not have any insurance. Payment may be made by cash or check.

Regarding Insurance: We accept assignment of insurance benefits. You are responsible for any co-pays, co-insurance and deductibles and for payment of any non-paid amounts as per your insurance company. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Regarding Insurance Plans where we are a participating provider, all co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, please refer to the above paragraph. If your insurance company does not cover the nature of your medical problem you are responsible for payment of bills related to that non-covered medical problem. You are responsible for informing the office immediately upon enrolling in a hospice program or skilled nursing facility, due to the fact that entering these programs causes payment denials for office visits and procedures. You will be responsible for any denied claims stemming from not informing us of your enrollment in these programs.

If your insurance company requires you to obtain a referral from your primary care physician in order to see the Specialist, please follow the following procedures to avoid non-payment of your bill by your insurance company.

1. The patient is responsible for obtaining any necessary referrals before the Specialist may see you as a patient.
2. As per your insurance company, if you do not have the proper referral when you go to a Specialist appointment, we must reschedule your appointment since your insurer will deny payment on all claims not having a proper referral.
3. The patient is always responsible for keeping track of how many visits to a Specialist each referral will cover. New updated referral and the obtaining thereof is always the patient's responsibility.
4. Please have your referral sent, faxed or brought to the office with you at time of visit.

Missed Appointments: Please notify us if you are unable to keep your appointment. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please understand that we are abiding by the rules and regulations of your insurance company. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X_____ Date:_____
Signature of Patient or Responsible Party

X_____ Date:_____
Signature of Co-Responsible Party

Patient Copy

NAZHA CANCER CENTER NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Information may be shared among members of the practice where necessary to provide treatment to the patient, obtain payment for the treatment and carry on routine business operations for the practice. (TPO)

In addition, the practice may disclose PHI (Protected Health Information) without patient consent or authorization to further certain public policy objectives including:

- Where disclosure is required by law;
- For a judicial or administrative proceeding;
- For public health activities;
- For health oversight activities:
- To report incidents of abuse, neglect or domestic violence;
- For law enforcement purposes;
- To avert a serious threat to health and safety;
- For national security and intelligence activities and protective services;
- For certain military and veterans activities and benefits;
- For health, safety and security of prison inmates or other detainees;
- To facilitate organ, eye or tissue donation, and
- Coroners, medical examiners, and funeral director.

By law, our practice must have your written permission (authorization) to use or give out your personal medical information for any purpose that is not stated in this notice.

Patients' Privacy Right Under HIPAA

The privacy regulations grant patients' the following rights regarding their PHI (Protected Health Information):

- The right to Notice of Practice's Privacy Practices for PHI;
- The right to inspect and copy their PHI;
- The right to request amendment or correction of their PHI;
- The right to receive an accounting list that provides information about disclosures of their PHI that were made to third parties for purposes other than treatment, payment and health care operations and other than those disclosures that were authorized by the individual;
- The right to request that the practice further restrict the way it uses or discloses their PHI;
- The right to request that the practice communicate with them by alternative means or at alternate locations. The practice will do their best to accommodate all reasonable requests.

If you believe our practice has violated your privacy rights as indicated in this notice, you may file a complaint with our practice in writing or call out office and ask to speak to our Compliance Officer. No one will retaliate or take action against you for filing a complaint.

NAZHA CANCER CENTER
NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____

Social Security Number:_____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Nazha Cancer Center

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address:

_____

_____

Telephone:

_____(daytime)

_____(evening)

HIPPA COMPLIANCE
AUTHORIZATION TO USE AND/OR DISCLOSE CONFIDENTIAL INFORMATION

INTRODUCTION: This authorization gives Naim T. Nazha, M.D., P.C. d/b/a Nazha Cancer Center and its employees and agents (the "Practice") permission to use and/or disclose health information about you, including the release of medical records.

You may refuse to sign this authorization. If you refuse to sign this authorization, it will not affect your ability to obtain treatment by the Practice, but you will not receive research-related treatment if you do not authorize use or disclosure of information for purposes of the research, and you will not receive health care intended for the purpose of evaluation by a third party (such as your employer or state agencies in connection with a workers' compensation claim) if you do not authorize use by or disclosure of the information to that party.

You have a right to revoke this authorization. You may revoke this authorization at any time in writing except to the extent that we already have relied on it. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:

Naim T. Nazha, M.D., P.C., 411 New Road, Northfield, NJ 08225 Attn: Privacy Officer

Re-disclosure of Information. Health information disclosed pursuant to this authorization may be subject to re-disclosure if it is not otherwise protected by the federal privacy rule or another privacy law.

PATIENT NAME: _____ **Date of Birth:** _____

Home Address: _____ **Home Telephone:** _____

1. COVERED HEALTH INFORMATION. This is a specific description of the health information to be used and/or disclosed:

_____

_____

In the event that any of the foregoing information contains genetic information, venereal disease-related records, tuberculosis-related records, mental health records (other than psychotherapy notes), drug and alcohol treatment records and/or HIV/AIDS-related diagnosis and treatment information (i.e., information regarding any HIV-related test, infection or illness including AIDS), I also authorize release of such information. (strike if not authorized)

2. PERSONS ENTITLED TO INFORMATION. Name of the person(s), or class of persons, to whom the Practice may disclose my health information and, if applicable, **the address** to which I instruct the Practice to send that information:

_____

_____

3. PURPOSE OF REQUESTED USE OR DISCLOSURE *(complete one item)*:

□ I have initiated this Authorization and do not elect to provide a statement of purpose other than that the use and/or disclosure is at my request.

□ The purposes of the requested use and/or disclosure are the following:

_____

4. EXPIRATION *(complete one item)*:

□ This Authorization shall be in force and in effect until: _____
(enter specific date of expiration of this authorization or write "NONE" for no expiration. You may revoke this authorization at any time as mentioned above)

AGREEMENT: I have read (or have had read to me) this Authorization and understand its terms. I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I knowingly and voluntarily authorize Naim T. Nazha, M.D., P.C. and its employees and agents to use and/or disclose my health information in the manner described in this Authorization.

Signature: _____ _____
PATIENT DATE

Printed Name: _____
PATIENT

NAZHA CANCER CENTER
PATIENT DEMOGRAPHIC INFORMATION

We have been mandated by CMS to inquire as to the following. Please assist us in complying with the federal regulations by completing the questions below.

*Patient Name:*_____ *Date of Birth:*_____

Preferred Language

- ☐ English
- ☐ Arabic
- ☐ Chinese
- ☐ French
- ☐ German
- ☐ Italian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other

Race

- ☐ I do not wish to answer
- ☐ African American
- ☐ Asian
- ☐ Caucasian or White
- ☐ Hispanic
- ☐ Mixed Race
- ☐ Unknown
- ☐ Other

Ethnicity

- ☐ I do not wish to answer
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Unknown

Naim T. Nazha, M.D., P.C.

Medical Oncology - Hematology
411 New Road
Northfield, NJ 08225
Tel: (609) 383-6033 - Fax: (609) 383-0064

Dear Patient or Patient's Family:

Under New Jersey Law (26:2H-62) it is the responsibility of the attending physician to inquire of you whether you have an Advanced Directive for Health Care (Living Will). Please advise us. If you have such a document please provide us with a copy that may be included in your office record in this office. Please advise us of any future changes in this written directive.

It is your right under New Jersey Law to have such a written Advance Directive for Healthcare. Should you desire more information about this please inquire of us and we will provide information.

Kindly acknowledge by signing below that we have fulfilled our obligation to notify you. Note that this paper is <u>not</u> in anyway binding, is <u>not</u> a living will and has nothing at all to do with your regular will.

ACKNOWLEDGED BY:

_____ Date:_____
Patient

_____ Date:_____
Family Member if patient is unable to sign

Advanced Directive: Discussed and present_____

Advanced Directive: Discussed and patient refused_____

Advanced Directive: Not discussed, documented or present_____

If none, do you have a surrogate? _____Yes _____No

Name:_____