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

Patient Registration

OLEG SHULIK, M.D.
SAMEET SHAH, D.O.
Verona Gastroenterology

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		
	Referring Doctor		

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

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. Please refer to the Notice of Privacy Practices for complete description of uses and disclosures. I acknowledge that I have received a written Notice of Privacy Practices.

By signing below, I acknowledge that I have received a copy of the Pascack Valley Medical Center Notice of Privacy Practices and that I agree to uses and disclosures described in the Notice of Privacy Practices listed under the section: How We May Use and Disclose Your Health Information.

_____	_____	_____
Patient Name (Print)	Signature	Date

-OR-

_____	_____	_____
Patient Personal Representative (Print)	Signature	Date

Pascack Valley Medical Center Use Only

Date acknowledgement received: _____

Signature of PVC employee: _____

-OR-

Reason acknowledgement was not obtained (declined to sign):

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

Hackensack Meridian
Mountainside
Medical Group

Verbal Disclosure

PATIENT NAME: MRN:

DATE OF BIRTH:

In accordance with the provisions of Section 164.510(b) of the Health Insurance Portability and Accountability Act (HIPAA), I agree that MPV New Jersey MD Services, PC and its duly authorized agents and employees may disclose Protected Health Information directly relevant to involvement with my care, or payment related to my care, to my family members, other relatives, close personal friends or any other individuals that I indicate below who may contact MPV New Jersey MD Services, PC on my behalf.

NAME OF INDIVIDUAL(S) AND RELATIONSHIP: (Please print)
Check the box next to the name to identify the type of information to be disclosed

☐ Medical ☐ Billing _____

☐ Medical ☐ Billing _____

☐ Medical ☐ Billing _____

I understand:

- At any time, I may add or remove individuals from this list by notifying MPV New Jersey MD Services, PC of my desire to do so. I understand that until I notify MPV New Jersey MD Services, PC of requested changes to this list, MPV New Jersey MD Services, PC may rely on this list and disclose information the individuals listed above.
- The authorization to release information to the parties listed above is good for one year from the date below unless you tell us otherwise.

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or non-communicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances *including* disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified. I understand that my medical information may indicate that I have or have not been treated for psychological or psychiatric conditions or substance abuse.

SIGNATURE OF PATIENT DATE

SIGNATURE OF PATIENT REPRESENTATIVE DATE

DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

REVOCATION OF VERBAL DISCLOSURE

I may revoke this permission at any time, in writing, except revocation will not apply to information already disclosed in response to this permission.

Patient/Patient Representative Signature Date Signed/Revocation

PATIENT INFORMATION

Place label here.
Scanning does NOT work if label is outside this guide.

Hackensack Meridian
Mountainside
Medical Group

GENERAL CONSENT FOR CARE AND ACKNOWLEDGEMENT OF RECEIVING INFORMATION

GENERAL CONSENT FOR CARE

I authorize MPV NJ MD Services ("Medical Group"), and the physician(s) participating in my care, to render care for my condition as may be deemed advisable by the physician(s), which may include evaluation and management visits, diagnostic procedures and routine care such intramuscular injections. I understand that no guarantees have been made to me regarding the outcome of this care or my condition.

INDEPENDENT PHYSICIANS

I understand that some of the physicians who will participate in my care and treatment are NOT employees of the medical group. This includes physicians who are assigned to my care and whom I have not independently selected. Examples of the physicians who may be assigned to my care but are NOT employees, agents or servants of the Medical Group include, but are not limited to: Anesthesiologists, Radiologists and Laboratory Services (Pathologists). I further understand and agree that the Medical Group is not responsible for the judgement or conduct of these physicians providing medical services at the Medical Group.

I understand that the fees charged by the medical group may not include fees charged by my treating physician(s). I understand that I may be billed directly by my treating physician(s). I understand that it is my responsibility, and NOT the responsibility of the Medical Group, to determine the extent of my insurance coverage for treatment proposed or rendered by any physician(s) at the Medical Group.

RELEASE OF PROTECTED HEALTH INFORMATION

I understand that my medical records will be maintained in the Epic Electronic Health Records ("EHR") system. I understand and agree that my information may be accessed by another facility or provider who participates in our EHR system for purposes of my treatment, as well as for purposes of system operations and management, and evaluating and improving patient care.

I have received and read a copy of the Notice of Privacy Practices for Protected Health Information ("the Notice"). This Notice provides a description of the Medical Group's potential uses and disclosures of my Protected Health Information ("PHI"). I authorize the Medical Group and/or any physician(s) participating in my care to release my PHI (either in writing or verbally) for the purposes of my continuing care to any person, corporation and/or government agency that is or may be responsible to satisfy all or part of the Medical Group's charges or who may be required to pre-certify or verify admission and/or treatment. I authorize the Medical Group to verify my address through the Federal Credit Reporting System and I understand that the Medical Group may be required to release my PHI to federal and state agencies that monitor physician practices.

I understand that the Medical Group participates in Jersey Health Connect and I consent to the Medical Group sharing my PHI with Jersey Health Connect. I understand that Jersey Health Connect is a Health Information Exchange (HIE) that allows the Medical Group to share my health information among participating providers including, but not limited to, physicians, hospitals, labs, radiology centers, and other healthcare providers through secure, electronic means. I understand that the purpose of the HIE is to allow my healthcare providers to have access to the most recent information available in order to facilitate my care. I understand that I may not wish to participate in Jersey Health Connect and that I may opt out at any time by completing one of the following steps:

Call toll free: 1-609-945-1183
Go to www.jerseyhealthconnect.org/patient/opt-out/ and print off your opt-out form. Then mail your completed opt-out form to the following address:

Jersey Health Connect
P.O. BOX 261
Oldwick, NJ 08858

Fax a completed opt-out form to: 1-609-945-5315

PRECERTIFICATION REQUIREMENTS

I understand and agree that if I do not comply with my insurance coverage referral to specialist requirements or if any service is not approved , then I may not be entitled to insurance benefits, and in that event, I will be responsible for any and all physician charges at its standard rates.

ASSIGNMENT OF BENEFITS

I hereby certify that the information given to the Medical Group regarding my health insurance and/or other form of health benefits, and the information provided regarding the coordination of my benefits (if I hold coverage under more than one policy) is accurate and current to the best of my knowledge.

I hereby designate the Medical Group as my authorized agent in all matters arising under a claim for benefits from any coverage source for any and all medical care provided to me and for all related expenses incurred. I therefore assign to the Medical Group all of my rights, benefits, privileges, protections, claims, causes of action, interests of recovery, to any and all rights, benefits, privileges, protections, claims, causes of action, interests, or recovery of any type whatsoever receivable by me or on my behalf arising out of any policy of insurance, plan, trust, fund, or otherwise providing healthcare coverage of any type to me (or to any third party responsible for me for the charges for services rendered to me by the Medical Group. This includes, without limitation, any private or group health/hospitalization plan, automobile liability, general liability, personal injury protection, medical payments, uninsured or underinsured motor vehicle benefits, settlements/judgments/verdicts, self-funded plan, trust, workers compensation, MEWA, collective, or any other third-party payer providing healthcare coverage of any type to me (or to another third party responsible for me) for the charges for services rendered to me by the Medical Group (collectively, "coverage source"). This is a direct assignment to the Medical Group of any and all of my rights to receive benefits arising out of any coverage source. I understand that this assignment of benefits is irrevocable. This assignment of benefits fully and completely encompasses any legal claim I may have against any coverage source, including, but not limited to, my rights to appeal any denial of benefits on my behalf, to request and obtain plan documents, to pursue legal action against any coverage source, and/or to file a complaint with the state department of banking and insurance.

FINANCIAL AGREEMENT

I hereby authorize and direct that payment of all benefits, payments, monies, checks, funds, wire transfers or recovery of any kind whatsoever from any coverage source be made to the Medical Group and I agree to assist the Medical Group in pursuing such payments from any coverage source. This includes without limitation, signing documents as required to pursue claims and appeals, obtaining document/information from the coverage source, or otherwise to support payment to the Medical Group. I further agree that any payments of any kind for services provided by the Medical Group that is received by me (or received by any other third party responsible for me) will be turned over immediately to the Medical Group, through whatever means necessary. This includes, without limitation, me, and if needed any guardian, endorsing any checks and/or other documents to the Medical Group. I also understand that if I fail to turn over to the Medical Group any such payments received by me (or by a third party responsible for me), I will be financially responsible to the Medical Group for the full amount of such payments, and I may be subject to civil or criminal prosecution to the fullest extent of the law.

If monies paid by me or on my behalf result in a credit balance in my favor I authorize and direct that the Medical Group apply such monies toward any unpaid balance owing and due by me on any accounts held by the Medical Group or by any of our affiliated entities, and clinicians. I understand that my current or future care is not dependent upon this authorization, and that if in the future I wish to dispute my obligation on any account and do not want that account to be subject to transfer of funds that I must expressly and unequivocally communicate that position to the Medical Group and/or affiliate in a timely manner.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand I am financially responsible for deductibles, coinsurance, and all services not covered by insurance benefits and/or entitlements. I understand that if the Medical Group or any of its affiliates are out-of-network with my insurance plan, then my financial responsibility may include: (1) higher coinsurance and deductible amounts; and (2) the Medical Group's full charges, including the amount that exceeds the allowable charges of an in-network preferred provider.

I understand that I am financially and legally responsible for charges not covered in full by the assignment of benefits described in the preceding sections, including, but not limited to, any deductibles, copayments, and coinsurance amounts provided under any coverage source; and charges for which there is no coverage source. I further agree that should I not pay any balance for which I am legally responsible as set forth in this section within thirty (30) days after the date of discharge, my account will be considered delinquent. I agree to pay any costs incurred by the Medical Group to collection any delinquent amounts, including reasonable attorney's fees and costs, collection agency fees and costs, and interest which shall accrue at the maximum rate allowed by law. The undersigned acknowledges understanding and agrees that a credit balance of $24.99 and less will not automatically be refunded but shall only be refunded upon explicit request

MEDICARE PAYMENT REQUEST

I certify that the information given by me in applying for payment under Tile XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services or authorize a physician or organization to submit a claim to Medicare for payment.

I understand that this consent shall operate as a complete release of liability in favor of the Medical Group, its agents, servants and employees and my physician(s) for the release of information as stated above.

CONSENT TO CONTACT

TELEPHONE CONSUMER PROTECTION ACT CONSENT DISCLOSURE - Consent to Email, Telephone Calls and Text Messages for Appointment Reminders, Healthcare Information, Discharge Instructions, Account and Billing Communications, and Other Communications.

By providing my telephone number (whether landline or wireless) and/or email address to the Medical Group , I expressly consent that the Medical Group and its employees and agents may contact me by telephone, short message services (SMS), or text at any telephone number (whether landline or wireless) I have provided to the Medical Group or, at any number forwarded or transferred from that number regarding any matter that is related to my treatment, my account, and/or the Medical Group's services, including, but not limited to the following:

> my treatment, my condition and plan of care, the services rendered, patient surveys, discharge instructions, communication made to me or related to my account, or my related financial obligations including, but not limited to, payment reminders, delinquent notifications, instructions and links to patient billing information, and other healthcare communications including, but not limited to, notification and reminders of appointments, notification and reminders that certain medications are ready for pick-up, information about programs or services that might be of interest to me, information about insurance coverage/eligibility, information about referrals, and information about available treatment options and capabilities

These communications may be transmitted by or on behalf of the Medical Group and its employees and agents using pre-recorded/automated voice messages, use of an automatic dialing device, or other technologies. I understand that providing my prior express written consent to receive such communications is not a condition of receiving services or care from the Medical Group. I understand that I will be able to change my preference at any time. This can be done via your MyChart account under Your Menu, then Accounting Settings, then Personal Information, or by contacting patient access/registration or your physician's office.

PHOTOGRAPHY

I hereby authorize the use of photography during my routine care, if ordered by my physician for the purposes of documenting treatment, diagnosis, condition identification and/or response to treatment.

AUTHORIZATION FOR SPECIFIC BLOOD TESTING

I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not limited to, Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I acknowledge that I have received an explanation of the HIV and Hepatitis B and C infections and meanings of the possible test results. I have been given the opportunity to ask questions and I understand that declining testing will not affect my care. I understand and agree that the results of the blood test(s) will be released to me and to any qualified personnel directly involved in my diagnosis or treatment. If test results are positive for HIV, the results will also be provided to the New Jersey Department of Health and Senior Services as required by law. I authorize my test results to be provided to the Occupational Medicine Service and to any healthcare provider (including a student, volunteer or physician) or first responder (including an emergency medical service worker or police officer) exposed to my blood or bodily fluids that makes a request for testing and the results of such testing. To the extent possible, these results will be provided to the healthcare provider or first responder without disclosing my name. I understand that in addition to the information provided to me concerning HIV and Hepatitis B and C, additional information and counseling are available through my physician.

PERSONAL VALUABLES

I understand that the Medical Group is not responsible for the loss of or damage to any personal property. I accept full responsibility for any personal property that I elect to keep in my possession.

COPAY REQUEST

A copay has been requested of me because I will be paying for all and/or part of the hospital bill. I understand that the hospital's acceptance of partial payment does not relieve me of my responsibility for the full amount.

I have read this form in its entirety, all of my questions have been answered, I understand the content of this form and agree to all of its content.

_____ _____

Signature of Patient | Date and Time

_____ _____

Signature of Person Signing on Behalf of Patient | Date and Time

_____ _____

Printed Name of Person Signing on Behalf of Patient | Relationship

_____

Reason Patient Is Unable to Sign

_____ _____

Signature of Witness (Hospital Employee) | Date and Time

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OLEG SHULIK, M.D.
SAMEET SHAH, D.O.
Verona Gastroenterology

YOUR MEDICAL HISTORY Date_____

Patient Name: _____ DOB: _____ Age: ___
(First) (Last)

Reason for visit: _____

_____

_____

Condition	Yes	No	**Condition**	Yes	No
DIGESTIVE SYSTEM	**Click box if YES**		***LIVER DISEASE (Continued)***	**Click box if YES**	
Difficulty Swallowing			Water in the Abdomen		
Painful Swallowing			Change in Stool Color		
Choking on Food			Receive Blood Transfusions before 1992		
Heartburn			Lupus		
Belching or Excess Gas			Liver Transplant		
Hiatal Hernia			***HEART DISEASE***		
Ulcer Disease			Chest Pain		
Nausea			Palpitation		
Vomiting			Heart Valve Disease		
Vomiting Blood			Irregular Heart Beat		
Rectal Bleeding			History of Heart Attack		
Black Stool			Heart Failure		
Abdominal Pain/Pressure			Difficulty in Breathing		
Pelvic Pain/Pressure			Hypertension		
Diarrhea			Pacemaker		
Constipation			Coronary bypass Surgery		
Unexplained Weight Loss			Angioplasty/Stent		
Unexplained Weight Gain			Do you take blood thinners?		
Hepatitis			Poor Circulation to Extremities		
Diverticulosis			***LUNG DISEASE***		
Colon Polyps			Difficulty in Breathing		
Colitis			Coughing		
Crohn's Disease			Chronic Bronchitis		
Pancreatitis			Emphysema		
LIVER DISEASE			Pneumonia		
Hepatitis A			Lung Cancer		
Hepatitis B			Asthma		
Hepatitis C			Wheezing		
Cirrhosis			***GENITOURINARY DISEASE***		
Iron Overload			History of Urinary Tract Infection		
Fatty Liver			Kidney Stones		
Liver Cancer			Blood in Urine		
Jaundice			Failing Kidney		
Gall Stones			Prostate Problems (Males)		
Bile Duct Obstruction			Frequent Urination		
Skin Itching			Dropped Bladder		
Intravenous drug use			Urinary Incontinence		

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Condition	Yes	No
NEUROPSYCHIATRIC	**Click box if YES**	
Headaches		
Convulsions		
Migraine		
Loss of Consciousness		
Numbness of Nerves		
Dizziness		
Depression		
Anxiety		
RENAL DISEASE		
Kidney Failure		
Dialysis/Hemo/Peritonial		
MUSCULAR / SKELETAL		
Joint Pain		
Joint Swelling		
Rheumatoid Arthritis		
Osteo Arthritis		
Back Pain		
Muscle Pain		
Spine or Disc Surgery		
ENDOCRINE DISEASE		
Diabetes		
Thyroid disorder		

FAMILY HISTORY

(Please indicate if mother or father's side)

Type of Disease	**Relationship**	**Age of Diagnosis**	**Age, if Deceased**
Colon cancer			
Colon Polyps			
Gastric Cancer			
Liver Cancer			
Breast Cancer			
Ovary Cancer			
Uterine Cancer			
Cervical Cancer			
Liver Disease			
Diabetes			
Ulcerative Colitis			
Celiac Disease			
Crohn's Disease			
Pancreatic Cancer			

Other significant family history, please explain:

_____

_____

_____

_____

_____

_____

HOSPITALIZATION HISTORY (recent inpatient/ER visit)

Date	Hospital/Type of Admission

PAST MEDICAL HISTORY

Please describe your current symptoms or complaints in this area. Also include any significant past medical history such as high blood pressure, diabetes mellitus, asthma, heart disease, or emphysema.

_____

_____

_____

_____

_____

_____

_____

_____

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PAST SURGICAL HISTORY

TYPE OF SURGERY	DOCTOR	YEAR	HOSPITAL

Other: _____

Did you have any of the following GASTROINTESTINAL procedures in the past?

Click circle if YES

		When	Where	Doctor
1) Colonoscopy	◯Yes ◯No			
2) Endoscopy	◯Yes ◯No			
3) Liver Biopsy	◯Yes ◯No			
4) ERCP	◯Yes ◯No			
5) CAT Scan(Abdomen)	◯Yes ◯No			
6) Ultrasound(Abdomen)	◯Yes ◯No			
7) Upper GI Barium X-Ray	◯Yes ◯No			
8) Small Bowel Barium X-Ray	◯Yes ◯No			
9) Barium Enema	◯Yes ◯No			
10) MRI Abdomen(MRCP)	◯Yes ◯No			

MEDICATION - Prescribed and Over the Counter (include vitamins, herbal medications,probiotics,etc)
(if you have a printed list with you, please give a copy to the front desk)

Name	Dosage	How Often?	How Long?	Name	Dosage	How Often?	How Long?

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL WORK? ◯**YES** ◯**NO**

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SOCIAL HISTORY

Approximate Daily Caffeine Intake: (includes soda, tea, coffees) _____

Click circle if YES

Smoking: Y ◯ N ◯ How Much? _____ How Often? _____
years ____ If quit, when? _____

Alcohol: Y ◯ N ◯ How Much? _____ How Often? _____
years ____ If quit, when? _____

Drugs: Y ◯ N ◯ How Much? _____ How Often? _____
(including marijuana) # years ____ If quit, when? _____

Recent Travel: Y ◯ N ◯ Where? _____

FEMALES ONLY: Last menstrual period:_____ Last Mammogram: _____
Last pap smear:_____

ALLERGY HISTORY

Are you allergic to any of the following?

Medication

Y ◯ N ◯

Name of Medication	Reaction (i.e. rash, hives)	Name of Medication	Reaction (i.e. rash, hives)

Food

Y ◯ N ◯

Type of Food	Reaction (i.e. rash, hives)	Type of Food	Reaction (i.e. rash, hives)

IVP/CAT Scan dye Y ◯ N ◯ Reaction? _____

Latex Y ◯ N ◯ Reaction? _____

Lactose Intolerance Y ◯ N ◯ Reaction? _____

Dust/Mold/Pollen Y ◯ N ◯ Reaction? _____

Other Allergies:_____

YOUR HEALTHCARE PROVIDERS

Family Doctor: _____ Lung Specialist: _____

Cardiologist: _____ Other: _____

Signature _____ Date: _____

For Official Use Only

Reviewed by: Dr. Shulik / Dr. Shah