RUTGERS
New Jersey Medical School

Division of Child Neurology
Neurological Institute of New Jersey
New Jersey Medical School
Rutgers, The State University of New Jersey
90 Bergen Street, Suite 5200
Newark, NJ 07101-1709

www.njms.rutgers.edu

973-972-7151
Fax: 973-972-5059

TODAY'S DATE / DATE OF FIRST APPOINTMENT _____

PATIENT INFORMATION

PATIENT NAME _____
LAST FIRST

PRIMARY ADDRESS _____

_____
CITY STATE ZIP CODE

HOME PHONE: (_____)_____ CELL PHONE (_____)_____

SEX: ☐ Male ☐ Female CURRENT AGE _____ BIRTHDATE_____

RACE_____ PATIENT SS#_____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN 1: RELATIONSHIP TO PATIENT: _____

FIRST PARENT/GUARDIAN'S NAME: _____
LAST FIRST

BUSINESS ADDRESS _____

OCCUPATION_____YEARS EMPLOYED_____ BUSINESS PHONE (____)_____

CELL PHONE: (_____)_____ E-MAIL _____

HOME ADDRESS (or ☐ *Check here if same as patient*) _____

_____
CITY STATE ZIP CODE

PARENT/GUARDIAN 2: RELATIONSHIP TO PATIENT: _____

SECOND PARENT/GUARDIAN'S NAME: _____
LAST FIRST

BUSINESS ADDRESS _____

OCCUPATION_____YEARS EMPLOYED_____ BUSINESS PHONE (____)_____

CELL PHONE: (_____)_____ E-MAIL _____

HOME ADDRESS (or ☐ *Check here if same as patient*) _____

_____
CITY STATE ZIP CODE

PHARMACY

NAME OF PHARMACY: _____

PHONE NUMBER: (_____)_____

PHARMACY ADDRESS _____

_____
CITY STATE ZIP CODE

REFERRING AND PRIMARY CARE PHYSICIAN INFORMATION

REFERRING PHYSICIAN

LAST/FIRST NAME _____

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PRIMARY ADDRESS _____

_____

CITY STATE ZIP CODE

TELEPHONE # (_____)_____ FAX # (_____)_____

PRIMARY CARE PHYSICIAN ☐ *Check here if Primary Care Physician is same as Referring Physician*

LAST/FIRST NAME _____

PRIMARY ADDRESS _____

_____

CITY STATE ZIP CODE

TELEPHONE # (_____)_____ FAX # (_____)_____

INSURANCE INFORMATION

PRIMARY INSURANCE ☐ *Check here if patient is the primary insurance / responsible party.*

NAME OF PERSON RESPONSIBLE FOR ACCOUNT _____

LAST FIRST

RESPONSIBLE PARTY'S BIRTHDATE _____ RESPONSIBEL PARTY'S SS# _____

RELATIONSHIP OF RESPONSIBLE PARTY TO PATIENT _____

INSURANCE COMPANY _____

MEMBERS ID# _____ GROUP # _____

INSURANCE CLAIMS ADDRESS _____

_____

CITY STATE ZIP CODE

MEMBER/CUSTOMER SERVICE NUMBER (*usually on back of card*): (_____)_____

SECONDARY INSURANCE ☐ *Check here if NO secondary insurance*

NAME OF PERSON RESPONSIBLE FOR ACCOUNT _____

LAST FIRST

RESPONSIBLE PARTY'S BIRTHDATE _____ RESPONSIBEL PARTY'S SS# _____

RELATIONSHIP OF RESPONSIBLE PARTY TO PATIENT _____

INSURANCE COMPANY _____

MEMBERS ID# _____ GROUP # _____

INSURANCE CLAIMS ADDRESS _____

_____

CITY STATE ZIP CODE

MEMBER/CUSTOMER SERVICE NUMBER (*usually on back of card*): (_____)_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressively agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or

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dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____
(NAME OF INSURED) (NAME OF INSURANCE COMPANY)
to pay and hereby assign directly to Dr. Jeffrey Kornitzer and the Neurological Institute of New Jersey all benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dr. Lisa Ford, Dr. Caroline Hayes-Rosen, Dr. Jeffrey Kornitzer, Dr. Jayoung Pak, Dr. Sue X. Ming, will be credited to my account, in accordance with the above said assignment.

_____ _____
(AUTHORIZED SIGNATURE) (DATE)

_____ _____
(PRINTED NAME OF PERSON SIGNING) (RELATIONSHIP TO PATIENT)

IS PATIENT A MINOR (UNDER 18 YEARS OLD)? ☐ Yes ☐ No

For Office Use Only

_____ _____
(SIGNATURE OF INDEPENDENT WITNESS) (DATE)

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NEW JERSEY MEDICAL SCHOOL / NEUROLOGICAL INSTITUTE OF NEW JERSEY ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICE

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask us to correct that record. We will not reveal your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contracting our office's Practice Administrator/ Manager.
Our Notice of Privacy Practices describes more in detail how your health information may be used and revealed, and how you can obtain your information.

** You May Refuse to Sign This Acknowledgement **

I,_____, have received a copy of this Office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (*please specify*)

_____

_____

_____

Employee's Signature_____ Date _____

NEW JERSEY MEDICAL SCHOOL / NEUROLOGICAL INSTITUTE OF NEW JERSEY AUTHORIZATION FOR RELEASE OF INFORMATION

For Office Staff: Reviewed by: _____ Date: _____

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1. I hereby request and authorize Neurological Institute of New Jersey to release information from the health record(s) of:

PATIENT NAME _____
LAST FIRST

BIRTHDATE _____ PATIENT SS# _____

I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV).

2. The requested information is to be sent to my child's school:

SCHOOL NAME _____

SCHOOL ADDRESS _____

_____
CITY STATE ZIP CODE

TELEPHONE # (_____)_____ FAX # (_____)_____

3. The information to be released is and the records to be sent include:

- ☑ Copy of medical records
- ☑ Physical Examinations
- ☑ Lab Tests

4. Purpose/reason for release of records:

- ☑ School / Academic

5. I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.

6. I understand that my treatment is not conditioned on obtaining this authorization.

7. I understand that this authorization is specific for release only to the above party and expires one year (365 days) following the date of signature.

8. I understand that information used or disclosed may no longer be protected by the federal privacy laws.

9. I understand that I can be charged for obtaining copies of my records according to the fee schedule established in the New Jersey Administrative Code.

10. If the requested information involves mental health information, I acknowledge that I am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed psychologist and that release of such information may waive this privilege. 11. I understand if this authorization is for marketing purposes that Rutgers may receive direct or indirect compensation.

** You can refuse to sign this form. **

_____ _____
(AUTHORIZED SIGNATURE) (DATE)

_____ _____
(PRINTED NAME OF PERSON SIGNING) (RELATIONSHIP TO PATIENT)

For Office Staff: Reviewed by: _____ Date: _____