



## New Patient Information Form (Page 1 of 3)

Today's Date:

Title: ☐ Ms. ☐ Miss ☐ Mrs. ☐ Mr. ☐ Dr.

Last Name:

First Name:

Middle Initial:

Suffix:

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth:

Race: ☐ African American ☐ Caucasian ☐ Asian ☐ Hispanic ☐ Other ☐ Declined

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Declined

Primary Language: ☐ English ☐ Spanish ☐ Polish ☐ Italian ☐ Other

Does your insurance require you to select a primary care provider? ☐ Yes ☐ No

If yes, who did you select?

Home Street Address:

Zip Code:

City:

State:

Home Phone #:

Mobile Phone #:

Work Phone #:

## New Patient Information Form (Page 2 of 3)

If we have to reach you by phone, what is the preferred order for us to call you? Please fill 1, 2, 3 in front of the phone type.

\_\_\_\_\_ Home Phone

☐ OK to leave messages on the home phone with detailed medical information

☐ DO NOT leave a detailed message on the home phone, leave call-back number

\_\_\_\_\_ only Cell Phone

☐ OK to leave messages on the home phone with detailed medical information

☐ DO NOT leave a detailed message on the cell phone, leave call-back number

\_\_\_\_\_ only Work Phone

☐ OK to leave messages on the home phone with detailed medical information

☐ DO NOT leave a detailed message on the work phone, leave call-back number only

Email Address:

**Preferred Contact Method** When we need to contact you about non urgent health care matters, how should we reach you? (check one):

☐ Secure email via the Patient Portal (recommended) ☐ Phone ☐ Email

**Preferred Reminder Method** How would you prefer to be contacted about appointment and health care reminders? (check one):

☐ Cell phone ☐ Home Phone ☐ Office Phone ☐ Mail

**Do you have a Living Will / Advance Directive?** ☐ Yes ☐ No (If yes, please give us a copy)

**Referred by** (check one): ☐ Friend ☐ Family ☐ Established Patient ☐ Health Plan Listing

☐ Internet Search ☐ Brochure/Direct Mail ☐ Yellow Pages ☐ Newspaper

## New Patient Information Form (Page 3 of 3)

### Emergency contact:

Name:

Phone 1:

Phone 2:

Relationship:

### Your local pharmacy:

Name:

Street:

Town:

### Your mail away pharmacy (if you have one):

Name:

Phone:

Fax:

Signature: \_\_\_\_\_





## Health History Form (Page 1 of 3)

**Past Medical History** Please circle any health problems you have had in the past or presently have. Feel free to add any notes below.

Heart problem	High blood pressure/hypertension
Elevated cholesterol	Blood clots or bleeding problem
Other heart or circulatory problems	Seasonal or environmental allergies
Asthma	Sleep apnea
Pneumonia	Other lung or breathing problems
Colitis	Reflux/GERD/chronic heartburn
Ulcers	Gallbladder
Hepatitis	Polyps
Other stomach or bowel problems	Cancer
Arthritis	Gout
Depression	Anxiety
Other emotional problems	Alcohol or substance abuse
Kidney disease	Prostate problems or BPH
Sexual dysfunction or erection problems	Urinary incontinence
Over or underactive thyroid	Other thyroid problems
Diabetes	Osteoporosis or low bone density
Fractures	Anemia
Other blood disorders	Seizures
Stroke	Migraines
Other chronic headaches	Dementia
Other nerve or neurological problems	Vision or hearing problem

### Surgeries:

Date or Year	Type of Surgery	Notes or Reason for Surgery



## Health History Form (Page 2 of 3)

### Other Hospitalizations:

Date or Year	Hospital	Reason for Hospitalization and any notes

### Family History:

	Father	Mother	Siblings	Children	Grand- parents	Other Relatives	Notes
<i>If deceased, what was the age of death</i>							
<i>If deceased, what was the cause of death</i>							
Anemia							
Asthma or allergies							
Bleeding or clotting tendency							
Cancer							
Diabetes / sugar							
Epilepsy (seizures, convulsions)							
Heart disease							
High blood pressure							
Kidney disease							
Mental or nervous disorder / suicide							
Alcohol or drug problem							
Migraines							
Osteoporosis							
Stroke							
Thyroid problem							
Sudden/unexplained death before age 60							



## Health History Form (Page 3 of 3)

### Exercise:

Do you exercise? ☐ Yes ☐ No

If yes, what do you do for exercise?

How long do you exercise for, and how often?

### Smoking History:

☐ Never smoked

☐ Smoked in past

☐ Currently smoke: ☐ cigarettes ☐ pipe ☐ cigars

How much?

### Alcohol Use:

☐ Non-drinker ☐ In AA

☐ Infrequent

☐ 1 - 2 drinks a week

☐ Daily How many per day on average?

☐ Other: I usually drink about \_\_\_\_\_ drinks, \_\_\_\_\_ times a week.

☐ What type of alcohol? ☐ beer ☐ wine ☐ liquor



## **Patient Financial Policy Agreement**

- I will present proof of Insurance coverage at every visit.
- I understand it is my responsibility to be educated about the benefits and limitations of my Insurance policy.
- I understand my insurance policy is a contract between me and my insurance company. In the event they do not pay for services rendered to me which may include vaccinations, injections and durable medical goods, I am financially responsible for payment for those services.
- I understand that my account may be sent to a professional collection agency if payment is not rendered within 90 days from the billing date and in that event my relationship with Vanguard may be terminated.
- I understand that if I disagree with any charges or would like to request an adjustment be made on my invoice or claim, I must contact the billing office in writing within 30 days of the billing date.
- I understand that it is my responsibility to provide Vanguard with any information necessary to be paid for services rendered to me or anyone covered under my insurance policy or I will be responsible and will pay the balance in full.

### **AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Vanguard to apply for benefits on my behalf for covered services rendered by my family physician, or by his/her order. I request that payment from my insurance company be made directly to Vanguard (or to the party who accepts assignment),

I certify that the information I have reported with regard to my insurance coverage is correct. I agree and accept the terms of the Vanguard Financial Policy.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing,

Date \_\_\_\_\_

Signature (Patient/Gaurdian) \_\_\_\_\_





## **New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations**

I understand as part of my health care, **VANGUARD MEDICAL GROUP**, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that his information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payor can verify that services billed were actually provided, and

I understand that I have the following rights and privileges as:

- The right to review the notice prior to signing this consent.

I understand that VANGUARD MEDICAL GROUP is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that VANGUARD MEDICAL GROUP reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

I have been presented with and understand VANGUARD MEDICAL GROUPS Notice of Privacy Policy as:

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**Patient's Signature**

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**Date**

Patient's **PRINTED NAME** \_\_\_\_\_

If not signed by patient, please indicate your relationship to the patient (parent, spouse) \_\_\_\_\_

### **FOR OFFICE STAFF ONLY**

( ) Consent received by \_\_\_\_\_ on \_\_\_\_\_

( ) Consent refused by patient, and treatment refused as permitted



## Patient Portal Account

PRINT Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

E-mail Address: \_\_\_\_\_

By signing this form, I authorize Vanguard Medical Group (VMG) to communicate via personal, secured-access Patient Portal with me for my medical care and treatment. VMG will provide notices via your personal e-mail that information can be found in your Patient Portal. No personal health information is transmitted via or into your personal e-mail. I understand that the following types of protected health information may be used, disclosed, and retained by the health care providers of VANGUARD MEDICAL GROUP as a result of the communications:

1. My personal health information;
2. Electronic displays of Radiological images (x-rays)
3. Laboratory Test results
4. Pathology reports
5. Other diagnostic tests results

Patients and/or personal representatives who want to communicate with their health care providers by clinic Portal should consider all of the following issues before signing this Authorization.

1. Portal communication is a convenience and **not appropriate for emergencies or time sensitive issues.**
2. Portal messages received at Vanguard Medical Group may be accessible to office staff in the course of their duties supporting the providers.
3. We advise caution when communicating highly sensitive or personal information via Portal messages (ie: HIV status, mental illness, chemical dependency, and workers compensation issues.)
4. Clinically relevant messages and responses will be documented in the medical record
5. VMG will not be liable for information lost or misdirected due to technical errors or failures
6. VMG does not own or have any interest in the Portal website. E-mds Portal is a secure conduit in which communication with our database is managed.

I understand that I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to Vanguard Medical Group. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this authorization. I also understand that Vanguard Medical Group cannot deny or refuse to provide treatment, payment, or medical records if I refuse to sign this Authorization.

I have read and understand the information in this authorization form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## HIPAA Authorization for Use or Disclosure of Protected Health Information

I understand as part of my health care, VANGUARD MEDICAL GROUP originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care/treatment. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or eligibility for benefits unless allowed by law. I understand that I have the right to revoke this authorization, except to the extent that the organization has already taken action in reliance thereon. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information, including disclosure by fax, and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This authorization is valid for one year from the date of signature. I wish to have the following restrictions to the use/disclosure of my health information:

☐ Please send my entire medical record OR ☐ Please send my medical record but exclude the following

- ☐ HIV / AIDS testing, diagnoses, and treatment
- ☐ Sexually Transmitted Disease testing, diagnoses, and treatment
- ☐ Mental Illness diagnoses and treatment
- ☐ Psychotherapy notes
- ☐ Drug or Alcohol Addiction diagnoses and treatment
- ☐ Genetic testing, results, and genetic information about me
- ☐ Other: \_\_\_\_\_

I hereby authorize the release of my medical records concerning my care and treatment. These include but are not limited to the records indicated below:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Emergency Department Report            | <input type="checkbox"/> Hospital Consults          | <input type="checkbox"/> Admission H & P               |
| <input type="checkbox"/> Discharge Summary with Medication List | <input type="checkbox"/> Labs                       | <input type="checkbox"/> ED Report & Hospital Abstract |
| <input type="checkbox"/> Radiology/diagnostic Results           | <input type="checkbox"/> Doctor's Office Evaluation | <input type="checkbox"/> ALL RECORDS                   |

☐ PLEASE FAX/MAIL MY RECORDS TO:

**Vanguard Medical at Verona, NJ**  
**271 Grove Avenue**  
**Verona, NJ 07044**  
**Phone: 201.337.3353 Fax: 973.239.0482**

☐ Please send my records to:

Provider/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

IF SIGNED BY A PATIENT REPRESENTATIVE, INDICATE YOUR RELATIONSHIP TO PATIENT: \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

Vanguard Medical Group

Effective Date: August 1, 2013

### SUMMARY

**WHAT IS THIS NOTICE FOR?** This Notice of Privacy Practices (Notice) describes how Vanguard Medical Group (We or Us) may use and disclose your medical information that we maintain and how you can get access to this information.

**WHO ARE WE?** Vanguard Medical Group is a Family Practice which consists of all employed doctors, nurses, employees and other healthcare professionals. This Notice applies to these individuals as well as all services that are provided to you at our facility/any of our facilities.

**WHY DO YOU NEED THIS NOTICE?** The Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, places certain obligations upon us with regard to how we may use and disclose your **personal health information** (PHI). Your PHI includes medical information about you such as your medical record and the care and services you have received. We are committed to **maintaining the privacy** of your PHI. When we need to use or disclose it, we will comply with the full terms of this Notice. Anytime we are permitted to or required to share your PHI with others, we only provide the minimum amount of data necessary to respond to the need or request unless otherwise permitted by law.

**WHEN CAN WE USE/DISCLOSE YOUR PHI?** There are certain uses and disclosures of your PHI that we may undertake **without your written or other authorization**. These uses and disclosures may be for purposes such as to provide you with treatment, obtain payment for services we have provided, and other health care operations (such as administration, quality improvement, cost studies and other activities designed to improve the care we provide to all our patients). Some other examples include: PHI made known to your relatives, close friends, or caregivers, public health activities and officials, reporting of abuse or neglect as may be required by law, health oversight activities, judicial and administrative proceedings, law enforcement officials, workers' compensation, and other individuals and activities as set forth in this Notice. Individuals who may have access to your information **without your written or other authorization** may include doctors, nurses, health care students, and other hospital staff.

**WE MUST OBTAIN YOUR WRITTEN AUTHORIZATION FOR ANY USE OR DISCLOSURE NOT SET FORTH IN THIS NOTICE.** You may revoke this authorization AT ANY TIME. In addition to obtaining your written authorization for uses or disclosures not described in this Notice, we generally will also need to seek your written authorization or approval prior to disclosing the following information:

- HIV/AIDS related information
- Sexually transmitted disease information
- Tuberculosis
- Psychotherapy notes
- Mental health information
- Drug & alcohol information
- Genetic information

- Any information where you, if a minor, sought emancipated treatment (e.g., care related to your pregnancy or child, sexually transmitted diseases, etc)

We will also seek your **written authorization** for any “marketing” activities we may conduct or where we would receive money for providing a third party with your PHI.

**WHAT RIGHTS DO YOU HAVE FOR YOUR PHI?** You have the right to ask us to limit certain uses and disclosures of your PHI. We will consider ALL requests but may not be *required* to agree to your requested limitations. You also have the right to inspect and receive copies of your PHI, the right to request a change or amendment be made to your PHI, the right to an accounting (a list) of certain disclosures of your PHI, and the right to revoke any authorization you may have made to the extent we have not yet relied upon it. You also have the right to receive a paper copy of this Notice at any time.

**CAN WE CHANGE THIS NOTICE?** We may change this Notice **at any time**. The revised Notice will apply to all PHI that we maintain. However, if we do change this Notice, we will only make changes to the extent permitted by law. We will also make the revised Notice available to you by posting it in a place where all individuals seeking services from us will be able to read the Notice on our web site [www.vanguardmedgroup.com](http://www.vanguardmedgroup.com). You may obtain the new Notice in hard copy as well from our Privacy Office.

**ADDITIONAL INFORMATION/COMPLAINTS.** You may contact our Privacy Office if you wish any additional information or have questions concerning this Notice or your PHI. If you feel that your privacy rights have been violated, you may also contact our Privacy Office OR file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. **We will NOT retaliate against you if you file a complaint with us or the Office of Civil Rights.**

**THE ABOVE IS ONLY A SUMMARY OF THE RIGHTS AND OBLIGATIONS WITHIN THIS NOTICE.  
PLEASE READ CAREFULLY THE ENTIRE NOTICE THAT FOLLOWS.  
WE WELCOME ANY QUESTIONS YOU MAY HAVE.**