ADVANCE MEDICAL GROUP

BOARD CERTIFIED

INTERNAL ME ...DICINE

92 Summit Ave ...e Suite 205
Hackensack, NJ ...07652

ADVANCE MEDICAL GROUP

201-342-0066
www.advancemedgroup.com
Hackensack - Haledon - Paramus

Email the packet to info@advancemedgroup.com please include a copy of your insurance card and photo id

PATIENT INFORMATION

Name_____ SS# _____
Last Name First Name Middle Initial

Address_____ Email _____

City_____State_____Zip _____

Home Phone (____)_____Cell Phone (____)_____

Sex □ M □ F Age____ Birthdate_____ □ Married □ Widowed □ Single □ Minor □ Divorced □ Separated

Patient Employer/School_____Occupation_____

Employer/School Address_____Employer/School Phone (___)_____

Whom may we thank for referring you? _____

In case of emergency who should be notified_____Phone (___)_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
Name of Insurance Company(ies)

Dr._____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 authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information amd may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name o Patient, Parent, Guardian, or Person Representative Relationship to Patient

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Consent to Share Confidential Medical Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____
Birth Date: _____

I HEREBY AUTHORIZE Advance Medical Group:

☐ Any of my medical/dental information, **including information about**:
☐ Sexually transmitted disease (STD) testing and treatment***** ☐ HIV/AIDS testing and treatment*****
☐ Mental health diagnoses and treatment***** ☐ Pregnancy testing and prenatal care*****
☐ Drug and alcohol use history and treatment***** ☐ Birth control/family planning*****
☐ My lab results ***(note: signing this form does NOT mean we will share result of STD or HIV/AIDS tests)***
☐ My appointment times, dates, and reasons for the visits
☐ The medications I am taking
☐ The following information (specify): _____

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time (by writing to NJIM Medical Records), but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires: When I cancel it in writing _____
If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.

Signature: _____ Date: _____
Relationship to minor patient (if parent or legal guardian) *****: _____
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)

Witness: _____ Date: _____

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PATIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information by Ehab Ibrahim, M.D., Roman Prager, M.D., Hussain Manji, M.D., Alla Roitman, D.O., APNs & our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent.

The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at 201-342-0066 and requesting a revised Notice. We will also post any revised notice in the office. You have the right to request that we restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operation, although we are not required to agree to these restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

AGREED AND ACKNOWLEDGED TO BY:

_____ _____
(Signature of Patient) (Date)

_____
Name of patient **(PLEASE PRINT)**

Or:

_____ _____
(Signature of Patient's Personal Representative) (Date)

_____ _____
Name of Patient's Personal Representative Relationship
(PLEASE PRINT)

(The information below is for Staff only)

_____ _____
(Signature of Witness/Staff) (Date)
(PLEASE PRINT)

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E-Prescribing PBM Consent Form

E-prescribing is defined as a Physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also, develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions**— Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**—Provides the Physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that *North Jersey Internal Medicine* can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Patient Name (printed) _____Date of Birth __/__/__

Signature of Patient (or representative) _____

Date __/__/__ Relationship if other than patient_____

Consent Denied_____ Date __/__/__

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ADVANCE MEDICAL GROUP

BOARD CERTIFIED

INTERNAL MEDICINE - FAMILY PRACTICE - BARIATRIC MEDICINE

92 Summit Avenue Hackensack

37 Pompton Rd.

1 W Ridgewood Ave Suite 205 Paramus, NJ 07652

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Patient Responsibility Form

It is the responsibility of the patient to ensure he/she receives results for all procedures, laboratory testing and radiology reports by making follow up appointments or as a minimum calling.

By signing below, you acknowledge that you have received this notice and understand this policy and are 100% responsible to follow up on your results.

_____ _____

Printed Name Date

_____

Signature

Email the packet to info@advancemedgroup.com please include a copy of your insurance card and photo id

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DISCLOSURE OF FINANCIAL INTEREST IN MEDICAL PRACTICE

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service. Accordingly, please take notice that practitioners in this office do have a financial interest in the following health care service(s) to which patients are referred:

Advance Medical Group

Please sign below to acknowledge that I have informed you of the ownership interest in the above entities prior to or at the time I referred you to the above entities.

_____ _____

PATIENT'S NAME (Please Print) DATE

_____

PATIENT'S SIGNATURE