gardenstate
RADIATION ONCOLOGY

Garden State Radiation Oncology
512 Lakehurst Road
TOMS RIVER, NJ 08755

(732) 240-0053 ☎
(732) 240-9360 FAX
www.gsmedicalcenter.org

Local, comfortable care.

OFFICE USE ONLY

Date of Consult/Office Visit:____________________
Account# ________________________________
Referring Dr's NPI# ________________________

WELCOME TO OUR PRACTICE

PATIENT DEMOGRAPHIC INFORMATION

Patient Name	Date of Birth	Today's Date
Social Security #	Gender: ☐M ☐ F	Marital Status: ☐Single ☐Married ☐Partner ☐Divorced ☐Widowed ☐Legally Separated ☐Other
Street Address		Home Phone
City, State, Zip		Cell Phone
Emergency Contact Name	Phone#	Relationship to Patient

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White ☐Hispanic ☐Other Race ☐No Answer

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐No Answer	Spoken Language other than English:

Employment Status: ☐Retired ☐Employed Full-Time ☐Employed Part-Time ☐On Leave ☐Military ☐Unemployed ☐Disabled

Last/Current Employer	Phone	Occupation

Referring Physician Name	Primary Care Physician Name
Address, City, State, Zip	Address, City, State, Zip
Phone	Phone
Are you currently hospitalized or in a skilled nursing facility? NO If YES, admission date: Discharged date:	Are you currently enrolled in a Hospice Program? NO If YES, date started: End date:
Name of Facility	Name of Hospice
Phone#	Phone#

Pharmacy: ______________________________ Address: ______________________________

Phone#: ________________ ______________________________

gardenstate
RADIATION ONCOLOGY

Garden State Radiation Oncology
512 Lakehurst Road
TOMS RIVER, NJ 08755

(732) 240-0053 ☎
(732) 240-9360 FAX
www.gsmedicalcenter.org

PLEASE COMPLETE

SOMETIMES COPIES OF CARDS ARE NOT LEGIBLE

PRIMARY INSURANCE INFORMATION	
Insurance Company Name	ID#
Claims Address	Group#
City, State, Zip	Phone#
Policy Holder: ☐ Self If other, Name & Date of Birth Relationship to Patient	

SECONDARY INSURANCE INFORMATION	
Insurance Company Name	ID#
Claims Address	Group#
City, State, Zip	Phone#
Policy Holder: ☐ Self If other, Name & Date of Birth Relationship to Patient	

DO YOU HAVE A CANCER POLICY? NO	If YES, Name:
Policy#	Address, City, State, Zip
Policy Holders Name/Relationship	Phone#

- I hereby authorize this medical facility and its representatives to release any pertinent information acquired in the course of my examination or treatment to my physician, insurance companies, claim adjustor, or attorney, for the processing of insurance claims to secure payment of said benefits.
- I understand that I am responsible for all charges whether or not paid by my insurance carriers. I understand that I will be responsible for all co-payments, coinsurances, and deductibles not met for the year as well as any non-covered services according to my health plan(s). With the exception of co-payments, which are payable at the time of visit, I understand that I will be billed for any of the aforementioned fees and payment is due upon receipt of the billing statement.
- I have provided accurate and current health insurance information at the time of service and understand that if the correct information is not presented a the time of service, I will be responsible for full amount of charges incurred. (If you do not have medical insurance, financial arrangements must be made prior to services rendered, otherwise full payment is expected at the time of service. We will attempt to resolve all past due balances amicably, however, non-payment will be subject to collection process.)
- I hereby authorize this medical facility to apply for heath insurance benefits (including Medicare, Medicaid, Blue Cross/Blue Shield and other third party insurance carriers) on my behalf and payments to be made directly to the above provider. This assignment will remain in effect until revoked by me in writing.

____ Date: ___________________________

Signature of Patient or Guardian/Guarantor

gardenstate
RADIATION ONCOLOGY

Garden State Radiation Oncology
512 Lakehurst Road
TOMS RIVER, NJ 08755

(732) 240-0053 ☎
(732) 240-9360 FAX
www.gsmedicalcenter.org

Local, comfortable care.

TO WHOM IT MAY CONCERN:

I give permission for the release of all my medical records, including history and physical, radiology reports, operative reports, pathology reports, consultations, radiology films, radiation oncology treatment records and port films to Garden State Radiation Oncology.

Thank you for your cooperation in this matter.

Specific information requested: ____

____

____

____

____

______________________________ ______________________

Patient Signature **Date**

______________________________ ______________________

Patient's Date of Birth **Patient's Social Security Number**

Garden State Radiation Oncology
512 Lakehurst Road
TOMS RIVER, NJ 08755

(732) 240-0053
(732) 240-9360 FAX
www.gsmedicalcenter.org

Your health information is protected by the "Health Insurance Portability and Accountability Act" and as a result, we cannot discuss any personal information with family or friends unless you give us permission.

Please list the names of persons we are allowed to speak with and what relation they are to you. Please let them know, they must be able to verify your name, social security number, and date of birth before any information may be released.

1. ____ relation: ________________________

2. ____ relation: ________________________

3. ____ relation: ________________________

4. ____ relation: ________________________

5. ____ relation: ________________________

6. ____ relation: ________________________

7. ____ relation: ________________________

8. ____ relation: ________________________

If you have any questions, please see the "Notice of Privacy Practices" form or ask the office staff.

Thank you.

Patient's Name: __________________________________

Patient's Signature: _______________________________ Date: ________________

gardenstate
RADIATION ONCOLOGY

Garden State Radiation Oncology
512 Lakehurst Road
TOMS RIVER, NJ 08755

(732) 240-0053
(732) 240-9360 FAX
www.gsmedicalcenter.org

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. PLEASE REVIEW IT CAREFULLY AND SIGN BELOW.

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization

- Treatment: We will disclose your protected health insurance information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, o your referring physician or other physicians involved in your care and treatment to ensure that the physician has the necessary information to diagnose or treat you.

- Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for testing from your insurance company may require that your relevant protected health information be disclosed to the approval for diagnostic testing or therapeutic radiation oncology.

- Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities includes, but are not limited to, quality assessment reviews, employee review activities, training of clinical and clerical staff, licensing, and accreditation boards, conducting or arranging for other business activities. In addition, we may use sign-in sheets at the registration desk where you will be asked to sign your name. We may call you by name in the waiting room when the physician or technician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

- When release is required by law, including in judicial settings, health oversight regulatory agencies, public health issues as required by law, communicable abuse, neglect, FDA, medical examiners, funeral directors, organ and tissue donation organizations, legal proceedings, criminal activity, military activity, national security, Worker's Compensation, and No-Fault. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of the federal privacy regulation, and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To your health plan.
- Unless required by law, other uses and disclosures will be made only with your written authorization , which you may revoke at any time, in writing, except to the extent that we have acted in reliance on your permission.

Your Rights: You have the following rights concerning your PHI:

You have the right to inspect and copy your protected health information. Under federal, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: To register a complaint with us, contact our Administrator at (732) 240-0053. You may complain to the U.S. Department of Health and Human Services or us if you feel your privacy right have been violated. The contact information is Office of Civil Rights, U.S. Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza Suite 3312, New York, NY 10278 or call (212) 264-3039, TDD (212) 264-2355. You will not be retaliated against for filing a complaint.

Our duties: We require by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices. We must abide by the terms of this notice or any update of this notice.

Privacy contact: For more information about our privacy practices, please contact: (732) 240-0053

Effective date: This notice was published and becomes effective on/or before **November 1, 2004.**

I hereby acknowledge that I have received a copy of **GARDEN STATE RADIATION ONCOLOGY** Notice of Privacy Practices that discloses in detail my rights and the Facility's legal duties with respect to uses and disclosures of my protected health information.

Sign: ____ Date: ____________________

Print name of patient: ____

If you are signing as the patient's representative: Print your name: ____

Describe your authority: ____

gardenstate
RADIATION ONCOLOGY

Garden State Radiation Oncology
512 Lakehurst Road
TOMS RIVER, NJ 08755

(732) 240-0053
(732) 240-9360 FAX
www.gsmedicalcenter.org

Local, comfortable care.

ACKNOWLEDGEMENT OF PATIENTS RIGHTS

I, ________________________________ hereby acknowledge I have been informed of my patient

(print name)

rights. I acknowledge that the Patient Rights have been explained to me and I have been given an opportunity to ask questions. Also I have been given a copy of the Patient Rights.

Patient or Responsible Party: _________________________________ Date: ___________________

Signature

Relationship: __________________________________

(self, spouse, or other)

I, ___________________________, certify that I have explained the Patient Rights to the patient, and/or other

(office use)

responsible person, who has signed above. They have also been given/offered a copy of the Patient Rights.

____ Date: _______________________

(Office Signature)

Garden State Radiation Oncology
512 Lakehurst Road
TOMS RIVER, NJ 08755

(732) 240-0053
(732) 240-9360 FAX
www.gsmedicalcenter.org

PATIENT BILL OF RIGHTS

Each patient receiving services at Garden State Radiation Oncology shall have the following rights:

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of terms the patient could understand. The facility shall have a means of notifying patients of any rules and regulations it has adopted governing patient conduct in the facility;

2. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for the services not covered by sources of the third-party payment or not covered by the facility's basic rate;

3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;

4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health conditional or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided a reason for not informing the patient directly, and it shall be documented in the patient's medical record;

5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;

6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when the guardian gives such consent for an incompetent patient in accordance with law, rule, and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;

7. To voice grievances or recommend changes in the policies and services to facility personnel, the governing authority; and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;

8. To be free from mental and physical abuse, free from exploitation, free from the use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;

9. To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility to which the patient's approval is needed, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is marked;

10. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and the right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when the facility personnel are discussing the patient;

11. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules;

12. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs, practices, or any attendance at religious services shall be imposed upon any patient; and

13. To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.

Patients may lodge complaints at the following offices:

Division of Health Facilities Evaluation and Licensing

New Jersey State Department of Health

PO Box 367

Trenton, NJ 08625-0367

Telephone: (609) 792-9770

State of New Jersey

Office of the Ombudsman for the Institutionalized Elderly

PO Box 808

Trenton, NJ 08625-0808

Telephone: (609) 624-4262