Ocean Family & Geriatric Associates LLC.

20 Hospital Dr. Suite 3 Toms River, N.J 08755
Phone: 732-341-9900 *Fax:* 732-341-9968

275 Atlantic City Blvd Bayville, N.J 08721
Phone: 732-269-8111 *Fax:* 732-269-8113

Patient Information:

Patient Name (Last, First, MI): .....

D.O.B: .....

Social Security #: .....

Address: .....

Phone: Home: ..... Cell: ..... Work: .....

Email: .....

Pharmacy: .....

Occupation: .....

Do you have a Living Will? (Please Circle) Yes No

Do you have P.O.A? (Please Circle) Yes No

Name: .....

Relation: .....

Phone: Home: ..... Cell: ..... Work: .....

Emergency Contact:

Name: .....

Relation: .....

Phone: Home: ..... Cell: ..... Work: .....

Are they HIPAA Compliant? (Please Circle) Yes No

Please flip to second page*

HIPAA Contact(s):

Name: .....

Relation: .....

Phone: Home: ..... Cell: ..... Work: .....

Name: .....

Relation: .....

Phone: Home: ..... Cell: ..... Work: .....

*****Please provide the receptionist with your Driver's License / State Issued I.D, and Insurance card(s)*****

Insurance Authorization & Assignment

I request that payment of authorized Medicare/other insurance company benefits be made either to me or on behalf of Ocean Family & Geriatrics Associates LLC for any services furnished me by that physician. I authorize any holder of medical information about me to relate to the Health Care Financing Administration and its agents any information needed to determine these benefits of benefits payable to related services.

I understand my signature request that payment be made and authorize release of medical information necessary to pay the claim. Item 9 of HCFA-1500 claims form is completed, my signature releasing of the insurer or agency shown. In Medicare/or insurance company and the full charges, and the patient is responsible only for deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon charge determination of the Medicare/other insurance company. This consent also applies to chronic care management.

Signature: ..... **Date:** .....

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General Consent for Care & Treatment Consent

TO THE PATIENT or Personal Representative: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative:	**Date:**
Printed Name of Patient or Personal Representative:	**Relationship to Patient:**
Signature of Witness:	**Date:**
Printed Name of Witness:	**Employee Job Title:**

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Privacy Policy

This is to certify that I, _____ (Patient/Guardian):

☐ Have been made aware of the notice of privacy practices and request that my medical information only be released to:

☐ Family

☐ Medical Offices/Laboratories

or

☐ I do not wish to have any of my health related information released to anyone other than myself

☐ I give my permission to leave messages in regards to: bloodwork results, outside testing, appointment reminders, etc. either on my answering machine or with a family member who answers my home phone.

or

☐ If I am unable to be reached by phone, no messages pertaining to myself are to be left on my home answering machine.

Signature: _____ (Patient/Guardian) Date: _____

Any changes of patient release information must be given in writing…..Verbal request for any changes **will not be honored.**

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Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip/Postal Code:_____

Telephone: _____

Office Currently Holding Records:

Practice/Doctor Name: _____

Address: _____

City: _____ State: _____ Zip/Postal Code:_____

Telephone:_____ Fax:_____

I authorize the release of my medical records or other health care information, including chart notes, reports, labs, radiology, correspondence, billing statements, and other written information concerning my health and treatment during the period of _____ to _____ ; to be sent to the following person or company.

Company: Ocean Family and Geriatrics Associates

Address: 20 Hospital Drive Suite 3 City: Toms River State: NJ

Zip/Postal Code:08755 Telephone: (732) 341-9900 Fax: **(732) 341-9968**

Patient Signature: _____ Date: _____