Date: ________________

First Name: ______________________________ MI_____ Last Name: ______________________________

SS#__________________ Date of Birth__________________

Current Address____ ☐None
Address *City* *State* *Zip*

***Phone Number**:* _________________________

Sex *(Check one)* ☐*Male* ☐*Female* Are you Head of household ☐*Yes* ☐*No* ***Are you Homeless*** ☐*Yes* ☐*No*

Are you currently living *(Check one)* ☐*By yourself* ☐*With a partner* ☐*With Family* *#of Family Members*_____
# of Dependants _________

Where did you spend last night? *(Check one)* ☐*Shelter* ☐*Street* ☐*Hospital* ☐*Jail/Prison/Transitional* ☐*Relatives* ☐*Other*

Race: *(Check one)*
White ☐
Asian ☐
Native Hawaiian ☐
Other Pacific Islander ☐
Black/African American ☐
American Indian ☐
Alaska Native ☐
More than one Race ☐

Ethnicity: Check one
Hispanic ☐
Non –Hispanic ☐

Language
English ☐
Spanish ☐
Other ☐_____________________

Translator needed YES ☐ NO ☐

Are you visually impaired? Y / N Are you hearing Impaired? Y / N

What is your Marital Status? *(Check one)* ☐*Single* ☐*Married* ☐*Separated/Divorced/Widowed* ☐*Unknownl*

How many Children do you have? ______ How many under 18 years old? _______ How many live with you? ______

Are you a Veteran*? (Check one)* ☐*Yes* ☐*No*

What is your monthly Income? ___________________________

When was your last Medical visit? ________________________

Where is your Pharmacy? ______________________

Additional Information
E-mail address ____________________________________ preferred method of contact Home / Cell / Email

Is it okay to leave messages at: Home? Y / N Cell? Y / N

How long have you been in Southern NJ? *(Check one)* ☐ Less than 1 month ☐ 1-5 months ☐ 6-12 months ☐ 1-5 years ☐ More than 5 years ☐ Unknown

What is your main reason for not having a regular place to stay? *(Check up to three)*

☐ Transient or traveling out of town ☐ My lifestyle ☐ Physical abuse ☐ Family conflict
☐ Released from psychiatric hospital ☐ Released from jail or prison ☐ Financial problems ☐ Other
☐ Eviction or foreclosure ☐ Drug / alcohol abuse ☐ Unemployed

Have you ever been employed? *(Check one)*
☐ Yes **What is your usual occupation?** ____________________________________ ☐ No

Are you currently employed? *(Check one)*
☐ Yes **What kind of work are you doing?** ___________________________________ ☐ No

Have you ever applied for public housing? *(Check one)*
☐ Yes **Where?** ______________________________ **Date** ________________ ☐ No

Where do you usually receive your health care? *(Check one)*
☐ Emergency room ☐ Clinic or hospital ☐ Private doctor ☐ Prison ☐ Haven't received care in _____ years

Who can we contact in case of emergency?

____
Last Name

____
Address ***Phone Number***

This person listed above is .... *(Check one)* ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Spouse ☐ Other relative ☐ Friend ☐ Other

Education *(Check off on the ONE that best describes the highest level completed)*
☐ None ☐ Grade school ☐ Some high school ☐ High school grad / GED
☐ Vocational / Tech School ☐ Some college ☐ College grad

Father's full name (First Name, MI, Last Name**)** ____

Mother's maiden name (First Name, MI, Last Name) ____

Where were you born? City ___________________________________ **State** (If U.S)_____________________________

Country (If outside U.S.) _________________________________

Primary Language Spoken._______________________________

Thank you for taking the time to provide AtlantiCare Mission Healthcare with this information
It allows us to serve you better

MEDICAL HISTORY: (please check all that apply)

High Blood Pressure	Drug Abuse
High Cholesterol	Alcohol Abuse
Diabetes	Ulcers
Cancer	Hepatitis
Tuberculosis	HIV
Urinary Tract	Thyroid
Infections	Asthma
Anemia	COPD
Kidney Stones	Stroke
Kidney Disease	Angina
Gallbladder Disease	Lyme's Disease
Heart Disease	Arthritis
Depression	Other (please describe)

Do you have any Allergies to Medication, food or other: Y / N

Please list all medications including vitamins and over the counter supplements and medications

Medication	MG/Strength	Dose/How Often

Surgical History: (please list type of surgery, if any, and date)

Family History: (please check all that apply)

Blood Pressure	Stroke
Diabetes	Heart Attack
Cancer	Kidney Disease
Other (please describe)	Depression

Social History

Alcohol:	Y / N	If yes, how many drinks are consumed, per week?
Cigarettes:	Y / N	If yes, how many packs per day?

Other treating providers: (please list the name and specialty of any other provider currently treating you)

Name: ______________________ Specialty: ______________________

Name: ______________________ Specialty: ______________________

CONSENT FORM

PATIENT NAME:

Consent for treatment: Knowing that I (or the patient indicated on the top of this form) am suffering from a condition requiring treatment, I voluntarily consent to such care. I consent to routine diagnostic procedures, x-rays, and to medical treatment by physicians in AtlantiCare Health Services Mission Health Care and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my care, treatment or examination at AtlantiCare Health Services Mission Health Care. Patients at AtlantiCare Health Services Mission Health Care will be treated regardless of race, color, age, national origin, disability or religion.

Signature of patient or patient representative:________________________________ Date from:_________to: 12/31/2016 (Representative signature required if patient is minor or unable to consent):________________________

Representative's relationship to patient:________________________ Witness:________________________

Patient is unable to consent because:____

Acknowledgement of Privacy Practice: I understand and have been provided with AtlantiCare's *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. AtlantiCare reserves the right to make changes to their Privacy Notice. Revised copies are available at all patient registration areas. By signing this form, I acknowledge that I have been afforded the opportunity to consider AtlantiCare's Notice of Privacy Practices prior to signing of this consent and making of healthcare decisions.

Signature of patient or patient representative:________________________________ Date from:_________to: 12/31/2015

General Terms and Conditions:

1. I understand that as a part of my healthcare, AtlantiCare Health Services Mission Health Care originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care. This information is used as described in the Notice of Privacy Practices and to: plan my care and treatment, communicate with professionals involved in my care, apply my diagnostic and procedural information to my bill, verify third party payers the services provided, and routine operations such as audits reporting requirements, utilization review, and quality assessment activities.
2. I am aware and have been advised that I (or the patient) am suffering from a condition requiring treatment and I am presenting myself for treatment and I voluntarily consent to such care. I consent to diagnostic procedures and medical treatment by physicians at AtlantiCare Health Services Mission Health Care medical staff and other affiliates and health care professionals who may be called upon to consult or assist in my care as is necessary in their professional judgment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my care, treatment or examination at AtlantiCare Health Services Mission Health Care.
3. AtlantiCare Health Services Mission Health Care maintains patient medical records in paper, microfilm and /or electronic media, including photo identification, which may be accessible to any physician or health care provider participating in my current or future care. I understand that these records will contain information about my diagnosis and treatment and may or may not contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Medical records are disclosed according to applicable New Jersey State Laws, Federal laws 42 & 45 C.F.R. and the provisions of this consent.
4. I herby assign to AtlantiCare Health Services Mission Health Care physicians participating in my care and other licensed providers any and all rights and benefits to which I may be entitled arising out of any health care or liability insurance. I hold AtlantiCare Physician Group harmless for any reduction in healthcare benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: notification, pre-certification, prior or retrospective authorization , or utilization review of the medical services I receive. I agree that I am financially responsible for deductibles, coinsurance and uncovered services that are not covered by my insurance policy.
5. I agree to pay AtlantiCare Health Services Mission Health Care the full and final amount of any and all bills rendered for me (or the named patient) which are not covered by insurance. I authorize AtlantiCare Health Services Mission Health Care to utilize the appeals process with my insurance carrier in my behalf for any denied service.
6. I certify that the information given by me in applying for payment under titles XVIII and XVIX of the Social Security Act is correct. As acceptable, I certify that I have received the Important Message from Medicare.

By signing this consent, I certify that I have received a copy of my Patient Rights. I am indicating that I understand the contents of this document and agree to its provisions including the disclosure of information in accordance with AtlantiCare's Notice of Privacy Practices. I am signing this consent voluntarily.

Signature of patient or patient representative:________________________________ Date from:___________to: 12/31/2016 Representative's relationship to patient________________________ Witness:________________________

Patient is unable to consent because:____

Registration Form
Fax: 609-441-7089

- AtlantiCare Community Health
- Mission Health Care 2009 Bacharach

Patient's Name: ___________________________________

Social Security #: _______________ Med Rec #: ________

Patient Date of Birth: __________/___________/________

Address: ____

______________________State: _______ Zip: ________

Phone Number: (   ) ______   Cell Phone: (   ) ______

Allergies:

☐ None ☐ Sulfa ☐ Penicillin ☐ Aspirin ☐ Codeine

☐ Other (please list): ____________________________

____

____

CLIENT NAME ____

PAYMENT METHOD (circle one)
*Medicaid *Medicare *DYFS *PAAD *Federal Probation Other (specify) __________

Copy of ID card must be attached

**Proof of income must be attached and will be reviewed every 3 months.*

Household Resources $________________ (gross income) # of Dependents ____

AtlantiCare Mission HealthCare Sliding Fee Scale:
Client's Responsibility
$__________ Cost of service for Medical and Psychiatric Visits
$__________ Cost of service for medication
$__________ Cost of service for group therapy

Private Insurance Company ____
(Copy of card must be attached)

Client's Responsibility $ _________ Deductible $ _________ Copay $ _________

CONDITIONS

Payment of deductibles and copay/co-insurance is due at the time services are rendered. We accept cash, checks, We emphasize that, as healthcare providers, our relationship is with you, not with your insurance company. We only file insurance claims with companies with whom we participate.

X_________________________________ _________________________________
Client/Legal Guardian Signature Date Registrar Signature Date

ATLANTICARE HOSPITAL BILL OF RIGHTS AMBULATORY CARE

As a patient of AtlantiCare Health Services Ambulatory Care Facility you have the following rights:

MEDICAL CARE:

• To receive the care and health services that the hospital is required by law to provide.
• To participate in the planning of your care and treatment in the Ambulatory Care Facility and to refuse such medication and treatment. Such refusal shall be documented in your medical record.
• To receive an understandable explanation from your physician and/or Licensed Allied Health Professional ("Licensed AHP") of your complete medical condition, recommended treatment, treatment options, expected results, risks involved and reasonable medical alternatives. If your physician believes that some of this information would be detrimental to your health or beyond your ability to understand, the explanation must be given to your next of kin or guardian and documented in your medical record.
• To give informed written consent prior to the start of specified, nonemergency medical procedures or treatments only after your physician or Licensed AHP has explained—in terms you can understand—specific details about the recommended procedure or treatment, the risks, time to recover and reasonable medical alternatives. If you are unable to give informed consent, consent shall be sought from your next of kin, guardian or to the extent authorized by law. Such consent shall be documented in your medical record.
• To refuse medication and treatment and to be informed of the medical consequences of such refusal, unless the procedure is required by law.
• To expect and receive appropriate assessment, management and treatment for pain as an integral component of your care.
• To be included in experimental research only when you have given informed written consent to participate. You may refuse to participate in experimental research, including the investigation of new drugs and medical devices.
• To have access to protective services and patient advocacy groups.
• To receive care in a safe setting by staff educated in patient rights.

COMMUNICATION AND INFORMATION:

• To know the names and functions of all Physicians, Licensed AHPs and other health care professionals directly caring for you.
• To expeditiously receive the services of a translator or interpreter, if necessary, at no cost to you, to communicate with the health care professionals.
• Be informed of the names, titles, and functions of any outside health care professionals and educational institutions involved in your treatment. You may refuse to allow their participation.
• To be informed of the written policies and procedures regarding life-saving methods and the use or withdrawal of life-support mechanisms.
• To be advised in writing of the rules regarding the conduct of patients and visitors.
• To be informed at the Ambulatory Care Facility of these rights, as evidenced by written acknowledgment or documentation in the medical record that you were offered a copy of these rights in terms you could understand.
•To receive a summary of your rights as a patient, including the name(s) and phone number(s) of the hospital staff member to whom you may direct questions or complaints about possible violations of your rights. If at least 10% of the hospital's service area speaks your native language, you can receive a copy of the summary in your native language.
• To submit in writing an advance directive and have health care professional comply with that directive.
• To be informed of these rights in terms you can understand as evidenced in the medical record. The Ambulatory Care Facility shall have a means to notify you of any rules and regulations it has adopted governing patient conduct in the facility.

TRANSFERS:

• To be transferred to another facility only if the current Ambulatory Care Facility is unable to provide the level of appropriate medical care or if the transfer is requested by you or your next of kin or guardian.
• Except in life-threatening situations where immediate transfer is necessary, to receive an advance explanation from a physician of the reasons for your transfer and possible alternatives, verification of acceptance from the receiving facility, and assurance that the movement associated with the transfer will not subject you to substantial, unnecessary risk of deterioration of your medical condition.

MEDICAL RECORDS:

• To have prompt access to your medical records. If your physician feels that this access is detrimental to your health, your legal representative has a right to see your records.
• To obtain a copy of your medical records at a reasonable fee within 30 days after submitting a written request to the hospital. If access is medically contraindicated, then your legal representative or physician shall have access to such records.

COST OF CARE:

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

DISCHARGE PLANNING:

• To be informed about any need for follow-up care and receive assistance in obtaining this care required after your discharge from Ambulatory Care Facility.
• To receive sufficient time before discharge to arrange for follow-up care.
• To be informed by the Ambulatory Care Facility about the discharge appeal process if you disagree with the discharge plans.

PRIVACY AND CONFIDENTIALITY:

• To be provided with physical privacy during medical treatment and personal hygiene functions, unless you need assistance. Your privacy shall be respected during all health care procedures and when personnel are discussing you.
• To be assured of confidentiality about your patient stay. Your medical and financial records shall not be released to anyone outside the Ambulatory Care Facility without your approval, unless you are transferred to another facility that requires the information, or the release of such information is required or permitted by law.

PERSONAL NEEDS:

• To be treated with courtesy, consideration, respect and recognition of your dignity, individuality, and right to privacy, including auditory and visual privacy.

FREEDOM FROM ABUSE, SECLUSION AND RESTRAINTS:

• To be free from neglect, exploitation as well as physical, verbal and mental abuse or harassment.
• To be free from seclusion or physical restraint unless authorized by a physician for a limited period of time to protect your safety or the safety of others. Drugs and other medications shall not be used for discipline of patients or convenience of facility personnel.

CIVIL RIGHTS:

• To receive treatment and medical services without discrimination based on age, religion, creed, race, skin color, national origin, ancestry, marital status, civil union status, domestic partnership status, sex, affection or sexual orientation, gender identity or expression, handicap or disability, genetic information, atypical hereditary cellular or blood trait, military service, AIDS or HIV related illnesses, diagnosis, ability to pay or source of payment.
• To retain and exercise constitutional, civil and legal rights, including your religious liberties, including the right to independent personal decision. No religious beliefs or practices, or attendance at any religious service shall be imposed on you.
• To voice grievances or recommend changes in policies and services to Ambulatory Care Facility personnel, governing authority, and/or outside representatives of your choice, either individually or as a group, and free from restraint, interference, coercion, discrimination or reprisal.
• To not be required to perform work for the facility unless the work is part of your treatment and performed voluntarily. Such work shall be in accordance with federal, state and local laws and rules.

QUESTIONS, COMPLAINTS AND APPEALS:

• To ask questions or file written grievances about patient rights with a designated hospital staff member and receive a response within a reasonable period.
• To be provided, by facility, with contact information for the New Jersey Department of Health and Senior Services unit that handles questions and complaints. You may directly write to the New Jersey Department of Health, Division of Health Facilities Evaluation and Licensing (Office of Acute Care Assessment and Survey), PO Box 367, Trenton, New Jersey, 08625-0367 or call the New Jersey Department of Health Complaint Hotline at 1-800-792-9770. You may also write to The Joint Commission, Office of Quality Monitoring, One Renaissance Boulevard, Oakbrook Terrace, Illinois, 60181 or call-1-800-994-6610. For an Ambulatory Care Facility, you may contact the State of New Jersey, The Office of the Ombudsman, P.O. Box 852, Trenton, New Jersey 08625-0852 or call 1-877-582-6995. Medicare Beneficiaries who have a complaint or grievance concerning quality of care, disagree with a coverage decision or wish to appeal a premature discharge may also call Livanta BFCC-QIO at 1-866-815-5440.

MEDICARE/MEDICAID COVERAGE INFORMATION:

For information regarding Medicare coverage, you may contact 1-800-633-4227 or write the Centers for Medicare & Medicaid Services at 7500 Security Boulevard, Baltimore, Maryland 21244. Medicaid coverage information may be obtained by contacting 1-800-356-1561 or by writing to the New Jersey Department of Human Services, Division of Medical Assistance & Health Services, PO Box 712, Trenton, New Jersey, 08625-0712.

An AtlantiCare Operator may be reached by dialing zero ("0") from inside the Hospital, or from outside the number is (609) 652-1000 to ask for the Customer Relations Representative in your location.

REVISED August 01, 2014