AtlantiCare
THE CANCER CARE INSTITUTE

NEW PATIENT PACKET

MRN#_____ *(to be filled in by AtlantiCare)*

Patient Name:_____

Appointment Date:_____ Date of Birth:_____ ○ **Male** ○ **Female**

Diagnosis / Reason for Visit:_____

Home Address:_____

Home Phone Number:_____ Cell:_____

Email Address:_____

Social Security # *(to verify insurance)*:_____

Referring Physician:_____

Name of **Primary** Insurance:_____

ID#:_____ Group#:_____ ○ **Self** ○ **Spouse**

Name of **Secondary** Insurance:_____

ID#:_____ Group#:_____ ○ **Self** ○ **Spouse**

Medical / Radiation Oncologist *(if applicable)*:_____

Prior Chemotherapy: ○ **Y** ○ **N** When/Where:_____

Current Chemotherapy: ○ **Y** ○ **N** When/Where:_____

Prior Radiation Therapy: ○ **Y** ○ **N** When/Where:_____

Prior Genetic Testing: ○ **Y** ○ **N** When/Where:_____

Is there a chance you could be pregnant? ○ **Y** ○ **N**

Recent Imaging Studies *(within the previous 3 months)*:

Type of Scan	Location	Type of Scan	Location

PAST MEDICAL HISTORY *(select all that apply)*:

CARDIAC / VASCULAR

- ☐ Hypertension
- ☐ High Cholesterol
- ☐ CAD
- ☐ Blood Clots
- ☐ Anemia
- ☐ Other Explain:_____
- ☐ HIV / AIDS
- ☐ Sickle Cell
- ☐ Sleep Apnea
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Other Blood Disorders
- ☐ Heart Problems (Valve Problems)

Manufacturer:_____

Manufacturer:_____

PULMONARY / LUNG / BREATHING

- ☐ Asthma
- ☐ Emphysema
- ☐ Other Explain:_____
- ☐ COPD
- ☐ Shortness of Breath

GASTROINTESTINAL

- ☐ Constipation
- ☐ Diarrhea
- ☐ Trouble Chewing
- ☐ Colitis
- ☐ Reflux
- ☐ Hernia
- ☐ Hepatitis
- ☐ Other Explain:_____
- ☐ Trouble Swallowing
- ☐ Indigestion
- ☐ Diverticulosis / Diverticulitis

GENITOURINARY

- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Other Explain:_____
- ☐ Urinary Problems
- ☐ Prostate Problems
- ☐ ED

NEUROLOGICAL

- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ Seizures
- ☐ Dizziness
- ☐ Balance Problems
- ☐ Epilepsy
- ☐ Other Explain:_____
- ☐ Headaches
- ☐ TIA
- ☐ Stroke

MUSKULOSKELETAL

- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Other Explain:_____
- ☐ Neck Problems
- ☐ Back Problems
- ☐ Muscle Disorder
- ☐ Bone Problems

ENDOCRINE

- ☐ Diabetes **IDDM / NIDDM**
- ☐ Other Explain:_____
- ☐ Thyroid Problems

SKIN

- ☐ Psoriasis
- ☐ Other Explain:_____
- ☐ Eczema
- ☐ History of Skin Cancer

GYNECOLOGIC

Age at start of menstrual period:_____

Number of pregnancies:_____

Ever used birth control: ○**Y** ○**N**

How many years:_____

Ever used hormone replacement therapy: ○**Y** ○**N**

How many years:_____

Age of Menopause (if applicable):_____

Number of births:_____

Last Pap Smear:_____

Bra Size:_____

Last Mammogram:_____

FAMILY HISTORY OF CANCER

☐ Father	Age of Diagnosis:_____	Type of Cancer:_____
☐ Mother	Age of Diagnosis:_____	Type of Cancer:_____
☐ Aunt	Age of Diagnosis:_____	Type of Cancer:_____
☐ Uncle	Age of Diagnosis:_____	Type of Cancer:_____
☐ Brother	Age of Diagnosis:_____	Type of Cancer:_____
☐ Sister	Age of Diagnosis:_____	Type of Cancer:_____
☐ Grandparents	Age of Diagnosis:_____	Type of Cancer:_____

PAST SURGICAL HISTORY **Please include biopsies*

Operation and Year	Operation and Year

ALLERGIES

☐ I have no allergies that I am aware of.

List of Allergies and Reactions:

Allergy:_____	Reaction:_____
Allergy:_____	Reaction:_____
Allergy:_____	Reaction:_____
Allergy:_____	Reaction:_____

VACCINATIONS

Pneumonia Vaccine:	○Y ○N	Date *(if known)*:_____
Influenza Vaccine:	○Y ○N	Date *(if known)*:_____
Shingles Vaccine:	○Y ○N	Date *(if known)*:_____
Measles Vaccine:	○Y ○N	Date *(if known)*:_____

I have a living will / advanced directive:	○Y ○N
I would like to have a living will / advanced directive:	○Y ○N
I have a POLST with my Primary Care Provider:	○Y ○N

If you have a living will, advanced directive, and/or POLST, please bring in a copy for our records.

SOCIAL / CULTURAL HISTORY

Martial Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Primary Language
- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ French
- ☐ Other:_____

Other
- ☐ Hearing Aids
- ☐ Vision Problems
- ☐ Glasses / Contact Lenses
- ☐ Need Interpreter
- ☐ Use Sign Language

Have you received the COVID-19 vaccination _____

SOCIAL / CULTURAL HISTORY CONTINUED

Smoking

- ☐ Never
- ☐ Previously but quit_____months/years ago

How many years did you smoke?_____

How many packs per day?_____

- ☐ Currently

How many packs per day?_____

Alcohol

- ☐ Never
- ☐ Rarely
- ☐ Socially
- ☐ Daily
- ☐ Previously but quit_____months/years ago

Recreational Drugs

- ☐ Never
- ☐ Currently Type_____ Frequency:_____

Daily Living

- ☐ Able to care for myself
- ☐ Rely on others for some care
- ☐ Rely on others for total care
- ☐ Live alone
- ☐ Other Explain:_____
- ☐ Use a walker
- ☐ Use a wheelchair
- ☐ Use crutches
- ☐ Wear braces
- ☐ Bedridden

Pain

- ☐ Yes Is this a new onset of pain? ○Y ○N Location:_____
- ☐ No

Rate your level of pain

0 1 2 3 4 5 6 7 8 9 10

MEDICATION LIST

Please list all of your current medications. Include over-the-counter, vitamins and herbals.

Name of Medication	Dosage	How often do you take this?

EMERGENCY CONTACT INFORMATION:

Name:_____ Relationship:_____

Phone Number:_____

Name:_____ Relationship:_____

Phone Number:_____

Do you have a Power of Attorney (POA): ○ **Y** ○ **N**

If yes, please provide name:_____

Please provide us with a copy for our records.

PROVIDER INFORMATION:

Family Physician:_____ Phone Number:_____

Referring Physician:_____ Phone Number:_____

Medical/Radiation Oncologist:_____ Phone Number:_____

Urologist:_____ Phone Number:_____

Surgeon:_____ Phone Number:_____

Pain Management:_____ Phone Number:_____

Other Physician:_____ Phone Number:_____

Pharmacy:_____ Phone Number:_____

WORK:

Please select one: ○ **Full Time** ○ **Part Time** ○ **Retired** ○ **Unemployed**

○ **Other:**_____

Occupation:_____

Employer:_____ Work Number:_____

If we need to contact you, may we call you at your place of business? ○ **Y** ○ **N**

_____

Signature of Patient **Date**

AUTHORIZATION FOR ACCESS TO PATIENT RECORDS

Name: _____
(Print name) (Date of birth)

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996, PUBLIC LAW 104-191

I specifically grant the following people the right to have full, complete and unfettered access to my medical records as my authorized agent in accordance with the **Federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191**, the regulations issued pursuance to said Act, and all other statues and regulations having to do with the privacy of medical records, whether enacted by the Federal government, any state government, of any local government.

	Name	Relationship	Phone
1)			
2)			
3)			

X _____ _____
Patient Signature **Date**

_____ _____
Witness **Date**

AtlantiCare

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the entity indicated below:

_____

To release the health information of: _____ _____
Patient Name **Date of Birth**

To the person or entity listed below:

Recipient's name: _____

Recipient's Address: Medical Oncology 2500 English Creek Ave. Bldg. 400 Egg Harbor Township NJ 08234

_____

Recipient's Telephone: **609-677-7777** Recipient's Fax: **609-677-7727**

Information to be released from records pertaining to: ☐ Inpatient ☐ Outpatient

□ Complete Medical Record	□ Clinic Notes	□ Colonoscopy	□ Consultation Reports
□ Discharge Summary	□ EEG, EKG, Stress Test	□ ER Notes	□ Endoscopy
□ History & Physical	□ Immunizations	□ Itemized Bills	□ Lab Reports
□ Medications	□ Operative Reports	□ Pathology Reports	□ Radiology Films/Reports
□ HIV/AIDS	□ Alcohol/Substance Use Disorder*	□ Mental Health	□ Other _____

For date(s) of service: _____

Reason for disclosure of health information: □ Personal □ Treatment/Coordination of Care □ Other _____

NOTICE TO PATIENT

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare's compliance with this request. The revocation must be in writing and is subject to terms described in AtlantiCare's Notice of Privacy Practices and other AtlantiCare policies. I understand that I am not required to sign this authorization and AtlantiCare may not condition treatment on my execution of this authorization. I understand that the information disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by HIPAA. The authorization will expire upon the release of the information described above or four (4) months after the date of the authorization, unless otherwise specified.

Expiration Date: _____

NOTICE TO RECORDS RECIPIENT*

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder.

Patient's Signature (Ages 14 and Older) X_____ **Date**_____

Parent/Legal Guardian/Patient Representative Signature_____ **Date**_____

Witness Signature_____ **Date**_____

Patient is entitled to a copy of signed authorization.

PATIENT ACCESS REQUEST FORM

□ AtlantiCare Regional Medical Center
□ AtlantiCare Behavioral Health
□ AtlantiCare Health Services
□ AtlantiCare Surgery Center
□ AtlantiCare Physicians Group
□ Other _____

Please note: Charges may apply. Failure to remit payment of invoice may result in submission to a collection agency.

Patient Name: _____

Address: _____

Address: _____

Date of Birth: _____

Patient Phone No.: _____

MRN (if known): _____

I request a copy of my medical information from the above checked facility for the time period of _____ to _____.
("Present" equals date of signature).

SPECIFIC INFORMATION TO RELEASE: (Check box of items to be released).

□ Complete Medical Record	□ Clinic Notes	□ Colonoscopy	□ Consultation Reports	□ Other _____
□ Discharge Summary	□ EEG, EKG, Stress Test	□ ER Notes	□ Endoscopy	
□ History & Physical	□ Immunizations	□ Itemized Bills	□ Lab Reports	
□ Medications	□ Operative Reports	□ Pathology Reports	□ Radiology Films/Reports	

*FOR DISCLOSURE TO PATIENT ONLY: Do not use this form if you are requesting information relating to any testing, diagnosis and/or treatment of the conditions below AND you are instructing us to send this information to a third party. Please use an Authorization to Disclose Health Information or a comparable form instead.

□ **HIV/AIDS*** □ **Alcohol/Substance Use Disorder*** □ **Mental Health/Rehabilitation***

DISCLOSURE FORMAT: (Select box to indicate how you want to receive the information).

□ Pick up (ID required)	□ Review & Inspect	□ US Mail (Paper)	□ Other _____
□ CD (secure .pdf)	□ Email	□ Fax (UNSECURE) **	*(Please specify)*

** If you elect to have your health information transmitted in an UNSECURE manner (i.e., unencrypted), AtlantiCare is not responsible for breach notification or liable for disclosures that occur in transit using unsecure methods.

RECIPIENT: Name: _____

Address of Individual or Organization: _____

_____

Phone No: _____ Fax No: _____
(If applicable)

For disclosures to third party recipients, AtlantiCare is not liable for what happens to this health information once the designated third party receives the information as directed by the patient in this request.

SIGNATURES

Date: _____ X _____
Patient Signature (If patient is unable to sign because of physical condition or age, complete the following):

Patient is a minor or patient or unable to sign authorization because: _____

Date: _____ _____ _____
Signature Relationship
(Parent/Guardian authorized under State law to make health care decisions for the patient).

AtlantiCare

Your healthcare provider wants to ensure you are aware of all services and information that could be valuable to you and your family. Please complete this form for staff to apply on your behalf for participation in any financial assistance programs that the financial advocacy staff decides you are eligible for.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION	Patient Label

I hereby authorize the AtlantiCare Cancer Care Institute to release my contact and diagnosis information to the following organizations that can provide financial, emotional and/or educational support during my treatment. I further understand the financial advocacy staff will utilize this information to complete forms and applications for enrollment in any assistance programs for which I may qualify.

Financial/Pharmaceutical Programs (included but not limited to the following):

Merck	**Amgen**	**Onco360**	**HealthWell Foundation**	**Other _____**
Novartis Genentech	**AstraZeneca**	**Lilly**	**PAN Foundation**	
Johnson & Johnson	**Pfizer**	**McKesson**	**CancerCare Co-Payment Assistance Foundation**	
GBT	**Bristol-Myers Squibb**	**IngenioRx**	**Bayer**	

Do you receive any of the following benefits?

___ Social Security
___ Unemployment Benefits
(not including the additional $600 for Covid-19 relief)
___ Disability Wages
___ Pensions
___ 401K/IRA
___ Dividends
___ Annuities
___ Rental Property
___ Other _____

Financial Aid/Grant Assistance Questions:

Current estimated annual income $_____
Type of income. Circle all that apply:
Social Security Pension Annuities Salary/Wages
Marital Status ___ married ____ single ____ divorced
Number of people in household_____
U.S. Veteran ___ yes ___ no
Do you have prescription plan coverage: ___ yes ___ no
If yes, name of provider_____

_____Financial/Pharmaceutical Programs do not apply

***Referrals dependent on treatment**

_____ I do not wish to disclose my information to the above assistance programs.

Cancer Related Programs (Included but not limited to the following):

American Cancer Society **Gilda's Club South Jersey**

X _____

Signature of Patient or Representative **Date**

Revised 8/24/2021

AtlantiCare

Off Campus Medicare Outpatient Coinsurance

This facility is an outpatient department of AtlantiCare Regional Medical Center (ARMC). When you receive services at this facility, you will receive two separate bills: a) one coinsurance and deductible for professional services and b) one coinsurance and deductible for facility services. In accordance with Medicare's laws and regulations, you will incur a co-insurance liability to ARMC that you would not have incurred if this office were not an outpatient department of the hospital.

If you are covered through a Medicare Advantage Plan (Part C) you may have to pay a coinsurance, co-payment or deductible amount for the facility services that you receive in addition to your physician co-payment or coinsurance. To find out your responsibility, please contact your Medicare Advantage Plan.

Since we do not know the exact type and extent of services that you may need, we are unable to provide you with a precise estimate of your liability. Actual coinsurance liability will be based on the services that you actually receive and also subject to final determination by the Medicare program.

If beneficiaries have any concerns regarding their possible or incurred financial liability, ARMC encourages them to please speak with our business office customer service department at (609) 272-2500 and one of our representatives will assist you.

As required by policy, for this outpatient department of the hospital, you will be required to read and sign this letter at every visit.

I have read and understand that I will incur a liability to AtlantiCare Regional Medical Center for Medicare coinsurance as permitted by law.

X _____ _____

Signature of patient or authorized representative Date

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [PRINT NAME], by marking [√] (or [x]) and signing below, agree to:

☒ representation by ARMC in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☒ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by ☐ and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date:_____
Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS:_____

_____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.