**181 High Street**
**Newton, New Jersey 07860**

**PATIENT INFORMATION** DATE________________________

Title:

Last Name First Name Middle Initial

Mailing Address: _______________________________________________ ________________________ _____________ ______
City State Zip

Physical Address: _______________________________________________ ________________________ _____________ ______
City State Zip

Home Phone ____________________ Cell Phone _____________________ Work Phone________________________

**E-Mail** _____________________________________

SS#: _________________________ Date of Birth: ___________ Age: _____ Sex Race

Primary Care Physician: __________________________________________ Phone: ______________________________

Occupation ________________Employer Name: _____________________________ **Is this visit work related** ?________

Employer Address: ___________________ ______________________________ ________________ ____________
City State Zip

Emergency Contact: ______________________ Relationship __________________ Phone _____________________

Marital Status: Do you have a living will?

*************************************************************************************************

## HEALTH INSURANCE

*Please present your identification cards, driver's license and any referral forms or authorization numbers to the receptionist at the time of your visit along with any co-payment.*

**PRIMARY INSURANCE COVERAGE** ______________________________

ID# ____________________________ Group#___________________

Subscriber's Name: ____________________________________ Date of Birth: ______________SS#_____________________

Employer Name & Address _____________________________________________Phone # _________________

**SECONDARY INSURANCE COVERAGE** ___________________________

ID# ____________________________Group# ___________________

Subscriber's Name: _____________________________________ Date of Birth: ____________SS# ______________________

Employer Name & Address _________________________________________________________ Phone # _________________

I request that payment of authorized insurance and/or Medicare benefits be made on my behalf to NEWTON URGENT CARE LLC. for any services furnished to me by the physician. I also authorize any holder of medical information about me to release to my insurance company and/or the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand medical information will be communicated to a designated representative of my employer **ONLY** if this is a Worker Compensation or an employer paid physical examination service.

I attest that all of the above information is accurate and current. ***Signature***: _____________________________________

**181 High Street**
**Newton, New Jersey 07860**

## NEWTON URGENT CARE CONSENT TO TREATMENT

I have given permission to Newton Urgent Care LLC and their staff to perform the following procedures/therapy deemed necessary: health history, physical exam, diagnostic procedures, x-rays, electrocardiogram, audiogram, pulmonary functions, venipuncture (drawing of blood for lab tests) and treatment for my injury/illness. If I should become ill while undergoing treatment, I give Newton Urgent Care LLC and their staff my permission to administer treatment which they consider necessary for my well being.
I understand that the information regarding the results of my physical exam, diagnostic procedures and/or nature of my illness may be released to the insurance carrier providing coverage to me. I understand that it is ultimately my responsibility to be aware of the benefits available under my insurance plan, and understand that should I have special requests regarding facilities to be utilized for diagnostic tests/treatment I should communicate those at the time of my visit.
I consent to have my medical information transferred to any physician and/or health care institution that I am referred to by Newton Urgent Care. I consent to authorize Newton Urgent Care to request any medical records from other Health Care providers.
I understand medical information will be communicated to a designated representative of my employer **ONLY** if this is a Worker Compensation or an employer paid physical examination service.
My signature (at bottom of page) indicates that I have read and understood this consent to treatment.

## Medical Information Release Form & Privacy Practices

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Newton Urgent Care's** NOTICE OF PRIVACY PRACTIVES. I am aware that NUC has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains. I have been notified of Newton Urgent Care's policy regarding "Request for Restriction" of my Protected Health Information, "Request for Alternative Communications" of my Protected Health Information and the procedure for making an objection to any item in the "Notice of Privacy Practices." I understand that this office is not required to honor any requested changes to the Notice of Privacy Practices.

## (HIPAA Release Form)

( ) I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
( ) Information is not to be released to anyone.
Name:_______________________________________ Phone:_________________
Name:_______________________________________ Phone:_________________ Primary
Doctor:_____________________________
This **Release of Information** will remain in effect until terminated by me in writing. **Messages**
Please call the following phone number: ______________________ If
unable to reach me:
( ) you may leave a detailed message. ( ) leave a message asking me to return your call.
( ) The best time to reach me is (day) or (night) ________ between ____________ time. By signing below, I agree to terms listed on above page.

Signed: ______________________________ Date: ___/____/___
Witness: ______________________________ Date: ___/___/____

# NEWTON URGENT CARE
# 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***************

NEWTON URGENT CARE LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy with respect to your protected health information.

**<u>Disclosure of Your Health Care Information</u>**

**Treatment**
We may disclose your health care information to other healthcare professionals for the purpose of treatment, payment or health operations.
**Payment**
We may disclose your health information to your insurance to your insurance provider for the purpose of payment or health care operations.
**Workers Compensation**
We may disclose your health information as necessary to comply with State Workers Compensation Laws.
**Emergencies**
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.
**Public Health**
As required by law, we may disclose your health information to public health authorizes for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
**Judicial and Administrative Proceedings**
We may disclose your health information in the course of any administrative or judicial proceeding.
**Law Enforcement**
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
**Deceased Persons**
We may disclose your health information to coroners or medical examiners.
**Organ Donation**
We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
**Public Safety**
It may be necessary to disclose your health information to appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the general public.
**Specialized Government Agencies**
We may disclose your health information for military, national security, prisoners and government benefits purposes.
**Telephone Contact**
We may contact you if a scheduled appointment is missing or to advise you of test results and to check your medical condition after a visit. If you are not home, we will leave a message.

Newton Urgent Care, LLC | Review of Systems | DOS: ____________________________

Patient Name: ____________________ Date of Birth: ____________________ Visit ID #: ____________________________

**Please check (√ ) all that apply for today's visit.**

**General**
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

**Skin**
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair and nail changes

**Head**
- ☐ Headache
- ☐ Head Injury
- ☐ Neck Pain

**Ears**
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage

**Eyes**
- ☐ Vision Loss/Change
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Last eye exam _____________

**Nose**
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

**Throat**
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores

**Neck**
- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

**Breasts**
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding

**Respiratory**
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

**Cardiovascular**
- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath w/ activity
- ☐ Difficulty breathing lying down
- ☐ Swelling
- ☐ Sudden awakening from sleep w/ shortness of breath

**Gastrointestinal**
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

**Urinary**
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Change in urinary strength

**Vascular**
- ☐ Calf pain w/ walking
- ☐ Leg cramping
- ☐ Burning or pain

**Musculoskeletal**
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

**Neurologic**
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

**Hematologic**
- ☐ Ease of bruising
- ☐ Ease of bleeding

**Endocrine**
- ☐ Head or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite

**Psychiatric**
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss

Other: ________________________________________________________________

**Physician Use Only**

- ☐ **Review of PMH, FMH & Medications completed.**
- ☐ **All other systems reviewed and negative, except as indicated in HPI.**

**Physician Signature**

Revised 11/25/2015

**Patient Name**: ____________________________________________________

**Date of Birth**: _____________________________________________________

**Pharmacy**: _____________________________

**Address**: ___________________________

___________________________________

**Phone #**: ___________________________

**MEDICATION ALLERGIES:**

____________________________________

____________________________________

____________________________________

____________________________________

**SOCIAL HISTORY:**

**Circle all that apply:**

Smoker: No Yes

Substance Abuse: No Yes

Alcohol Use - Number of Drinks:

_____ Day, _____ Week, _____ Month

**Living Arrangements:**

Self: ____________

Family: ____________

Other: __________________________

**FAMILY HISTORY:**

**Circle all that apply:**

F for Father or M for Mother

Diabetes F or M

Heart Disease F or M

High Blood Pressure F or M

Stroke F or M

Cancer:

____________________ F or M

____________________ F or M

____________________ F or M

==========================================================================================================

**Past Medical History:** __________ **None**

**Check all that Apply:**

__________ Seasonal Allergies
__________ Anemia
__________ Anxiety
__________ Arthritis of Aging
__________ Arthritis/Rheumatoid
__________ Asthma
__________ Atrial Fibrillation
__________ Back Pain
__________ Bladder Problems
__________ Cataracts
__________ Glaucoma
__________ Diabetes on Insulin
__________ Diabetes No Insulin
__________ Depression
__________ Edema/Swelling
__________ Emphysema/COPD
__________ GRD/Acid/Reflux
__________ Heart Attack/Angina
__________ Heart Failure
__________ Heart Palpitations
__________ Heart Valve Problems
__________ Hepatitis
__________ High Blood Pressure

__________ High Cholesterol
__________ HIV
__________ Kidney Problems
__________ Kidney Stones
__________ Liver Problems
__________ Migraines
__________ Neck Pain
__________ Prostate Problems
__________ Pancreatitis
__________ Seizures
__________ Stroke/TIA
__________ Thyroid Problems

**Cancer - Personal History:**

**Type Cancer/Treatment:**

_________________________________

_________________________________

_________________________________

_________________________________

**Other Health Conditions:**

_________________________________

_________________________________

_________________________________

**Surgeries: Type & Year**

_________________________________

_________________________________

_________________________________

**Please List Your Medications:**

_________________________________

_________________________________

_________________________________

_________________________________

_________________________________

_________________________________

_________________________________

_________________________________

_________________________________

_________________________________

**Physician Review Date & Signature**

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# NEWTON URGENT CARE

181 HIGH STREET
Newton, NJ 07860

**David G. Mattes, MD**
Board Certified Family Practice
Board Certified Emergency Medicine

**Michael Ganon, DO**
Board Certified Family Practice

**Patient Name:** ______________________________

**Today's Date:** ______________________________

Due to changes in the insurance industry, most insurance plans have significant in-network patient responsibility with greater deductibles and co-insurance being the patient's responsibility.

***All patients must leave a credit card on file if they wish to be patients of our practice.***
The practice will continue to send out claims to patients' insurance company and bill patients for their portion of the balance, per the insurance carrier's explanation of benefits. However, if we are unable to collect in full for our services after several attempts to collect, we reserve the right to process the patient's credit card.

**WE WILL NOT BE CHARGING YOUR CREDIT CARD TODAY**

Card Type: MasterCard Visa Discover

Bank Debit Card Visa MasterCard

Card Number: ________________________________ **CVS#**________ (3 digits)

Card Expiration Date _______/_______/_______

Card Holders Name ________________________________
(Exactly as it appears on the credit card)

Billing Address ________________________________

City & State ________________________________ZIP____________

Cardholder's Signature________________________________

Date of Signature ____________________

# **This form must be completely filled out in order to be seen by a physician in our practice**

Phone: (973) 383-9898 Fax: (973-383-9665

181 High Street
Newton, New Jersey 07860

## NEWTON URGENT CARE FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy.

Payment for all professional services and supplies, whether or not paid by an insurance carrier or health plan is your responsibility. When we are a participating provider with your health insurer, only the applicable co-pay or deductible is due at the time of service. We will be happy to process your insurance form for your reimbursement if we participate with your insurance. This is a courtesy we extend to you. Under certain circumstances patient financial responsibility is limited by applicable law (e.g., Medicare) or if we have a preferred provider or other agreement with the patient's health insurer.

All patients must leave a credit card on file if they wish to be patients of our practice. The practice will continue to send out claims to patients' insurance company and bill patients for their portion of the balance, per the insurance carrier's explanation of benefits. However, if we are unable to collect in full for our services after several attempts to collect, we reserve the right to process the patient's credit card.

We accept cash, checks, or major credit cards. Returned checks are subject to a $30 service charge and bank fees. Patient balances not paid within thirty days of billing will be charged a $25.00 billing fee. If your account becomes delinquent and is referred to collection, a collection fee representing 30% of the outstanding balance will be added.

Medical insurance is a contract between you, your employer (in some cases) and your insurance company. We are not a party to that contract unless we have chosen to be a participating provider with the insurance plan.

Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover, and regardless of our practice participation with a plan, payment for any non-covered services are the patient's responsibility.

We emphasize that as a medical care provider, our relationship is with you and not your insurance company. If you have any questions concerning the above information, please do not hesitate to ask us. We are here to help you.

### All Patients

Must present a valid driver's license or legal picture form of identification.

### Participating Insurance Plans

- You must present a current insurance card.
- You must be prepared to pay your plan's office copay prior to being seen.
- You must know if a written referral or authorization is needed to be seen.
- You must be familiar with your plan's benefits.
- You must know if your plan requires preauthorization prior to any office procedures.
- You are personally responsible to pay any deductibles or co-insurance required by your insurance company.

### Patient Financial Responsibility Non-Participating Insurance Plans

- Payment for all office services is due at the conclusion of your visit. You will be given a receipt with all information necessary to receive reimbursement from your insurance plan. If the additional fees are not collected at the time of your visit, we will balance bill you.

### Patient's With NO Insurance

- Payment for an office visit is to be made upon arrival for your visit. Additional charges incurred during the visit are to be paid at the conclusion of the visit. If the additional fees are not collected at the time of your visit, we will balance bill you.

**I have read and understand your payment policies and understand that all fees, including fees for services not covered or fees for services denied (in full or in part), unless limited by law or contract, regardless of the insurance coverage, are ultimately my responsibility.**

Patient/Guardian Signature___________________________________ Date:________________________ revised 7-15