VITA Medical Associates, P.C.

Anna A. Niewiarowska, M.D.

NEW PATIENT REGISTRATION

Date:_____ **Social Security #:** _____

Name: _____
(First) (MI) (Last)

Address:_____
(No./Street Name) (City) (State) (Zip Code)

DOB: _____ **Age:** _____

Email Address:_____**May we contact you through e-mail? Y N**

Marital Status: Married Single Other _____

Race: _____ **Sex:**_____ **Preferred Language:**_____

Ethnicity: Non-Hispanic or Non-Latino: **Y N** Hispanic or Latino: **Y N**

Cell Phone:_____

Home Phone:_____

May we contact you at *all* of the above numbers? Y N

Best Contact number we can keep on file (Preferred method of contact) _____

Employed: Y N **Occupation:**_____

Employer's Name: _____

Date of Onset/Description of Problem/Duration of Problem:

_____

_____

Emergency Contact Information:

NAME:	RELATIONSHIP:	CONTACT NO.:

Please Note: This is a Confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Referring Physician:_____

Phone Number:_____**Address:** _____

Primary Physician:_____

Phone Number:_____**Address:** _____

Which of your Doctor(s) would you like to receive a letter from our Practice?

Please provide as much information as possible:

Name: (First and Last)	Specialty	Address:	Phone #/Fax#

FINANCIAL POLICY

We are committed to providing you with the best possible care. To achieve this goal, we need your assistance and your understanding of our payment policy.

We are Blue Cross/Blue Shield and Medicare participating providers as well as participating providers with several other insurance plans/networks. Not all services are a covered benefit by all insurance companies. Any services not covered by your insurance will be your responsibility. It is your responsibility to check with your insurance carrier regarding pre-certification and/or second opinion coverage, procedures or clinical studies. Should you need any assistance, our staff will be happy to help you.

Your insurance is a contract between you and the insurance company. If your insurance company requires a referral form, this must be brought at the time of the visit. If it is an electronic referral, it would be greatly appreciated if you would bring in the referral number. If you do not bring the referral, we will need to reschedule your appointment or you can pay for the charges on that day. Without referrals, we cannot bill your insurance company and, therefore, the patient is billed directly. Patients are responsible to make "co-pay" payments the day of service.

All charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance. There are many options the billing department can offer such as payment plans, co-pay foundations, and drug co-pay cards.

I understand that fees for services rendered by any physician and/or employee of **VITA Medical Associates, P.C.** are payable to same by myself or my insurance carrier (if assignment of benefits is not accepted, I understand I am responsible for the remaining balance, including deductibles or co-payments, upon receipt of the first billing statement). I authorize **VITA Medical Associates, P.C.** to release to my insurance company any information necessary to complete claims. I further authorize payment of medical benefits by my insurance company to **VITA Medical Associates, P.C.**

Patient or Guardian's Signature: _____ Date: _____

Print Name: _____

Witness Signature: _____ Date: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Address: _____ Phone No.: _____

Subscriber: _____ DOB: _____ S.S. #: _____

Secondary Insurance: _____ ID#: _____

Address: _____ Phone No.: _____

Subscriber: _____ DOB: _____ S.S. #: _____

Tertiary Insurance: _____ ID#: _____

Address: _____ Phone No.: _____

Subscriber: _____ DOB: _____ S.S. #: _____

INSURANCE RELEASE

I hereby authorize VITA Medical Associates, P.C. to release any information necessary to process my insurance claims acquired in the course of my examinations or treatment; and allow a photocopy of my signature to be used to process my insurance claims until I revoke this usage in writing. I authorize and direct my insurance carrier to issue payment checks directly to Vita Medical Associates, P.C. In the event that my insurance carrier does not pay in full, I understand that I am ultimately financially responsible for any and all fees incurred and I agree to pay such fees in full. If I do not fulfill my contractual obligations with my insurance company, I understand that Vita Medical Associates, P.C. will forward my account to an outside collection agency for processing. The insurance information furnished here represents full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements, for any and all plans to which I subscribe, may cause me to incur full liability for professional charges as a result of non-payment by any of my insurance carriers.

Signature of Patient/Responsible Party: _____ Date: _____

Print Name _____

PHARMACY INFORMATION

Pharmacy Plan Name: _____

Policy No. _____

Pharmacy Name: _____

Pharmacy Phone No.: _____

Pharmacy Fax No.: (if known) _____

REQUEST TO RELEASE MEDICAL RECORDS

Date: _____

I, (Patient's Name) _____ DOB: _____
authorize the release of my medical records or copies of such to:

VITA Medical Associates, P.C.
306 S. New Street, Suite 201
Bethlehem, PA 18015
Phone: (610) 866-0113
Fax: (610) 974-8589

- Initial History/Physical
- Operative Reports
- Colonoscopy Reports
- EGD Reports
- Pathology Report
- Laboratory Reports
- Radiology Reports (CTs, MRIs, X-rays, PET/CT, Mammograms, MUGA scan)
- Radiation Treatment Records
- Chemotherapy/Treatment Records
- Hospital Records
- Pathology Slides
- Other (please specify) _____

Specific Requests:

_____

_____

_____

Signature of Patient: _____

Records must be received by: _____

(Date)

COMBINED ACKNOWLEDGEMENT AND CONSENT
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Please read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes **VITA Medical Associates, P.C.** to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices: VITA Medical Associates, P.C. has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to Contact our Privacy Officer

Mail:	VITA Medical Associates, P.C. ATTN: Privacy Officer 306 S. New Street, Suite 201 Bethlehem, PA 18015
Telephone:	(610) 866-0113
FAX:	(610) 974-8589

Acknowledgement and Consent

Print or Type all information except for Signature

I have received the Notice of Privacy Practices for **VITA Medical Associates, P.C.** and authorize them to use and disclose health information about _____ (Patient's Name) for treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of Patient (or Patient's Personal Representative) Date

Personal Representative Information (if applicable):

_____ _____

Name of Personal Representative Relationship to Patient (or Other Authority)

COMMUNICATION CONSENT

It is the office policy of **VITA Medical Associates, P.C.** and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail and/or cell phone number. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize **VITA Medical Associates, P.C.** and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Cell Phone and/or Voice Mail: _____	Yes	No
Work Phone and/or Voice Mail: _____	Yes	No
Home Phone/or Voicemail: _____	Yes	No
E-mail Address: _____	Yes	No
Send/Receive Medical Records/Electronic Prescription History for Referrals to Other Doctor's Facilities	Yes	No

If you would like to have information released to someone other than yourself, please complete the following:

Please list the names of authorized people:

Spouse: _____ Phone: _____

Life Partner: _____ Phone: _____

Other Names (Please list relationships such as boyfriend, fiancé, girlfriend, sister, brother, etc.)	Yes	No

Other: _____ Phone: _____

Other: _____ Phone: _____
Printed Name: _____

Patient/Guardian Signature: _____ Date: _____

Please Bring All Your Medicine Bottles to Your Next Appointment

Please make sure you bring (in the original container)…

All your medicines from
All your doctors!

☐ Prescription and non-prescription medications.

☐ Medicines you buy without a prescription (like Tylenol® or cold medicine).

☐ Ointments or Creams.

Even Medicines you
don't take all the time!

☐ Eye drops.
☐ Inhalers.
☐ Injection syringes.

This **is extremely important** because it…gives you a complete medicine list that can be shared with other doctors and hospitals, but most importantly, avoids medication errors.