PATIENT REGISTRATION FORM

Dr. Richard P. Campo, MD, MPH, FACS
277 Forest Avenue, Suite 206, Paramus, NJ 07652
Phone: (201) 489-8900; Fax: (201) 489-0877

PATIENT INFORMATION

Patient's Last Name: _____ Suffix (e.g., Jr.) _____ First Name: _____ MI: _____

Street Address: _____ Apt.#: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ Alternate Phone #: _____ Type? □ Cell □Work □Other: _____

D.O.B.: ___/___/___ Sex: _____ SSN: _____ Marital Status: _____ Primary Language: _____

Race: □ American Indian/Alaska Native □ Asian □ African American □ Hawaiian/Pacific Islander □ White □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Preferred Pharmacy Name and Phone Number: _____

Primary Care Physician's Name and Phone Number: _____

Preferred Communication Method: □ Phone □ Fax: _____ □ Mail □ Other: _____

Email: _____

EMERGENCY NOTIFICATION & DISCLOSURE OF INFORMATION

In Case of Emergency, Who Should Be Notified? _____ Phone: _____

Relation to Patient: □ Parent □ Spouse □ Child □Other: _____

I Hereby Give Permission to Disclose Personal Health Information to: _____

Phone: _____ Relation to Patient: □ Parent □ Spouse □ Child □Other: _____

EMPLOYER INFORMATION

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ May We Contact You at Work: □ Yes □ No

PRIMARY INSURANCE

Primary Insurance Company Name: _____ Telephone #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____ Co-pay $: _____ Effective: _____

Name of Insured: _____ Relation to Patient: □ Self □ Spouse □ Child □Other: _____

Insured D.O.B.: ____/____/____ Insured SSN: _____

SECONDARY INSURANCE

Secondary Insurance Company Name: _____ Telephone #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____ Co-pay $: _____ Effective: _____

Name of Insured: _____ Relation to Patient: □ Self □ Spouse □ Child □Other: _____

Insured D.O.B.: ____/____/____ Insured SSN: _____

Your signature below indicates your consent for treatment and responsibility for paying the bill. Thank you. I hereby authorize the release of any information acquired in the course of my examination or treatment to my insurance carrier if requested

X_____ _____

Patient/Authorized Signature **Date**

I hereby authorize the payment of medical benefits directly to Dr. Richard Campo.

X_____ _____

Patient/Authorized Signature **Date**

Richard P. Campo, MD, MPH, FACS
Adult & Pediatric Urology

Patient Name: _____ Today's Date: _____

Did a medical doctor refer you to this practice? ☐YES ☐NO

If YES, please indicate the doctor's name: _____

Address: _____

Phone# _____

Please write your Primary Care Physician's information, if different from above: _____

_____

Why are you seeing the doctor today? _____

Do you have ☐ LEFT or ☐ RIGHT sided pain or injury? Where? _____

When did this start? _____

Were you seen in the emergency room for this? ☐ YES ☐ NO If YES, where? _____

PAST MEDICAL HISTORY

Illness: have you ever had any of the MEDICAL PROBLEMS below? Please check ☑ all that apply.

		Date/Details			Date/Details
A-Fib	☐Yes	_____	High Blood Pressure	☐Yes	_____
Asthma	☐Yes	_____	High Cholesterol	☐Yes	_____
Bronchitis	☐Yes	_____	Kidney Stones	☐Yes	_____
Cancer(Specify)	☐Yes	_____	Lyme's Disease	☐Yes	_____
Cataracts	☐Yes	_____	Hypothyroidism	☐Yes	_____
Colitis	☐Yes	_____	Hyperthyroidism	☐Yes	_____
Congestive Heart Failure	☐Yes	_____	Neurological Disorder	☐Yes	_____
Diabetes (Type I or II?)	☐Yes	_____	Osteoporosis	☐Yes	_____
Emphysema	☐Yes	_____	Osteopenia	☐Yes	_____
UTI	☐Yes	_____	Phlebitis	☐Yes	_____
Epilepsy	☐Yes	_____	Stroke	☐Yes	_____
Heart Disease	☐Yes	_____	Tuberculosis	☐Yes	_____
Heart Attack	☐Yes	_____	Ulcer	☐Yes	_____
Hepatitis	☐Yes	_____	Other: _____		_____
Herpes	☐Yes	_____	_____		_____

FAMILY HISTORY

Has anyone in your immediate family been diagnosed with the following disease(s)? Please indicate family member.

Breast Cancer	☐Yes	_____	Heart Disease	☐Yes	_____
Bleeding Disorder	☐Yes	_____	High Blood Pressure	☐Yes	_____
Other Cancer	☐Yes	_____	Other Conditions	☐Yes	_____
Diabetes	☐Yes	_____			

REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____

Please check ☑ any of the following symptoms that you have experienced in the last 3 months.

Constitutional:
☐ Fatigue ☐ Fever ☐ Weight Loss ☐ Night Sweats ☐Malaise (general discomfort)
☐Body Aches ☐Chills ☐Weight Gain

Eyes:
☐Double Vision ☐Blurred Vision ☐Impaired Vision ☐Changes in Vision

HENT:
☐Recent Head Injury ☐Headaches ☐Nose Bleeding ☐Lightheadedness ☐Neck Stiffness
☐Neck Pain ☐Dental Problems ☐Neck Tenderness

Cardiovascular:
☐Syncope ☐Varicosities ☐Lower Extremity Edema (Swelling)

Gastrointestinal:
☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation

Genitourinary:
☐Incontinence ☐Urgency ☐Frequency ☐Urinary Retention ☐Difficulty Voiding

Integument:
☐Rash

Neurologic:
☐Seizures ☐Loss of Balance ☐Radicular (radiating) Pain ☐Tingling/Numbness
☐Changes in Bowel or Bladder Habits

Musculoskeletal:
☐Joint Pain ☐Joint Swelling ☐Muscle Pain ☐Muscle Weakness ☐Muscle Cramps
☐Back Pain ☐Neck Pain ☐Limitation of Motion

Psychiatric:
☐Anxiety ☐Depression

Heme-Lymph:
☐Easy Bleeding ☐Easy Bruising

PAST SURGICAL HISTORY

Surgery:	Date/ Details:	Surgery:	Date/Details:

MEDICATION

Please list all current medications.

Medication	Dosage

Do you have any INTOLERANCE to OTC Drugs?

Please List: _____

_____

ALLERGIES

☐NO KNOW DRUG ALLERGIES

Are you allergic to any MEDICATIONS below?

☐Lidocaine ☐Betadine ☐Codeine ☐Sulfa
☐Novocaine ☐Penicillin ☐Percocet ☐Aspirin

Other: _____

_____

Are you allergic to any FOODS?

Please List: _____

_____

Do you have any ENVIRONMENTAL/OTHER allergies?

Please List:

_____

_____

SOCIAL HISTORY

Alcohol Use: ☐Currently Drink Alcohol How Much?_____Drinks/wk
☐Former Drinker How Much?_____Drinks/wk
☐Never Drink Alcohol

Tobacco Use: ☐Currently Smoker Date stated _____ Packs/day_____
☐Former Smoker Date stated _____ Date stopped _____ Packs/day_____
☐Never Smoke Cigarettes

Drug Use: ☐YES ☐NO If YES, describe: _____

Exercise: ☐Heavy/Competitive Athlete ☐Moderate ☐Minimal ☐Sedentary

Weight: _____LBS Height: _____ft _____in B/P _____/_____

Any Other Problems? _____

_____

NJ Urology

ACKNOWLEDGEMENT OF RECEIPT
OF SUMMARY NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (973) 873-7002.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. NJ Urology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The participant understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations. NJ Urology has a Notice of Privacy Practices and that the participant has the opportunity to review this notice.
- NJ Urology reserves the right to change the Notice of Privacy Practices.
- The participant has the right to request restrictions to the uses of their information but NJ Urology does not have to agree to those restrictions.
- The participant may revoke this Consent in writing at any time and full disclosures will then cease.
- NJ Urology may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

_____
Name of Participant (print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Participant Representative Date
(Required if participant is a minor or an adult who is unable to sign this form)

_____
Relationship of Participant Representative to Participant Print Name

STATEMENT OF PATIENTS' FINANCIAL RESPONSIBILITIES

Our goal is to provide our patients with excellent and affordable medical care. To accomplish this goal, the practice has designated a financial officer who is able to help you understand the nature of any bills that you may receive, resolve issues with your insurance company, and establish sensible payment plans.

Please review the following billing procedures that are followed by our practice.

- Pursuant to federal and state law, as well as our contract with insurance carriers, our practice is required to collect all patient responsibility payments [patient responsibility payments include co-payments, coinsurances, and deductibles]. To ensure efficiency in our billing, it is the policy of our practice to **collect patient responsibility amounts at the time of your visit.**
- It is your responsibility to understand your insurance plan. While we work very hard to help ensure that your insurance covers services provided, there is a large number of different insurance plans, and we are unable to know all of them. If your insurance requires a referral, it is *your* responsibility to request your primary care doctor to issue one. If you arrive for your appointment without a referral, you will not be able to see your doctor.
- If your physician participates with your insurance plan, after your appointment, our billing department will submit a bill to your insurance company (insurance claim). The insurance claim will list all the services that have been provided to you as well as diagnosis codes for each complaint that you have related to your doctor. Upon receiving our claim, your insurance company may send you an explanation of benefits ("EOB"); **it is NOT a bill** – it is simply a statement from your insurance company explaining what is being paid for and what might not be covered. Please save the EOB for your records. If you receive a bill from our office that is inconsistent with the EOB you received from your insurance company, please contact our office immediately.
- If more than 60 days have passed from the time of your appointment, and your insurance company has not paid your doctor, you should contact your insurance company.
- If your insurance company denies your claim, the **charged amount of the claim becomes your responsibility.** Your insurance company may deny the claim for reasons that may be stated in your insurance policy (e.g. some diagnoses may be considered non-covered services under your contract, or your insurance company may establish that your condition is pre-existing). If you believe that the claim was erroneously (or incorrectly) denied, **contact our billing supervisor immediately. Our billing supervisor will work with you to attempt to get payment from your insurance company.** Depending on the reason for the denial, the balance due may be reduced to our cash payment rate.
- If you receive a bill from our practice, please forward the payment to our office at your earliest convenience and prior to the due date. If you are unable to afford the payment, please contact our billing supervisor who will set up a payment plan for you. If you believe that you have received the bill in error, please contact our office. Please be aware that if no payment is received within 90 days of the due date on the bill, the practice will engage in collection efforts, which may include forwarding your account to a credit-reporting collection agency.
- If your physician does not participate with your insurance company, your cash-rate payment is due at the time of your visit. If you have out-of-network benefits with your insurance company, our office will help you submit a claim for reimbursement.

We work very hard to make sure that our services are affordable and that your insurance company pays what it is supposed to. Please reach out to our billing supervisor if you have a question or an issue.

Date_____ Patient Name_____

Signature_____

NEW JERSEY
UROLOGY
Excellence In Care

1515 Broad Street, Suite B130, Bloomfield, NJ 07003-3085
P 973 873 7000 • F 973 743 8943

CANCELLATION AND NO SHOW POLICY

At Urologic Institute of N.J., we understand that situations arise in which you must cancel your appointment. Should you have to cancel, it is requested that you do so at least 24 hours in advance of your scheduled visit. In doing so, it will enable us to schedule someone who may be waiting for an appointment in your timeslot.

Office appointments cancelled with less than 24 hours' notice and not rescheduled will be subject to a **$50.00** cancellation fee.

Procedure cancellations without 24 hour notification will be subject to a **$150.00** cancellation fee. Patients who fail to show for an appointment or procedure without a call to cancel will be considered **"No Show"**, and will be subject to a **$150.00 No Show** fee.

The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with approval.

Our practice firmly believes that a quality physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and no show policy.

_____ **Date of Birth**_____

Patient Name (Please Print)_____

NEW JERSEY UROLOGY
Excellence In Care

PATIENT NOTICE REGARDING PATHOLOGY CHARGES

Please note that charges for laboratory testing services (e.g. specimen, tissue, blood or bodily fluids) are not included in your physician's fees and are separate from any payments made to your doctor during your office visit. NJ Urology (NJU) will submit a claim to your insurance carrier for any laboratory test performed at the request of your physician; you will receive a statement for any amount you are required to pay after insurance has paid its portion of the bill or denied payment. By ensuring our office has your most current insurance information, you can help expedite this process.

You may receive a bill from a laboratory which may appear to be a duplicate for a service performed. However, these charges are not included in any other statement. The doctor's charge relates to the professional services provided during your office visit or surgical procedure and the pathology bill relates to the professional services associated with the interpretation or diagnosis of the specimen, tissue, blood or bodily fluids.

If you have questions regarding your pathology statement or outstanding balance, or would like to make a payment, please contact Patient Account Services at 877-366-5876.

PATIENT/RESPONSIBLE PARTY ACKNOWLEDGEMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the **NOTICE REGARDING PATHOLOGY CHARGES**. I understand that I am financially responsible for non-covered services not paid by the insurance carrier within the confines of my policy.

_____ _____

Signature, Patient Date

_____ _____

Signature, Financially Responsible Party (if not patient) Date