SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

254 Easton Avenue
New Brunswick, NJ 08901
732-745-8600 • www.saintpetershcs.com

Dear Patient:

Saint Peter's is committed to providing you with the best medical care possible. This includes the handling of your bill. We want to help you understand your bill and answer any questions you may have.

Saint Peter's University Hospital Ambulatory Services area is a "Hospital-Based" service area. Receiving care in our Ambulatory Services area may result in a hospital charge (facility fee), as well as a physician charge (professional fee) for outpatient services and/or procedures. These charges will be reflected on the patient statement you receive for services provided.

Patients are advised to review their insurance benefits or contact their insurance provider to determine what their policy will cover and identify any out-of-pocket expenses.

If you still have unanswered questions after reading this message, please see a representative at the registration desk or contact our billing department at:

1-800-871-3085	Physician Statement
1-732-745-8550	Hospital Statement

Thank you,

Garrick J. Stoldt
Chief Financial Officer

ADM-157 (9/13)

SAINT PETER'S UNIVERSITY HOSPITAL
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254 Easton Avenue
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Department of Radiation Oncology

T: 732-745-8590
F: 732-745-9786

Gopal R. Desai, MD, DABR
Kenneth R. Blank, MD
Alexander Z. Haas, MD, FACR

Welcome to Saint Peter's University Hospital Radiation Therapy Department. The first 45 minutes of your appointment will consist of the registration process and data collection with the nurse and then consultation with the doctor will follow. Please plan on being here 1½ to 2 hours. We would appreciate your promptness and understanding since we may need to reschedule your appointment in the event of a major delay.

At the end of your consultation, future appointments are usually made. Please do not leave the office until these additional appointments have been scheduled, or you are otherwise directed. These appointments may be for any number of purposes, including laboratory studies, X-rays, etc. Each service may need to be scheduled before leaving so that you have specific directions on when to return after you leave.

If you must cancel your appointment, please call us at least 48 hours in advance at (732) 745-8590. We will be happy to reschedule your appointment for another convenient time.

We hope to provide you with a complete and thorough consultation. In order to do so, the following information is vital:

1. ***Medical summaries***, including all hospital records such as history and physicals, lab reports, treatment records, discharge summaries, and consultations.
2. ***X-rays/scans*** – we prefer the original films of all studies which relate to your condition, along with the reports. The films will be reviewed at the time of your visit.
3. ***Pathology*** – if you had any biopsies or surgery, it is extremely important that we have a copy of the pathology report(s).
4. If you are currently undergoing treatment of any kind, we need records which indicate the type of treatment and dosages.

All records and X-rays must accompany the patient at the time of the appointment, otherwise the appointment may need to be cancelled and rescheduled for a later date.

If possible, please be prepared to pay a "co-pay" at the time of the consultation appointment, if applicable to your insurance plan.

Rev. October 30, 2014

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Date: _____
Unit #:_____

NEW PATIENT INFORMATION/REGISTRATION CARD

RADIATION ONCOLOGY

732-745-8590

PLEASE PRINT

Name: _____

DOB: _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address:_____ City:_____ Zip Code: _____

Home phone #:_____ Cell #: _____ Email:_____

Employer:_____

Employer's Address: _____ City:_____ Zip Code:_____

Social Security #:_____ Medicare #:_____

Referring Physician: _____ Phone #:_____

Diagnosis:_____

Relative/Friend whom we can contact if you are unavailable:

Name:_____ Relationship:_____

Address:_____ City:_____ Zip Code:_____

Home phone #:_____ Cell #: _____ Business #:_____

Have you ever received radiation therapy before? If yes, when and where? _____

_____

Please list all insurance that you currently have along with your **identification numbers**:

Company:_____ Insurance #:_____

Company:_____ Insurance #:_____

Company:_____ Insurance #:_____

How did you hear about us? Radio_____ TV_____ Print_____ Other_____

Would you like to be notified about upcoming events? Yes_____ No_____

If you are covered by your spouse's insurance, please include the following information:

SPOUSE'S NAME:_____

SPOUSE'S DATE OF BIRTH: _____

SPOUSE'S SOCIAL SECURITY #: _____

OCCUPATION: _____

SPOUSE'S EMPLOYER: _____

ADDRESS OF SPOUSE'S EMPLOYER: _____

_____

_____

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

HEALTH INFORMATION MANAGEMENT DEPARTMENT

Telephone (732) 745-8511 Fax Number (732) 729-9476

Patient Name:_____ Date of Birth:_____ Telephone #:_____

Home Address: _____

Medical Record Number: _____ Account Number: _____

TYPE OF REQUEST: I hereby request that Saint Peter's University Hospital provide me with:

☐ **Copies of** my Health Information, as requested below: ☐ **Access** to Review Originals
(Note that if access is requested, it is subject to review at a time and place chosen by the Hospital.)

RELEASE INFORMATION TO: ☐ Myself (the patient or representative) ☐ To organization/individual below:

Organization	Individual Name	Phone
Street Address	City	State Zip Code

DATES OF SERVICE FOR WHICH PROTECTED HEALTH INFORMATION IS TO BE DISCLOSED:

Date(s) _____

INFORMATION TO BE RELEASED: (check all that apply)

☐ Medical Abstract*	☐ Discharge Summary	☐ Surgery Reports
☐ Emergency Dept Records Only	☐ History and Physical	☐ X-Rays
☐ Outpatient Records Only	☐ Progress Notes	☐ EKG/EEG
☐ Consultation Reports	☐ Pathology Reports	☐ Labs

☐ Other: _____

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- ***Medical Abstract includes:*** *Face Sheet, Discharge Summary, Emergency Room Records, History & Physical, Consultations, Laboratory, Radiology, EKG, Operative Report, Pathology Report.*

DELIVERY METHOD: (check one)

☐ Please mail
☐ Please copy for pick-up
☐ Please provide electronically (for health information contained in an Electronic Health Record ("EHR").
[Patient/Authorized Representative: also complete HealthPort Electronic Record Delivery Request and **fax with authorization.]**

USB Flash Drive Password: _____

SPECIFIC CONFIDENTIAL INFORMATION:

Please sign your initials next to those specific categories of highly confidential information that you authorize Saint Peter's University Hospital to release for the treatment date(s) above. *If a line is **NOT** initialed, that information will **NOT** be released.*

_____ HIV/AIDS Information	_____ Mental Health/Psychotherapy Information	_____ Drug/Alcohol Information
_____ Genetic Information	_____ Sexually Transmitted Disease Information	_____ Tuberculosis Information

PURPOSE OF RELEASE: I authorize Saint Peter's University Hospital to release the above Health Information for the following Purpose(s): _____

R-07 (Rev. 12/14). This form supersedes R-07 (06/13)

TERM/EXPIRATION: This Authorization is valid for a period of ninety (90) days ("Term"), unless a shorter term is stated here: _____, and therefore expires on ___/___/___.

FEES: (apply to copies given to patients and their legally authorized representatives only; other fees may apply to other requestors): I accept that Saint Peter's University Hospital, Inc. is able under state and federal law to charge me a fee for electronic copies or photocopies and any applicable mailing/postage fees for my medical records. I further accept that these copy fees are based on the current hospital fee schedule in keeping with New Jersey law.

I accept that information given to me based on this request will not include information compiled in anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be prohibited by law.

I accept that Saint Peter's University Hospital may deny this request on a limited basis under federal and state law protecting the privacy of health information. I further accept that, except as otherwise prohibited under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by Saint Peter's University Hospital who did not take part in Saint Peter's University Hospital's finding to deny my request.

I accept that Saint Peter's University Hospital will notify me of its finding to approve or deny my request to access or obtain a copy of the requested information within thirty (30) days of getting this request.

The information to be disclosed from my records is confidential and is protected by federal and state law. I accept that once Saint Peter's University Hospital releases my health information to the person(s) listed on this Authorization, Saint Peter's University Hospital cannot guarantee that the person(s) will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I accept that this Authorization will stay in effect until its Term expires, or I provide a written repeal to Saint Peter's University Hospital. The repeal will be effective immediately upon Saint Peter's University Hospital receipt of my written notice, except that the repeal will not have any effect on any action taken by Saint Peter's University Hospital in good faith before Saint Peter's University Hospital received my written notice of repeal.

I have read, understand and accept the terms describe in this Authorization and I have had the opportunity to ask questions about my rights to access my health information and any Protected Health Information that Saint Peter's University Hospital uses to make medical decision about me. I also understand that if I have further questions or concerns about my Protected Health Information, I may contact Saint Peter's University Hospital Health Information Management Department by mail: 254 Easton Avenue, New Brunswick, New Jersey 08901 or by telephone at (732) 745-8511 or by **FAX # (732) 745-9476**.

I hereby authorize Saint Peter's University Hospital to release/disclose the health information as listed for the purposes as written in this Authorization.

Patient Signature: _____ Date: _____ Time: _____

If the patient is a minor or otherwise unable to sign this Authorization, then the signature of the patient's legally authorized representative must be recorded below:

Description of Authority: _____

Representative Signature: _____ Date: _____ Time: _____

Interpreter/Translator: _____ Date: _____ Time: _____

Notice to Recipient of Information

If the patient or their legally authorized representative authorized release of "Alcohol and Drug Abuse" information, as indicated by their initials under part 2. of this form, the following Notice applies to the information you have received pursuant to this authorization: This information has been disclosed to you from records protected by Federal confidentiality rules 42 C.F.R. Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 A general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

R-07 (Rev. 12/14). This form supersedes R-07 (06/13)