PULMONARY SPECIALISTS OF NORTH JERSEY

Selwyn E. Levine, M.D., F.C.C.P.*
Theophanis A. Pavlou, M.D., F.C.C.P.* †
Victor Gorloff, M.D., F.C.C.P.*
Paul S. Han, M.D., F.C.C.P. *†
Harris Tesher, M.D
Richard May Jr, MD
Cassandra DeSmet, NP

☐ ENGLEWOOD OFFICE
200 Grand Avenue, Suite 102
Englewood, New Jersey 07631
Phone (201) 871-3636
Fax (201) 871-2286

☐ NORTH BERGEN OFFICE
8305A Bergenline Avenue
North Bergen, New Jersey 07047
Phone (201) 854-7200
Fax (201) 854-0827

HOLY NAME PULMONARY ASSOCIATES, PC (A)
DIPLOMATES, AMERICAN BOARD OF INTERNAL MEDICINE
PULMONARY DISEASE, *CRITICAL CARE MEDICINE AND †SLEEP MEDICINE

PATIENT NAME: _____
FIRST NAME MIDDLE INITIAL LAST NAME

STREET ADDRESS:

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

SEX: M [ ] F [ ] **EMAIL ADDRESS:**

CELL PHONE: _____ **HOME PHONE:** _____ **WORK PHONE:**

PREFERRED CONTACT METHOD: CELL PHONE [ ] HOME PHONE [ ] WORK PHONE [ ] EMAIL ADDRESS [ ]

DOB: _____ **SS#:** _____ **MARITAL STATUS:** S [ ] M [ ] D [ ] W [ ]

NAME OF SPOUSE: _____ **DO YOU RESIDE IN A SKILLED NURING FACILITY?** YES [ ] NO [ ]

EMPLOYER: _____ **EMPLOYER ADDRESS:** _____

EMERGENCY INFORMATION

CONTACT PERSON: _____ RELATIONSHIP TO PATIENT:

CELL PHONE: _____ HOME PHONE: _____ WORK PHONE: _____

REFERRING PHYSICIAN / FRIEND: _____

IF FULL-TIME STUDENT INDICATE SCHOOL CURRENTLY ATTENDING: _____

PRIMARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

ADDRESS: _____ EFFECTIVE DATE: _____

RELATIONSHIP TO INSURED: _____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT): _____ SS#: _____ DOB: _____

SECONDARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

ADDRESS: _____ EFFECTIVE DATE: _____

RELATIONSHIP TO INSURED: _____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT): _____ SS#: _____ DOB: _____

ASSIGNMENT OF BENEFITS: MY SIGNATURE BELOW INDICATES MY CONSENT FOR TREATMENT AND CONFIRMS MY UNDERSTANDING THAT ALL NON-COVERED ITEMS, CO-PAYMENTS AND DEDUCTIBLES ARE MY RESPONSIBILITY AND THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIMS THAT WAS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY INSURANCE COMPANY. IF I AM UNCOVERED BY ANY INSURANCE, I AGREE TO PAY THE SELF-PAY FEE FOR THE SERVICES I RECEIVE.

X **SIGNED:** _____ **DATE:** _____

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND THE CENTER FOR MEDICARE AND MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURACE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

X **SIGNED:** _____ **DATE:** _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PROVIDER OF SERVICE AND (OR) SUPPLIER FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER AND SERVICE AND (OR) SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICARE INFORMATION ABOUT ME RELEASE TO:

MEDIGAP INSURANCE: _____ **HIC #:** _____

ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED: _____ **DATE:** _____

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AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I HEREBY AUTHORIZE _____ TO FURNISH TO:

PHYSICIAN:
[ ] VICTOR GORLOFF, MD **[ ] PAUL HAN, MD** **[ ] CASSANDRA DESMET, NP**
[ ] SELWYN LEVINE, MD **[ ] HARRIS TESHER, MD**
[ ] THEOPHANIS PAVLOU, MD **[ ] RICHARD MAY Jr, MD**

NAME: **PULMONARY SPECIALISTS OF NORTH JERSEY – (DIVISION A)**
ADDRESS: **200 GRAND AVENUE, SUITE 102**
ENGLEWOOD, NEW JERSEY 07631

PHONE #: **(201) 871 - 3636**
FAX #: **(201) 871 - 2286**

INFORMATION, ACCESS TO, OR PHOTOCOPIES OF THE MEDICAL RECORDS OF:

PATIEN'S NAME: _____ MR #:
ADDRESS: _____ DOB: _____
_____ PHONE #: _____

THE FORGOING IS SUBJECT TO THE LIMITATIONS AS LISTED BELOW:

1. NATURE OF INFORMATION TO BE RELEASED:

[ ] HISTORY / PHYSICAL EXAM **[ ] DISCHARGE SUMMARY** **[ ] CONSULTATIVE REPORTS**
[ ] OPERATIVE REPORTS **[ ] PATHOLOGY REPORT(S)** **[ ] X-RAY REPORTS**
[ ] LABORATORY REPORTS **[ ] PHYSICAL THERAPHY NOTES** **[ ] PROGRESS NOTES**
[ ] NURSES NOTES **[ ] EMERGENCY DEPARTMENT RECORDS**
[ ] OTHER: _____

2. THIS AUTHORIZATION IS CONFINED TO THE FOLLOWING DATES OF TREATMENT: FROM _____ TO _____
(MONTH / DATE / YEAR) *(MONTH / DATE / YEAR)*

3. PURPOSE OF RELEASE: _____

SENSITIVE INFORMATION: I UNDERSTAND THAT THE INFORMATION RELEASED FROM MY MEDICAL RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASES, **HIV / AIDS** RELATED INFORMATION (INCLUDING THE FACT THAT **HIV** TEST WAS ORDERED, PERFORMED OR REPORTED, REGARDLESS OF WHETHER THE RESULTS OF SUCH TEST WERE POSITIVE OR NEGATIVE). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES, DRUG AND ALCOHOL INFORMATION, GENETIC INFORMATION AND TUBERCULOSIS INFORMATION. I APPROVE OF THE RELEASE OF SUCH INFORMATION BY INITIATING:

HIV / AIDS _____ DRUG OR ALCOHOL _____ MENTAL HEALTH _____ GENETICS _____

**** PLEASE NOTE, ALL COPIES FOR PATIENT RECORDS FOR PERSONAL USE CARRY A PER PAGE FEE. THE STATE OF NEW JERSEY ALLOWS 30 DAYS TO COMPLY WITH A RECORD REQUEST AND WALK-INS WILL BE HANDLED ACCORDINGLY UNLESS THERE IS AN EMERGENCY. IF YOU ARE PICKING UP THE RECORDS PERSONALLY, YOU WILL BE REQUIRED TO SHOW A LEGAL FORM OF IDENTIFICATION. ****

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THE AUTHORIZATION MAY BE SUBJECT TO DISCLOSURE BY THE RECIPIENT AND NO LONGER BE PROTECTED BY THE RULE.

I FURTHER DIRECT THAT ONLY INFORMATION PRIOR TO THE DATE OF MY SIGNATURE BELOW BE HONORED, AND THAT A PHOTOCOPY OF THIS AUTHORIZATION BE GRANTED THE SAME AUTHORITY AS THE ORIGINAL.

I FURTHER HEREBY RELEASE HOLY NAME MEDICAL CENTER AND YOU PERSONALLY FROM ALL LEGAL RESPONSIBILITY AND / OR LIABILITY THAT MAY ARISE FROM THE RELEASE OF SUCH RECORDS AS SPECIFIED ABOVE, AND I HEREBY WAIVE ALL RIGHTS I HAVE TO PRESERVE THEIR CONFIDENTIALITY.

I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND IF I REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE HEALTH INFORMATION MANAGEMENT DEPARTMENT. I UNDERSTAND THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASE IN REPONSE TO THIS AUTHORIZATION. I UNDERSTAND THE REVICATION WILL NOT APPLY TO MY INSURANCE COMPANY WHEN THE LAW PROVIDES MY INSURER WITH THE RIGHT TO CONTEST A CLAIM UNDER MY POLICY. UNLESS OTHERWISE REVOKED, THE AUTHORIZATION WILL EXPIRE IN ONE YEAR'S TIME. IF I FAIL TO SPECIFY AN EXPIRATION DATE, EVENT OR CONDITION, THIS AUTHORIZATION WILL EXPIRE IN ONE YEAR.

SIGNATURE OF PATIENT: _____ **DATE:** _____

IF THE PATIENT IS A MINOR OR IS OTHERWISE UNABLE TO SIGN THIS AUTHORIZATION, OBTAIN THE FOLLOWING SIGNATURE:

SIGNATURE OF PATIENT'S REPRESENTATIVE: _____ **DATE:** _____

DESCRIPTION OF AUTHORITY _____

(PLEASE NOTE, A COPY OF THE LEGAL DOCUMENTS MUST BE PROVIDED IN ORDER TO PROVE AUTHORITY IF NOT SIGNED BY THE PATIENT.)

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE _____ TO FURNISH TO:

[ ] PHYSICIAN [ ] INSURRANCE CO. [ ] LEGAL [ ] HOSPITAL [ ] OTHER

NAME: _____

ADDRESS: _____ PHONE #:

_____ FAX #: _____

INFORMATION, ACCESS TO, OR PHOTOCOPIES OF THE MEDICAL RECORDS OF:

PATIEN'S NAME: _____ MR #:

ADDRESS: _____ DOB: _____

_____ PHONE #: _____

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[ ] OPERATIVE REPORTS **[ ] PATHOLOGY REPORT(S)** **[ ] X-RAY REPORTS**
[ ] LABORATORY REPORTS **[ ] PHYSICAL THERAPHY NOTES** **[ ] PROGRESS NOTES**
[ ] NURSES NOTES **[ ] EMERGENCY DEPARTMENT RECORDS**
[ ] OTHER: _____

2. THIS AUTHORIZATION IS CONFINED TO THE FOLLOWING DATES OF TEATMENT: FROM _____ TO _____
(MONTH / DATE / YEAR) *(MONTH / DATE / YEAR)*

3. PURPOSE OF RELEASE:

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HIV / AIDS _____ DRUG OR ALCOHOL _____ MENTAL HEALTH _____ GENETICS _____

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FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE AND YOUR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. PLEASE ASK IF YOU HAVE ANY QUESTIONS REGARDING OUR FEES AND POLICIES.

DUE TO RAPID CHANGES TAKING PLACE IN THE HEALTH INSURANCE INDUSTRY, IT IS IMPERATIVE THAT YOU ARE AWARE OF THE BENEFITS AND REQUIREMENTS OF YOUR INSURANCE PLAN. THERE IS NO WAY WE CAN POSSIBLY KNOW, OR KEEP UP TO THE DATE WITH EACH PROGRAMS PROVISION.

IT IS YOUR RESPONSIBILITY TO KNOW AND ADVISE US OF YOUR PLANS REQUIREMENTS IN ADVANCE, EACH AND EVERY TIME WE PROVIDE SERVICE. PLEASE BE ADVISED THAT IF WE HAVE NOT BEEN INFORMED OF YOUR PROGRAMS REQUIREMENTS AND WE PROVIDE A PHYSICIAN OR LABORATORY SERVICE, YOU WILL BE RESPONSIBLE FOR THE FEES. WE WILL DO OUR BEST TO COMPLY WITH YOUR INSURANCE REQUIREMENTS. PATIENTS MUST INFORM US OF CHANGES IN INFORMATION AND INSURANCE PLANS PRIOR TO BEING SEEN. THERE WILL BE A $25.00 CHARGE FOR INCORRECT INFORMATION.

PARTICIPATING PLANS: COPAYS ARE DUE AT TIME OF SERVICE. $50.00 SURCHARGE IF NOT PAID.

NON-PARTICIPATING/OUT OF NETWORK SERVICES: PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE, UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH THE OFFICE MANAGER.

REFERRALS: IF YOUR PLAN REQUIRES A REFERRAL FROM YOUR PCP IT IS YOUR RESPONSIBILITY TO PRESENT THE REFERRAL PRIOR TO THE SERVICE, OR YOU MAY BE RESPONSIBLE FOR THE PAYMENT IN FULL.

LABORATORY SERVICE: PATIENTS MUST INFORM THE NURSE PRIOR TO BLOOD DRAWING, WHICH LABORATORY IS PARTICIPATING WITH YOUR INSURANCE.

YOU ARE RESPONSIBLE FOR YOUR ANNUAL DEDUCTIBLE AND CO-INSURANCE OF 20% / 30% ECT. WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS.

CANCELLATION POLICY: 24HRS NOTICE IS REQUIRED OR A FEE OF $50.00 WILL BE CHARGED.

NO-SHOW POLICY: NO-SHOW FEE OF $50.00 WILL BE BILLED TO YOU IF YOU CONFIRM YOUR APPOINTMENT, AND DO NOT SHOW UP.

I ACKNOWLEDGE THE ORIGINAL COPY OF THE INFORMATION.

SIGNATURE: _____ **DATE:** _____

PLEASE PRINT YOUR NAME: _____

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TO ALL OUR PATIENTS:

IF THE PHYSICIAN HAS ORDERED A TEST FOR YOU (LABS / BLOOD WORK / CT SCAN / PET SCAN / ULTRASOUND / DOPPLER, ETC) PLEASE:

- **CALL THE PHYSICIAN / NURSE TO LET THEM KNOW WHEN AND WHERE YOU ARE HAVING THE TEST.**

- **IF YOU HAVE NOT RECEIVED A PHONE CALL REGARDING YOUR TEST RESULTS AFTER 2 WEEKS OF TAKING THE TEST, PLEASE CALL THE PHYSICIAN / NURSE.**

I HAVE READ THE ABOVE:

PLEASE PRINT YOUR NAME: _____

SIGNATURE: _____ **DATE:** _____

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OFFICE RECORD

Use our new online Patient Portal!

The patient portal is a web-based system that is your secure communication link. The Patient Portal is a secure way to access the information listed below through the internet. When you log into the Patient Portal with your private user name and password, you can do the following:

Feature (s):	Can Do:
Messaging:	Appointment Request. Billing Question. Sleep Study Question. Medical Record Question. Prescription Question. Prescription Refill Request. (non-narcotic) General Question / Concern. Login Assistance / Portal Navigating.
Upload Document (s):	Insurance Card (s) *(format: pdf and jpg).* Identification Card *(Format: pdf and jpg).* Clinical Document (s) *(Format: pdf and jpg).*
View Clinical Summaries:	Upcoming Appointments Recent Medications Visit Summery Education Form (s) **Medical History:** Vitals Lab Result (s) *(Only for Holy Name and Quest Diagnostic. Excluded: Lab Corp).*
Modification:	Update Patient Demographic Information

Patient Portal Consent Form

Please read following policy carefully:

- We are offering the patient portal as a convenience to you at no cost.
- The portal is for non-emergency uses only. Online communications should never be used for emergency or urgent request. We will reply to your request / inquiries within three business days.
- We are not allowed to refill narcotic or other controlled medications through the internet portal.

By using the online patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen.

Patient Name:	Date of Birth:	Email Address: *(required)*

Signature of Patient: Date:

Keep for your record

Patient Portal Login Information

After we create your Patient Portal Account

Go to: www.njlung.com
click on "For Patients" → click on the button "Visit the Aprima Patient Portal".

User Name:	Password: