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Preparing for your appointment:

- ☐ Make a list of your symptoms and health questions.
- ☐ Bring a list of all current medications that you take on a regular basis, including over-the-counter and herbal medications.
- ☐ Make a list of other doctors you have visited. Write down their names, addresses, phone numbers, and reasons that you visited them.
- ☐ Bring copies of any test results, x-rays, and imaging results.
- ☐ Bring a copy of your personal and family health history.
- ☐ Bring your insurance card or other insurance information.
- ☐ If you want to, ask a family member or friend to go to your appointment with you.
- ☐ **Please complete and bring the forms included within this envelope to your appointment.**

During your appointment:

- ☐ Write down the names of your care team – your doctor, nurse, and Local Care Team Director.
- ☐ Use your list of questions.
- ☐ Use your own words to repeat what you have discussed with your care team and write down any instructions.
- ☐ Ask how your problem can be treated.
- ☐ Ask how you can improve your health.
- ☐ Ask if you need to come back for a follow up visit or if you need to call your doctor within the next few days about how you are feeling.
- ☐ Ask how you reach your doctor after hours.

POS Reorder # 1900520

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Adult Registration Form

☐ New Patient ☐ Edit Information

***For All Patients over 18 years of Age ***

Please complete this form to ensure proper billing of your services. **Please Print.**

Today's Date: ____________

Patient Information

Please provide Photo ID

Patient Last Name: ____________________

First Name: ____________________ MI: ________

Preferred Name: ____________________

Date of Birth ____________ SS#: ____________

Gender:

☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F

☐ Decline to specify

Marital Status:

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Life Partner ☐ Significant Other

☐ Other ____________________

Student Status:

☐ Full-time ☐ Part-time ☐ N/A

Primary Care Provider:

Name: ____________________

Address: ____________________

____

City, State, Zip: ____________________

Phone: ____________________

Fax: ____________________

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Declined to specify

Race:

☐ American Indian/Alaska Native ☐ Asian

☐ African American ☐ Native Hawaiian/Pacific Islander

☐ White ☐ Declined to specify

Preferred Language:

☐ English ☐ Spanish

☐ Other ____________________

Translator?

☐ YES ☐ NO

Comments: ____________________

Referring Provider:

Name: ____________________

Address: ____________________

____

City, State, Zip: ____________________

Phone: ____________________

Fax: ____________________

Patient's Primary Address

Address: ____________________

City, State, Zip: ____________________

Home Phone: (______) ____________ Cell Phone: (______) ____________ Work Phone: (______) ____________

Patient's Reminders/Communication

This section is related to communication and Patient Portal access (See 'Patient Portal FAQs')

Due to HIPAA regulations all patients over 18 must use their own information unless a legal guardian/court document is supplied.

Home Phone: (______) ____________ Cell Phone: (______) ____________ Work Phone: (______) ____________

☐ Web Enabled E-Mail: ____________________

☐ No Email ☐ Patient Refused *(must be patient's email, not Proxy)*

☐ Voice Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work

☐ Text Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work

Types of reminders you wish to receive:

☐ Appointments ☐ Lab results ☐ Health Maintenance ☐ RX Confirmation ☐ General ☐ **ALL** ☐ **NONE**

Patient's Employment Information

Emp. Status:

☐ Employed FT ☐ Employed PT ☐ Not Employed ☐ Self ☐ Active Military ☐ Retired ☐ Reserved for Nat'l assignment

Employer: ____________________ Occupation: ____________________

Preferred Pharmacy Information

Primary Pharmacy Name, Address & Phone #: ______________________________
____

Patient's Emergency Contact

Last Name, First Name: ______________________ Patient's Relationship to Contact: ______________

Home Phone: (_____) ______________________

Work Phone: (_____) ______________________

Cell Phone: (_____) ______________________

Insurance Information

Please provide a copy of ALL Insurance cards

Please let us know if this is a ☐ Worker's Comp Issue ☐ MVA ☐ Legal Case ☐ School Insurance

☐ Self-Pay (no insurance)

☐ Medicaid – ID Number: ______________________

Patient relationship to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other ______________

PRIMARY INSURANCE NAME:

Benefit Plan Name ______________________

Member ID: ______________________

Group#: ______________ Effective Date: __________

Subscriber's Name: ______________________

Subscriber's DOB: ______________________

Gender:

☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F

☐ Decline to specify

PCP listed on Card: ______________________

SECONDARY INSURANCE NAME:

Benefit Plan Name ______________________

Member ID: ______________________

Group#: ______________ Effective Date: __________

Subscriber's Name: ______________________

Subscriber's DOB: ______________________

Gender:

☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F

☐ Decline to specify

PCP listed on Card: ______________________

I have completed this form to the best of my knowledge and I understand I am to contact the office with changes to my personal information. I understand that I am responsible for all outstanding patient liabilities and financial obligations.

Patient Name: ______________________________ *Date:* ______________

Patient Signature: ______________________________

If Patient has a Legal Guardian, a copy of the legal document granting you such power must be attached or on file with Advocare LLC.

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Medical History

Date: ____________________

Name ______________________ Age __________ Birthdate ____/____/____

Address ______________________ Sex: ☐ Male ☐ Female

______________________ Home Phone ______________________

______________________ Work Phone ______________________

Occupation ______________________ Emergency Contact ______________________

Phone: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Married, Spouse's Name ______________________

Children's Names and Ages ______________________

Allergies to Medications

Allergies to Medication, X-Ray Dyes, or Other Substances ☐ Yes ☐ No
(If yes, please list name of medicine and type of reaction):

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Past Medical History & Review of Systems

Please circle if **you** have had problems with or are presently experiencing any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest Pain / Chest Tightness
6. Shortness of Breath
7. Swollen Ankles
8. Palpitations
9. Lightheadedness
10. Frequent Urination
11. Rheumatic Fever
12. Asthma
13, Bronchitis
14. Pneumonia
15. Persistent Cough
16. T.B.
17. Hay Fever
18. Abdominal Discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in Stool
25. Ulcers
26. Change in Bowel Habits
27. Unexplained Weight Gain / Loss
28. Hemorrhoids
29. Gall Bladder Disease
20. Colitis
31. Hepatitis or Jaundice
32. Thyroid Disease
33. Head or Neck Radiation
34. Headache
35. Kidney Disease
36. Kidney Stones
37. Difficulty Urinating
39. Arthritis
39. Low Back Problems
40. Skin Diseases
41 Blood Disorders
42. Venereal Diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol Abuse
47. Drug Abuse
48. Gout
49. ______________________
50. ______________________

____

____

____

Gynecologic and Obstetric History

Age at onset of periods: ____________ Frequency: ____________ Length of period: ____________

Pregnancies: ____________ Births: ____________ Miscarriages: ____________

Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please describe) ______________________

Leakage of urine: ☐ No ☐ Yes (Please describe) ______________________

Pelvic Pain: ☐ No ☐ Yes (Please describe) ______________________

Abnormal discharge: ☐ No ☐ Yes (Please describe) ______________________

History of abnormal PAP smear: ☐ No ☐ Yes (Type of treatment) ______________________

This information is for use by your physician as part of your confidential medical record.

Please continue to other side →

Patient Name: ______________________ Date: __________

Medical History

Please List and Supply the Dates of:

Operations: ______ ______ ______

Hospitalizations other than for surgery: ______ ______ ______

Immunization History – Have you had:
- Hepatitis B? ☐ No ☐ Yes When? ______
- Other?______ ☐ No ☐ Yes When? ______
- Pneumovax immunization? ☐ No ☐ Yes ☐ When? ______
- Flu immunization? ☐ No ☐ Yes ☐ When? ______
- Tetanus immunization? ☐ No ☐ Yes ☐ When? ______

When was your last:
- Pap smear? ______
- Mammogram? ______
- Breast exam? ______
- Cholesterol check? ______
- Stool check for blood? ______
- Prostate exam? ______

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which Family/Members?	Approx. Age When Diagnosed
Cancer (describe type)		
Hypertension (High Blood Pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental Disease (anxiety, depression, etc.)		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Diseases		
Other: ______		

Medications

Medications (Prescriptions, Over-the-Counter, Vitamins, herbs, etc.)

Drug Name	Dose	Drug Name	Dose

Prevention

Question	Answer	
Do you wear seat belts?	☐ No ☐ Yes	If no, why not? ______
Do you wear a bike helmet?	☐ No ☐ No	☐ N/A
Do you exercise regularly?	☐ No ☐ Yes	If yes, type, duration and number of times per week? ______
Do you smoke?	☐ No ☐ Yes	If yes, how many packs per day? ______
Do you drink alcoholic beverages?	☐ No ☐ Yes	If yes, how much per week? ______
Do you drink coffee?	☐ No ☐ Yes	If yes, how many cups per day? ______
Do you drink tea?	☐ No ☐ Yes	If yes, how many cups per day? ______
If there is a gun in your home, do you keep it unloaded and out of children's reach?	☐ No ☐ Yes	☐ N/A
Do you use drugs? (marijuana, cocaine, crack, etc).	☐ No ☐ Yes	If yes, explain: ______
Have you engaged in any activity which has put you at risk of getting AIDS?	☐ No ☐ Yes	If yes, explain: ______
Do you wish to be tested for AIDS?	☐ No ☐ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	☐ No ☐ Yes	If yes, explain: ______
Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, punched, bruised) by your partner?	☐ No ☐ Yes	
Do you ever feel afraid of your partner?	☐ No ☐ Yes	☐ N/A
Do you have a "living will"?	☐ No ☐ Yes	
Do you have a donor card?	☐ No ☐ Yes	

Method of birth control: ______

This information is for use by your physician as part of your confidential medical record.

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
Phone 609-826-4860 • Fax 609-826-4866
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS) CONSENT TO PARTICIPATE

RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD

REGISTRANT INFORMATION	**PARENT/GUARDIAN INFORMATION** (if NJIIS Registrant is a minor)
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider **ADVOCARE GROVE FAMILY MEDICAL ASSOCIATES**	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD

Annual Consent and Acknowledgment Form

This form is to be completed annually for Advocare LLC and scanned into each Patient's File

Patient Name: ______________________________ DOB: ______________

Address: ____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

Advocare and its parent, affiliates, associates, agents, services, debt collectors, independent contractors, assigns, successors, subsidiaries and employees (defined here collectively as "ADVOCARE" and referred to as "ADVOCARE" or "we") provide healthcare services (referred to collectively as the "Services"). By using the Services or accessing your account, any recipient of the Services accepts and also agrees to be legally bound by the terms of this Agreement to the extent permitted by law.

General Consent for Examination and Treatment

I hereby consent and authorize Advocare and all its physicians and ancillary medical personnel to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration and other routine care for which my specific informed consent is not otherwise required. This consent includes consent and authorization to photograph or otherwise take images of me for purposes of identification, diagnosis, treatment, payment and healthcare operations. Any photographs or other images taken will become part of my medical record. Advocare will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Advocare will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have been offered a copy of Advocare's Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that Advocare has the right to change its Notice of Privacy Practices from time to time and that whenever an important change is made, Advocare will post a new notice in its offices. I may contact Advocare at any time to obtain a current copy of the Notice of Privacy Practices. I may also access a copy on the Advocare website at www.advocaredoctors.com

Assignment of Benefits/Authorization/Notice of Collection

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles and charges denied by my insurance company as not covered or not medically necessary. You agree to reimburse Advocare the fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt added to the debt at the time it is placed with the agency for collection, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Consent to Contact

You expressly authorize, and specifically consent to allowing, ADVOCARE and/or its outside collection agencies, outside counsel, or any other agents acting by or on behalf of ADVOCARE to contact you or any recipient of the Services with informational messages regarding your account, including but not limited to contact in connection with any and all matters relating to unpaid past due charges billed to you. You agree that such contact may be made to any mailing address, telephone number, cellular phone number, e-mail address, or any other electronic address that you or a recipient of the Services have provided, or may in the future provide, to ADVOCARE and to any and all telephone numbers billed on your account or any number where you or a recipient of the Services can be reached by ADVOCARE. You expressly consent and agree that such contact may be made using, among other methods, pre-recorded, artificial voice, or other message delivered by any type of telephone equipment including a dialer, automatic telephone dialing system, predictive dialer, interactive voice recognition system, or text message delivered by an automated system, pre-set e-mail messages delivered by an automatic e-mailing system, or any other pre-set electronic messages delivered by any other automatic electronic messaging system, including numbers assigned to any paging, cellular or mobile service, even for any service for which you are charged for the call or contact. Carrier message and data rates may apply. You agree to provide true, accurate, current and complete contact information about yourself and any recipient of the Services to ADVOCARE and its authorized agents and to promptly update this contact information to keep it true, accurate and complete. If you do not want ADVOCARE to use these telephone contact methods to reach you or a recipient of the Services, please contact us at 856.221.2700 to discuss how we may communicate about this account.

Vaccine Registry (if applicable)

Our office submits confidential data of children and adult vaccinations to your state's Immunization Registry as permitted by state law. The purpose of this registry is to keep a central record of patients' immunization history.

Disclosures to Authorized Individuals

I designate the following person(s) listed below as a person(s) involved with my medical treatment and/or payment for my medical treatment. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office address. A copy of the authorization may be used with the same effectiveness as the original. This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Name: ______________________ Relationship: ______________________

Address: ______________________ Phone: ______________________

Medical Treatment Information: Yes No   Payment Information: Yes No

Name: ______________________ Relationship: ______________________

Address: ______________________ Phone: ______________________

Medical Treatment Information: Yes No   Payment Information: Yes No

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Question	Y	N	Question	Y	N
Are you or your spouse employed?	☐Y	☐N	Has treatment been authorized by the V.A.?	☐Y	☐N
Do you or your spouse have other insurance?	☐Y	☐N	Are you covered under the Black Lung Program?	☐Y	☐N
Are you disabled or have end stage renal disease?	☐Y	☐N	Is there Medigap coverage secondary to Medicare?	☐Y	☐N
Is illness/injury the result of an auto accident?	☐Y	☐N	Is there insurance coverage primary to Medicare?	☐Y	☐N
Did illness/injury occur at work?	☐Y	☐N	Is there employer supplemental coverage secondary to Medicare?	☐Y	☐N

Consent and Authorization

A copy of this consent and acknowledgment may be used in place of the original. I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my PHI and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name: ______________________ Date: ______________

Patient Signature: ______________________

Legal Representative (if other than patient) Print Name: ______________________ Date: ______________

Legal Representative Signature: ______________________ Relationship to Patient: ______________

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Medical Record Request
For Treatment Purposes Only

Patient Name: ____ DOB: ____________________

Advocare Grove Family Medical Associates is committed to protecting the privacy of patients' medical information as set forth by the Health Insurance Portability Accountability Act (HIPAA). In order to provide our patients with the highest quality of care, Advocare Grove Family Medical Associates is requesting a copy of specified medical information for treatment purposes only from:

Requesting records from: ____

____

____

Phone: ____________________ Fax: ____________________

The following specified medical information is requested:

☐ Entire medical record

☐ Partial medical record, specifically ____

Release records to:

Advocare Grove Family Medical Associates
132 Grove Street
Haddonfield, NJ 08033
Phone: 856-354-2211 • Fax: 856-354-6181

I understand that:

- The information in my medical records may include information about behavioral or mental health services, treatment for alcohol or drug abuse, genetic testing, and testing for sexually transmitted diseases, including HIV or AIDS. I understand that I may inspect a copy of the information used or disclosed under this authorization in accordance with HIPAA regulations.
- This authorization is voluntary and I do not need to sign this form to ensure health care treatment. I have the right to revoke this authorization at any time by notifying the entity releasing medical records. This revocation will not apply to information already released.
- This authorization will expire in ninety (90) days, unless I specify a different time period.

Signature of Parent or Legal Guardian: ____ Date: ____________

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Patient Portal Signup Sheet

Name of individual requesting account: ______________________________

Select Relationship:
- ☐ Self
- ☐ Spouse / Legal Guardian / Other (please describe): ____________________
- ☐ Parent

Requester's Home Address: ______________________________

____

Requester's Phone Number: ______________________________

Requester's Date of Birth: ______________________________

Requester's Email Address: ______________________________

Please select a User Name: ______________________________
(case sensitive – at least 5 characters – letters and numbers only)

Please list the name of the individual whose medical you are requesting access to.
(A proxy authorizing form may need to be completed)

Name: ______________________________ DOB: ____________

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Payment Policy

Insurance: We participate with most major insurance plans, including Medicare. Knowing what benefits your insurance plan provides for you is your responsibility. Please contact your insurance company with any questions.

IF WE PARTICIPATE WITH YOUR INSURANCE CARRIER, all services provided in our office (unless otherwise indicated) will be submitted to your insurance. All co-payments are due at time of service. Deductibles and coinsurance are your responsibility, and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse. The doctor's fees may be higher than what the insurance carrier reimburses, or it may not be a covered service. Therefore, any balances not covered by insurance become the responsibility of the patient.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE CARRIER OR IF YOU DO NOT HAVE HEALTH INSURANCE, payment in full is expected from you at the time of your visit.

Proof of Insurance: All patients must complete our patient registration form before seeing the doctor. Photo identification and a current valid insurance card are required at every visit to provide proof of insurance. It is your responsibility to verify that the office staff has the most current and correct information regarding your health insurance policy. Failure to provide current information may result in non-coverage for services provided, and the resulting charges will be your responsibility.

Co-payments and Deductibles: In accordance with your insurance plan and services provided, you are responsible for any and all co-payments, deductibles, and coinsurances at the time of service.

Referrals: In accordance with your insurance carrier, it is your responsibility to know if a written referral is required to see a specialist, or for a certain procedure. When a referral is not presented at the time of service to the provider, the patient may be responsible for payment in full at the time of service.

Claims Submission: Submission of claims is a courtesy extended to our patients. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. Your insurance coverage is a contract between you and your insurance carrier. We are not party to that contract.

Non-covered Services: Certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", "cosmetic" or simply "non-covered" by your insurance carrier. You are responsible for payment of these services. In the event your care exceeds a plan limitation, the balance becomes your responsibility.

Non-payment of patient balances: Should your account become delinquent, the patient or guarantor agrees to pay all costs associated with collecting the balance due. This includes, but is not limited to, attorney, collection, and contingent fees.

Non-sufficient funds (NSF)/ Returned Checks: A fee of $35.00 will be charged for all returned checks.

Missed Appointments: Failure to cancel your appointment without 24 hours notice from your scheduled visit may result in a fee of $50.00.