TOVBA CARE MEDICAL PC **Date**_____

Patient's Name:_____**Date of Birth:**_____**Chart #**_____

Patient's Gender: __M __F **Marital Status: ___Single ____Married ___Partnered____Widowed____Divorced**

Address:_____**City:**_____**State____Zip**_____
Telephone: Home:_____**Cell:**_____**Other:**_____

SS #_____**E Mail Address:**_____

Employer:_____**Employer Tel #**_____
Employer Address:_____**City**_____**State____Zip**_____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

__Physician __Family Member __Friend ***Name of Referring Person***_____
__Internet ___Website __Facebook ***Other***_____

INSURANCE INFORMATION

Primary Insurance:_____Are you the Policy Holder? __Yes __No

Is this a managed care Medicare or other Program (HMO) ___Yes ___No

Insured Information:
Subscriber Name:_____Relationship:____Self ___Spouse ___Child____Other
Phone#_____Sex __Male __Female DOB_____/_____/ _____
Address:_____Policy#_____Group #_____
Employer:_____

Secondary Insurance:_____Are you the Policy Holder? Yes __No

Is this a managed care Medicare or other Program (HMO) ___Yes ___No

Insured Information:
Subscriber Name:_____Relationship:____Self ___Spouse ___Child____Other
Phone#_____Sex __Male __Female DOB_____/_____/ _____
Address:_____Policy#_____Group #_____
Employer:_____

What is the Primary Reason for Today's Visit? _____
How Long Has This Been Bothering You? _____ days weeks months years

Please Read and Sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_____ _____ _____
Signature of patient or representative Print Name Date

Medical History

Please Circle if You Have Had Any of the Following:

AIDS/HIV
Anemia
Arthritis
Artificial Heart/Valve/Joint
Asthma
Back Problems
Bladder Problems
Bleeding Disorders
Cancer, Type: _____
Chemical Dependency
Chest Pain
Cholesterol
Chronic Constipation
Chronic Diarrhea
Circulatory Problems
Diabetes, Type: _____
Ear Problems
Epilepsy
Fainting
Frequent Infections
Gout
Hearing Problems
Heart Disease
Hemophilia
Hepatitis or Jaundice
High Blood Pressure
Immune Disorders
Kidney Problems
Liver Disease
Low Blood Pressure
Neurological
Neuropathy
Phlebitis
Psychiatric Care
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Shortness of Breath
Sinus Problems
Stroke
Swelling in Ankles, Feet
Swollen Neck/Glands
Thyroid
Tuberculosis
Ulcers - Stomach, Other:__
Urinary Incontinence
Varicose Veins
Vision, Type: _____
Venereal Disease
Weight Loss, unexplained

OTHER:_____

SURGICAL HISTORY

Please Provide Your Surgical History:

Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

By signing at the bottom of this page, you have read and understood the following:
Treatment Consent: I hereby Consent and give my permission to the doctor (and doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Please Read and Sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_____ _____ _____
Signature of patient or representative Print Name Date

SOCIAL HISTORY:

Do You Smoke ___Yes __No If yes how many packs per day_____For How Long _____

Alcohol Use___Yes everyday (5-7 days/week) __Yes Occasionally/socially __No/rarely
Substance Abuse ___Yes, I have a current substance abuse problem.
Please specify: _____
__No, I have never had a substance abuse problem.
Occupation:_____Does it involve mostly __standing sitting
Exercise: _____I do not exercise regularly ____Yes, I do the following regular exercise:
Special Diet:_____

FAMILY HISTORY: PLEASE INDICATE WHICH FAMILY MEMBER

___Alzheimer's _____ ___Depression _____
___Arthritis _____ ___Diabetes _____
___Bleeding disorders _____ ___Emphysema _____
___Blood clot _____ ___Heart Disease _____
___Cancer _____ ___High Blood Pressure _____
___Cataracts _____ ___Neurological _____
___Circulation Problems _____ ___Strokes _____
___Other (please specify_____ ___Other (please specify) _____

I prefer not to answer _____

Privacy Information Preferences:

Can we call the phone number on file? _____**Yes** _____**No**
Can we leave voicemail on machine? _____**Yes** _____**No**
Who can we leave message with? _____**Wife** _____**Husband**_____**Other**
Name(s)_____

Vital Signs

Blood Pressure:_____/_____
Height:_____Weight:_____

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_____ _____ _____
Signature of patient or representative Print Name Date

TOVBA CARE MEDICAL PC

Patient's name:_____ Date of Birth:_____

Pharmacy Name:_____ Pharmacy Phone:_____
Pharmacy Address:_____

Current Medications

Name:_____Dose:_____

Name:_____Dose:_____
Name:_____Dose:_____
Name:_____Dose:_____
Name:_____Dose:_____
Name:_____Dose:_____
Name:_____Dose:_____
Name:_____Dose:_____

Allergies

_____No Known Allergies

Name_____Reaction:_____
Name_____Reaction:_____
Name_____Reaction:_____
Name_____Reaction:_____
Name_____Reaction:_____

By signing at the bottom of this page, you have read and understood the following:
(Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practice Notice. (Medication History): I authorize the Doctor's office to retrieve my medical history.

Please Read and Sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_____ _____ _____
Signature of patient or representative Print Name Date

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
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	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 -

Medical Record Release Form

Tovba Care Medical PC

Dr. Eduard Fuzaylov

225 Taylors Mills Road Manalapan, NJ 07726

Tel: 732-851-6673Fax: 732-851-6674

TO: _____

_____

_____

_____

I_____, hereby request and authorize you to send all of my progress notes, labs, x-rays, or other tests and hospital discharge summaries that are in my medical records. Please limit this information to that after_____.

Please send this information to:

_____

_____

_____

Date X_____

Patient's Signature X _____

Print Patient's Name X_____

Patient's Date of Birth X_____

TOVBA CARE MEDICAL PC
EDUARD FUZAYLOV MD
225 TAYLORS MILLS RD
MANALAPAN, NJ 07726

~ OUR FINANCIAL POLICY ~

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All information must be completed before seeing the doctor.

Full payment (co-pays, deductibles, co-insurances, non-covered services, self-pays, etc.) is due at time of service. For your convenience, we accept cash, checks, Visa, and MasterCard. **A fee of $25 will be assessed for returned checks and for any appointment cancelled with less than 24-hour notice.**

~ Regarding Insurance ~

Your insurance policy is a contract between you and your insurance company. If we participate with your insurance company, all co-pays, deductibles, and co-insurances are due at the time of service. Please be aware that some of the services provided (e.g., immunizations, annual physicals, preventive tests and exams) may be non-covered services and not considered reasonable and necessary by your medical insurance company. If your insurance plan deems a service a non-covered one, you will be responsible for the charges.

While we will try our best to bill and collect on your behalf payment for our services from your insurance company, we are not always successful. Payment delays, denials, stalling are common. Therefore, to keep our costs down and to provide you with the best possible service, we require that you provide us with a credit card authorization on file.

~Patient Responsibility/Balance~

We follow **"one-statement"** policy regarding patient responsibility towards copay, co-insurance, deductible and non-covered services. Your credit card on file will be charged for the outstanding balance fifteen days after we send the invoice (if not paid during that time). The receipt of the payment will be sent to you.

~ Outstanding Accounts ~

Any account with an outstanding patient balance over 60 days will be considered delinquent, and **delinquent accounts will be turned over to a collection agency and will be subject to a collection fee of 25% of outstanding balance.**

~ Insurance Commissioner ~

I authorize **Tovba Care Medical, P.C**. to file any appeals and/or complaints to the insurance commissioner on my behalf.

~Assignment of Benefits~

I hereby authorize **Tovba Care Medical, P.C.** to furnish information to my insurance carriers. I request that payment of authorized Medicare and/or other insurance benefits be made to **Tovba Care Medical, P.C**. for any services furnished by her to me, my dependents or the person for which I am claiming responsibility. I understand that I am responsible for any co-payments, deductibles, and payments for non-covered services.

I have read this Financial Policy. I understand and agree to this Financial Policy.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice*.

_____ _____

Patient Name (please print) Date

_____

Patient or Authorized Representative/Responsible Party's Signature

**Note: This acknowledge shall remain valid for a period of five (5) years from the date of signing.*

Practice Name and address

Patient Credit Card Payment Authorization

I authorize **Tovba Care Medical, P.C.** to charge my credit card for outstanding balance on my account towards copay/coinsurance/deductible and non-covered services from Payers.

This money would be charged either at the time of service if its copay/coinsurance or deductible or after insurance adjudication.

This authorization is valid for five years unless I cancel the authorization through written notice to Dr. Fuzaylov. I also agree to inform of any changes in the credit card number or expiry date to ensure that the information provided here is current and valid.

_____ _____

Cardholder signature Date

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip _____

Visa____ MasterCard ___

Credit Card Number:_____Expiry Date: _____

CVV Number: _____