



PRINT

Welcome to the Central Jersey Oncology Center (CJOC). You may have already scheduled your initial appointment with our Consultation Coordinator, who can be reached by phone at 732.390.7750. We will mail you our New Patient Packet, which contains information on our practice, along with Patient Information forms necessary for you to complete and bring to your initial consultation. If you prefer to download these forms for completion, please see a complete set of these forms below.

In the event you are unable to attend your scheduled appointment, we would appreciate your notifying us at least 48 hours in advance to reschedule. This will enable us to ensure the timely rescheduling of your appointment and the appointments of other patients.

Please be sure to schedule future appointments at the end of your consultation. CJOC requests you do so to ensure that your treatment is conducted appropriately and on a timely basis, assuring you the best of care.

You may contact our front desk to schedule appointments for all services; including follow-up appointments, laboratory studies and treatments taking place at the hospital. Our nursing department is available to schedule any treatments in our office. CJOC makes a concerted effort to accommodate scheduled patients in a timely manner, and therefore does not have the ability to treat “drop-in” patients.

If your insurance plan requires a referral, you will be responsible for faxing or mailing your referral prior to your appointment, or you may bring it with you on the day of your appointment. CJOC must receive your referral *before* providing medical services. It is the patient’s responsibility to keep track of the number of visits remaining and time period left for each referral.

CJOC participates with most major insurance carriers. Please contact your insurance carrier to confirm that we participate with them. Please review our Billing Policy in this packet.

CJOC operates in compliance with the Health Insurance Portability and Accountability Act (HIPAA), which insures the privacy and protection of all of our patients’ medical information. Please review and sign the HIPAA Notice of Privacy Practices included in this packet.

In consideration of others who may be sensitive, we request patients refrain from using any strong fragrances when visiting our offices.

Thank you for choosing Central Jersey Oncology Center. We look forward to seeing you on the day of your visit. If you have any questions, please contact our office at 732.390.7750.

9/11

CENTRAL JERSEY ONCOLOGY CENTER

TAX ID NUMBER: 22-2982447

PATIENT INFORMATION

Today's Date: _____

Account #: _____

Staff Initials: _____

CJOC MD: _____

Patient Name: _____
Last First Middle

Street Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Sex (please circle): Male / Female Marital Status (please circle): M S D W Other

Social Security #: _____ Date Of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we contact you at *all* of the above numbers? Yes No

E-Mail Address: _____ May we contact you through e-mail? Yes No

Employer: _____ Address: _____

Emergency Contact: _____ Phone: _____
Name Relationship

Primary Care Physician: _____ Phone: _____

Referring Physician (if different than PCP): _____ Phone: _____

SPOUSAL/PARTNER INFORMATION

Name: _____ Date Of Birth: _____ Social Sec. #: _____

Employer: _____ Address: _____

Phone Number: _____

PLEASE REVIEW AND COMPLETE THE FOLLOWING PAGES →

**CENTRAL JERSEY ONCOLOGY CENTER
INSURANCE INFORMATION PAGE**

Primary Insurance: _____ ID #: _____

Address: _____ Phone Number: _____

Subscriber: _____ D.O.B.: _____ Social Sec. #: _____

Co-Pay: _____ Referral Required: Yes No

Secondary Insurance: _____ ID #: _____

Address: _____ Phone Number: _____

Subscriber: _____ D.O.B.: _____ Social Sec. #: _____

Co-Pay: _____ Referral Required: Yes No

Tertiary Insurance: _____ ID #: _____

Address: _____ Phone Number: _____

Subscriber: _____ D.O.B.: _____ Social Sec. #: _____

Co-Pay: _____ Referral Required: Yes No

With whom may we discuss financial matters? _____
Name

Phone

Relationship

INSURANCE RELEASE

I hereby authorize Central Jersey Oncology Center to release any information necessary to process my insurance claims acquired in the course of my examinations or treatment; and allow a photocopy of my signature to be used to process my insurance claims until I revoke this usage in writing. I authorize and direct my insurance carrier to issue payment checks directly to CJOC. In the event that my insurance carrier does not pay in full, I understand that I am ultimately financially responsible for any and all fees incurred and I agree to pay such fees in full. If I do not fulfill my contractual obligations with my insurance company, I understand that CJOC will forward my account to an outside collection agency for processing. The insurance information furnished here represents full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements, for any and all plans to which I subscribe, may cause me to incur full liability for professional charges as a result of non-payment by any of my insurance carriers.

Signature of Patient/Responsible Party: _____ Date: _____

Print Name: _____



**CENTRAL JERSEY ONCOLOGY CENTER
REQUIRED SIGNATURE FORMS**

PERMISSION FOR CJOC TO RELEASE MEDICAL RECORDS TO OUTSIDE FACILITIES

I hereby request and authorize the employees of Central Jersey Oncology Center to disclose, make available, and furnish to physicians, hospitals, radiology groups, or any other persons involved in my medical care - all medical information related to my examinations, consultations, confinement and/or treatment, and to make copies or abstracts thereof, as required for my medical care.

Signature of Patient: _____ Print Name: _____

Date: _____

RADIOLOGY PRECERTIFICATION POLICY

Patients may schedule their own radiology exams (i.e. MRIs, PET scans, CT scans);
or they may request that our office schedule the exams.

Many insurance carriers *require precertification for radiology exams*. Precertification ensures that your insurance company will pay for the radiology exam that is ordered. In the event that your insurance company requires radiology exams to be precerted, our Radiology Precertification Clerks will contact your insurance company to obtain the precertification. It is *essential* that you notify our Precertification Clerks **72 hours prior** to the time of your exam in order to provide sufficient time for your insurance company to authorize the radiology exam. If you requested our office to schedule the radiology exam, we will automatically contact your insurance carrier for precertification; however, if you choose to personally schedule your exam, you are responsible for giving us the 72 hour notice, as stated above. In the event that you do not inform us of your exam; and precertification is not obtained in time, you will be responsible for any resulting costs from not receiving authorization prior to your exam.

I acknowledge that I have read and understand the CJOC Radiology Precertification Policy. I understand that I will need to give **72 hours notice** for all radiology exams that I schedule myself. In turn, I also understand that CJOC will be responsible for precertifying all radiology exams that I inform them of at least 72 hours ahead of time, as well as all exams that the office schedules for me.

Signature of Patient: _____ Print Name: _____

Date: _____



CENTRAL JERSEY ONCOLOGY CENTER
PERMISSION FOR CJOC TO REQUEST RECORDS FROM OUTSIDE FACILITIES

Patient Name: _____ Date of Birth: _____

CJOC Physician: _____

I hereby authorize the release of my medical records or copies of such to:

CJOC
205 EASTON AVENUE
NEW BRUNSWICK, NJ 08901
Ph: 732/828-9570
Fax: 732/828-7638

CJOC
J-2 BRIER HILL COURT
EAST BRUNSWICK, NJ 08816
Ph: 732/390-7750
Fax: 732/390-7725

CJOC
253 WITHERSPOON ST.
PRINCETON, NJ 08540
Ph: 732/390-7750
Fax: 732/390-7725

Signature of Patient: _____

-----Office Use Only-----

To: _____

Date: _____

Please fax records on the above patient to:

New Brunswick 732/828-7638 and/or Princeton and East Brunswick 732/390-7725

- Consult/Office Notes Operative Reports Pathology Reports Laboratory Reports
- Radiology Reports (CT, MRI, X-Ray, Pet/CT) Mammogram Reports Muga Scan Reports
- Radiation Treatment Records Chemotherapy Records Hospital Records Pathology Slides

Specific Requests: _____

Records must be received by: _____

Thank you for your assistance



CENTRAL JERSEY ONCOLOGY CENTER

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. In an additional example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations with your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect: Food and Drug Administration requirements; Legal Proceedings; Law Enforcement: Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates: Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.



Your Rights. Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published, and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, in person, or by phone at our main office number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Signature: _____

Print Name: _____

Date: _____



**CENTRAL JERSEY ONCOLOGY CENTER
PHARMACY and PRESCRIPTION PLAN INFORMATION
REFERRAL INFORMATION**

In order to efficiently and expediently process your prescription requests, we will need your pharmacy contact and prescription coverage information. Please provide us with the following:

Patient Name: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Prescription Plan Name: _____ Policy No: _____

Referral Information

Please tell us how you found out about Central Jersey Oncology Center. Circle your choice(s).

CJOC Patient

Family/Friend

Insurance Company

Referring Physician

Internet Search

Other:

**CENTRAL JERSEY ONCOLOGY CENTER
MEDICATION RECORD**

Name: _____

Date: _____

PLEASE LIST ANY ALLERGIES: _____

Please list the physicians you would like your consultation notes forwarded to:

<u>Name</u>	<u>Address/Phone</u>
_____	_____
_____	_____
_____	_____
_____	_____

Medication	Frequency	Dosage	Ordering Physician	Date Began Medication

CENTRAL JERSEY ONCOLOGY CENTER

PERMISSION TO RELEASE MEDICAL INFORMATION

I, _____, authorize
(Print Patient Name)

the Central Jersey Oncology Center staff and physicians to release medical information (such as test results, plan of treatment, etc.) to the following people:

Name

Relationship

1) _____

2) _____

3) _____

4) _____

5) _____

Patient Signature: _____

Date: _____

CENTRAL JERSEY ONCOLOGY CENTER

FAMILY HISTORY QUESTIONNAIRE COMMON HEREDITARY CANCER SYNDROMES

PATIENT NAME:	CJOC PHYSICIAN:
DATE OF BIRTH:	TODAY'S DATE:

Please place a check mark in the boxes below for yourself and family members who have had cancer as indicated. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

YOU

DIAGNOSIS	NO	YES	AGE OF DIAGNOSIS	MOTHER'S SIDE	Y*	N	FATHER'S SIDE	Y*	N
Breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
Two or more breast cancers (bilateral or contralateral)?	<input type="checkbox"/>	<input type="checkbox"/>							
Ovarian cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
Male breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
Colon cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
Two or more colon cancers in one individual?	<input type="checkbox"/>	<input type="checkbox"/>							
Uterine (endometrial) cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
10 or more colon polyps found in 1 or more exams?	<input type="checkbox"/>	<input type="checkbox"/>							
Melanoma?	<input type="checkbox"/>	<input type="checkbox"/>							
Pancreatic cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
Other cancers: stomach, kidney/urinary tract, brain, small bowel, thyroid?	<input type="checkbox"/>	<input type="checkbox"/>							

Are you of Ashkenazi Jewish descent? (please circle) YES / NO

List any other cancers in you or your family:

*List all relatives (relation, not name) diagnosed with the above cancers, along with the age of diagnosis:

If you checked yes in one or more boxes on this form, ask your doctor to assess your cancer history. If your history indicates that you may have an inherited risk of cancer, there is a blood test that can help determine if you are at risk for hereditary cancer.

CENTRAL JERSEY ONCOLOGY CENTER CONSULTATION CHECKLIST

In an effort to ensure you receive the most comprehensive care and enable us to provide you with a thorough evaluation, CJOC prefers having your records for review *prior* to the time of your appointment, and would appreciate your faxing or delivering them to our office. If you are unable to do so in advance, we request you bring the following records to your appointment. If we do not have your records at the time of your visit, we will need to reschedule your appointment. These records include:

- Medical records from other physicians. If you are currently undergoing treatment of any kind, CJOC needs the “flow sheet” prepared by your current physician. This will note the types of treatment you are receiving, along with the dosages.
- All hospital records (histories, physicals, lab reports, treatment records, discharge summaries and consultations).
- The original films or CDs of all x-rays, MRIs or scans, along with the radiologist’s reports.
- The pathology and operative reports of any biopsies or surgeries. These materials can be obtained from the Pathology Department of the facility where the procedure was performed.

CHECKLIST

For your convenience, below is a checklist of items needed for your visit:

_____ *All Pages* of this CJOC Patient Information Packet
Completed and Signed

_____ Insurance Card(s)

_____ Prescription Plan Card

_____ Photo ID

_____ Referral (if required)

_____ X-ray, MRI, CT, PET, etc. Films and Reports

_____ Pathology Reports

_____ Laboratory Test Reports

CENTRAL JERSEY ONCOLOGY CENTER BILLING POLICY

Central Jersey Oncology Center (CJOC) participates with most major insurance carriers and will work diligently as your patient financial advocate in an effort to help you understand and access your benefits. Please contact your insurance carrier to confirm that we participate with them and be sure to *bring your insurance cards every time* you come to the office. Also, make sure to inform our staff whenever you have a change of insurance.

Our staff of insurance experts will file your insurance claims and will be pleased to work with you on any questions or concerns you may have. For your peace of mind, CJOC also maintains firm policies and procedures on cost containment and ethical billing practices. Operating in compliance with the Health Insurance Portability and Accountability Act (HIPAA), CJOC protects and secures your health information and privacy, ensuring that all of your information will remain confidential.

As a participating provider with your insurance carrier, we are contractually obliged to collect co-pays at the time of service. Your insurance company may require co-pays, not only for office visits with your physician, but also for chemotherapy treatments, injections and laboratory appointments. We must collect co-pays at the time of service for these visits as well. Upon completion of your visit and payment of your co-pay, CJOC will bill your insurance company for the remaining balance due. In the event you are unable to pay the co-pay at the time of your visit, we regret we will be unable to accommodate you and your appointment will need to be rescheduled. In the case of an *emergency*, your physician will see you; however it is CJOC policy to add a \$10 surcharge to your bill to cover our billing costs.

In the event that CJOC is not a participating provider with your insurance company, we will still forward your billing claims to your insurance company at the time of your visit. CJOC will then bill you for any remaining charges not covered by your insurance company. You will be responsible for this remaining balance.

Patients without any insurance must be prepared to make a full payment at the time of service.

If your insurance requires referrals, it is your responsibility to ensure the referral is either sent to our office prior to your visit or you may also bring it with you to your appointment. We suggest that you retain a copy so that you may keep track of the number of visits left on your referral and its expiration date. Please feel free to ask CJOC to make a copy of your referral for you. We may have to reschedule your visit if you do not have a current referral on file.

If you are unable to make your appointment at CJOC, it is important to call us to cancel the appointment a minimum of 24 hours in advance. In the event you do not call us to cancel, we regret we must charge a fee, as we have reserved this time for you.

CJOC will bill patients on a monthly basis for the balance of charges not covered by their insurance companies. CJOC requests payment of any balance due within sixty days of the date of the CJOC bill. After sixty days, balances due will be billed at a rate including an additional 1.5% interest fee per month. CJOC accepts payments in the form of cash, check, VISA, Mastercard, Discover or AMEX. Please contact our billing office at 732.390.7750 if you have any questions regarding our billing policies. It will be our pleasure to address your needs.

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CENTRAL JERSEY ONCOLOGY CENTER

FREQUENTLY ASKED QUESTIONS

What will occur during my initial visit?

Initial consultations generally last about an hour to an hour and a half. You may first meet with a CJOC Nurse Practitioner, who will obtain a medical history and complete a physical. Your physician will then see you for a consultation which will generally consist of a physical examination, discussion of medical history and diagnosis, probable plan of care, as well as time for any questions you may have. It is necessary to have your medical records forwarded to our office in advance of your appointment so your Central Jersey Oncology Center physician and nurse practitioner may review them prior to your visit.

Will I have any testing done while I'm in the office?

Your physician may order some Laboratory testing (blood work) upon the completion of your consultation. This may be completed in our Labs, which are located in our New Brunswick and Princeton offices; and just across the courtyard from our Princeton office at the University Medical Center at Princeton. Other diagnostic tests, such as scans or x-rays, may be ordered and scheduled for a later date at the appropriate location (these diagnostic tests are not completed in our offices).

Will I start chemotherapy treatment the same day as my consultation?

Chemotherapy treatment will not begin the same day as your consultation. Chemotherapy often requires additional testing such as scans and biopsies before the treatment begins. It is also necessary to have your health insurance company authorize chemotherapy in advance (this generally takes approximately one week) to ensure that your treatment will be covered by insurance. The timing of initial chemotherapy treatments varies on a case by case basis. After your physician has obtained any required test results and your insurance company has authorized the treatment, you will receive a call from the CJOC nursing staff to schedule your treatment.

Where will I receive chemotherapy treatment?

Many of our patients receive chemotherapy here in our offices in New Brunswick and East Brunswick. Our Oncology Nurses are trained in the administration of the latest chemotherapy treatments. Occasionally, due to insurance reasons, we will schedule our patients for their treatment on an out patient basis at Saint Peter's University Hospital or Robert Wood Johnson University Hospital. Patients receiving chemotherapy at our Princeton site will receive treatment at the University Medical Center at Princeton, which is located across the courtyard from our office.

I need to see a hematologist and understand CJOC physicians treat not only oncology (cancer) patients, but also hematology (blood) disorders. Can you please explain?

Our physicians are not only board-certified in oncology, but hematology as well. Our physicians have extensive knowledge and experience in the diagnosis and treatment of diseases of the blood, ranging from anemia to clotting problems. We treat many hematology patients with non-cancerous blood disorders. (It is very common for oncologists to also practice hematology, as many of the side effects of chemotherapy are blood related, for example, anemia and neutropenia.)

What hospitals is CJOC affiliated with?

We are affiliated with Robert Wood Johnson University Hospital and Saint Peter's University Hospital, both located in New Brunswick, NJ and University Medical Center at Princeton, located in Princeton, NJ. We are not able to treat patients at other hospitals, as we are not on staff.

I am aware that I will require chemotherapy treatment and am concerned about the co-payments. Are there any assistance programs available?

In the event that you will be receiving chemotherapy treatments, our billing department will meet with you prior to your first treatment to discuss assistance programs that are available. In cases of need, we will discuss your options regarding assistance from several organizations.