

**Family Practice of CentraState
225 Willow Brook Road, Unit #9
Freehold, New Jersey 07728
(732) 462-9622 phone
(732) 780-0014 fax**

GENERAL CONSENT

Patient Name: _____

- 1. TREATMENT CONSENT:** I request and give consent for treatment and authorize Family Practice of CentraState (FPCS); and all medical provider(s) and other personnel on its medical, nursing and other professional staffs and such associates, assistants as may be selected by my medical provider(s) to participate and provide medical care and treatment, which may include the administration of such routine diagnostic, and/or therapeutic procedures or examination deemed necessary and advisable by my medical provider(s) in my diagnosis, care and treatment. My consent shall include, but is not limited to, pharmaceutical products, the taking of blood, fluids and other body samples. I agree to permit students of approved programs to observe and participate in my care and treatment, including the performance of non-invasive procedures and physical examinations under the direct supervision of my medical provider(s) or designee.
- 2. RECURRING VISITS:** If the services rendered qualify me for recurring status, my signature on this consent shall be valid for care rendered through this period. I will notify FPCS staff of any changes to my registration information, i.e. address, phone, employment, insurance, guarantor, etc.
- 3. RELEASE OF MEDICAL INFORMATION:** FPCS maintains patient medical records in electronic media that may be accessible to any medical or health care provider participating in my current or future care. I understand that these records will contain information about my diagnosis and treatment and may or may not contain sensitive information pertaining to drug and alcohol abuse, genetic testing, mental health/psychiatric care, sexually transmitted disease and HIV related information including counseling and testing and care received as an emancipated minor under State law. By my signature below, I hereby grant permission for FPCS and my treating medical provider(s) to release information about me to and or obtain information about me from my health care insurer (including Medicare and Medicaid), my current health care providers and/or other potential health care providers consistent with applicable law, to facilitate my treatment, and to promote continuity of care. **I understand that I may revoke this authorization at any time.**
- 4. HEALTH INFORMATION EXCHANGE:** I understand that the release of my information may be facilitated through health information exchange (HIE). HIE allows healthcare providers to properly and securely access and share patient medical information electronically using computers and other devices. I hereby authorize FPCS to share my medical information through the HIE(s) in which FPCS participates. I understand that I may Opt-Out of this electronic information exchange and, if I do not, my health information that may be shared

CONFIDENTIAL

**Family Practice of CentraState
225 Willow Brook Road, Unit #9
Freehold, New Jersey 07728
(732) 462-9622 phone
(732) 780-0014 fax**

may include (if applicable to me) the sensitive information detailed above. **I understand that I am entitled to Opt-Out of this electronic information exchange by contacting FPCS. I also understand that I can ask an FPCS representative for assistance in opting out of participation in the HIE.**

5. **MEDICARE BENEFICIARIES:** I certify that the information given by me in applying for payment under Medicare is correct.
6. **MEDICAID BENEFICIARIES:** If applicable, I certify that I am receiving the services covered by this claim, and I request that payment for these services be made on my behalf. I certify that payment has not yet been made by me or anyone on my behalf.
7. **HIPAA/PRIVACY NOTICE:** I acknowledge that I have received a copy of FPCS Notice of Privacy Practices that provides a more complete description of information uses and discloses. I acknowledge that I can also view the FPCS Notices of Privacy Practices on-line at <https://centrastate.blob.core.windows.net/familypractice/2018/03/Notice-of-Privacy-Practices-for-Physician-Practices10-2-14.pdf>. FPCS reserves the right to make changes to its Notice of Privacy Practices, and I understand I have the opportunity to ask questions and receive answers.
8. **FINANCIAL RESPONSIBILITY:** I hereby authorize and assign all claims for payment of any insurance or third parties directly to FPCS and/or medical provider(s) for services rendered. I agree, in consideration of the services rendered by FPCS and/or medical provider(s) to be responsible for payment in full including any collection fees in the event that payment is not made in full acknowledge that it is the medical provider(s) choice whether to appeal such a denial or seek payment from me. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for any deductibles, copayments and/or non-covered services. I authorize FPCS or its designee to contact me regarding my financial responsibility in various methods such as but not limited to text message, email, or pre-recorded voice message and/or use of an automated dialing device.
9. **FOR MINOR PATIENTS ONLY: NEW JERSEY IMMUNIZATION INFORMATION SYSTEM:** I have received information about the New Jersey Immunization 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 records 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 NJSA 26:4-131 and rules at NJAC 8:57-3. There is no cost to participate in this program. I understand that I can get a copy of my/my child's records from my primary health care provider, my local health department or the New Jersey Department of Health (NJDOH). The NJDOH Vaccine Preventable Disease Program may be contacted at www.njiis.nj.gov, at P.O. Box 369 Trenton, New Jersey 08625-0369 or phone: (609) 826-4860 or fax: (609) 826-4866.

Yes, I would like to participate in this Program. No, I do not want to participate in this program.

CONFIDENTIAL

**Family Practice of CentraState
225 Willow Brook Road, Unit #9
Freehold, New Jersey 07728
(732) 462-9622 phone
(732) 780-0014 fax**

I HAVE READ THIS FORM OR HAD IT EXPLAINED TO ME AND CERTIFY THAT I UNDERSTAND ACCEPT ITS CONTENTS.

PATIENT'S SIGNATURE OR PATIENT'S REP. _____

DATE: _____ TIME: _____

Representative's relationship to patient: _____

Witness to signature: _____ Date: _____ Time: _____

Patient unable to sign because: emergency refusal other Reason: _____

RELEASE OF PATIENT: I, the undersigned, am leaving/taking _____ against medical advice. I have been informed of the risk involved and release Family Practice of CentraState (FPCS) and providers of all responsibility and any ill effects which may result from this action.

SIGNATURE OF PATIENT/PATIENT REPRESENTATIVE: _____

WITNESS: _____ **DATE:** _____

*Robert Pedowitz, D.O.
Richa Gopal, M.D.
Philip Angello, M.D.
Shira Meyer, D.O.
Charisma Lanez, D.O.*

*Nancy Peters, M.D.
Christopher K. Wong, M.D.
Edward D. Stoner, M.D.
Paul Luparello, M.D.
Paola Raguseo, APN*

*Christopher J. Skeehan, M.D.
Sabine Paul-Yee, M.D.
Jaclyn Guliano, M.D.
Laura Pedowitz, P.A.
John Verdoni, M.D.*

CONFIDENTIAL