Woodbridge Internal Medical Associates

1000 Route 9 North, Suite 302, Woodbridge, New Jersey 07095
732/634-0036 • Fax: 732/634-9182 • www.woodbridgemed.com

Gastroenterology
Seth M. Webber, M.D.
Internal Medicine
Mary T. O'Donnell, M.D.
Lauren Maza, M.D.
Louis Friedman, D.O.
Nurse Practitioner
Stacey Riley, APN

The Physicians and Staff of Woodbridge Internal Medical Associates would like to thank you for choosing our Practice. Please remember to visit our website www.woodbridgemed.com for detailed information about the Practice including office hours, information about the care we provide, forms and policies and useful resources and links.

We consider you to be an important member of our Team; and believe that you should always play an active role in your health.

Think you need to go to the Emergency Room? Call us first before heading to the ER. Your healthcare provider can tell you whether emergency treatment is necessary. Our office has same day appointments available.

Our physicians remain on call for emergencies and urgent calls with access to your medical records. Save our office number in your phone now, 732-634-0036.

Please note: If you're in a life-threatening situation, call 911.

Patient Portal

login

Our office is online: Our online patient portal gives you convenient 24 hour access to personal health information from anywhere with an internet connection. Using a secure username and password, patients can request an appointment, request medication refills, change personal demographics, request a copy of lab results, and forward non urgent messages to your clinical team. All information is encrypted and stored securely. Register for our patient portal at www.woodbridgemed.com today!

Please take a moment to complete the necessary forms below prior to your appointment.

-Registration Form
-Notice of Privacy Practice & Acknowledgement
-Financial Agreement
-Medical History
-List of Other Physicians
-New Jersey Immunization Information System (NJIIS)

On behalf of all the physicians and staff, we welcome the opportunity to get to know you better and work with you to meet your health goals.

September 2023

Woodbridge Internal Medical Associates

REGISTRATION FORM

(PLEASE PRINT)

Today's date:	**PCP:**

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Home Phone No.: ( )	Cell Phone No.: ( )	Social Security No.:	Birth Date: / /	Age:	Sex: ☐ M ☐ F

Street Address:	City:	State:	ZIP Code

eMail Address:	Employer:	Employer Phone No.: ( )
Emergency Phone No.:	Person to Notify/Relationship	Language Preference (circle one) English / Spanish / Other ________________

Ethnicity:	☐ Hispanic or Latino	☐ Not Hispanic	☐ Unknown

Race: (✓ Check ONE)	☐ White ☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native
	☐ Native Hawaiian/Pacific Islander ☐ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate **primary** insurance carrier:				Effective Date:	
Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse ☐ Child	☐ Other		
Please indicate **secondary** insurance (if applicable):				Effective Date:	
Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse ☐ Child	☐ Other		

ACCIDENT CASES

Name of Insurance Company **Contact Person & Phone Number:**			Medical Claims Address:	
Date of Accident	☐ Workers Comp	☐ Auto	Claim No.:	

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION

The above information is true to the best of my knowledge. I hereby authorize my insurance carrier to pay Woodbridge Internal Medical Associates directly for all bills incurred for services that are provided by Woodbridge Internal Medical Associates, under the terms of my policy. Furthermore, I also authorize Woodbridge Internal Medical Associates to release to my insurance company any information required to process my claims. I fully understand that no further authorization is necessary to release this information other than this document.

Patient/Guardian signature	*Date*

WOODBRIDGE INTERNAL MEDICAL ASSOCIATES
NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

____________________	____________________	____________________
Please Print Your Name	**Date of Birth**	**Today's Date**

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY AND ANSWER ALL QUESTIONS.

This Notice of Privacy Practices describes how Woodbridge Internal Medical Associates, ("WIMA") may use and disclose **your protected health information** ("PHI") to carry out treatment, payment and/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 of your PHI. We are committed to maintaining the privacy of your (PHI). Your PHI includes information about you such as your medical record and the care and services that you have received from us but not limited to, including demographic information that may identify you. We need this information to provide you with the appropriate level of care and also to comply with certain legal obligations we may have.

The Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical health Act, places certain obligations upon us with regard to your PHI and requires that we keep confidential any medical information that identifies you. We take this obligation seriously and when permitted to or required to share your PHI with others, we only provide the **minimum** amount of data necessary to respond to the need or request.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT DO NOT REQUIRE YOUR AUTHORIZATION:

We are permitted by law to use and disclose your PHI without your written or other form of authorization under certain circumstances as described below. This means that we do not have to ask you before we use or disclose your PHI for purposes such as to provide you with treatment, seek payment for our services, or for health care operations. We may also use or disclose your PHI without asking you for other activities or to State and/or Federal officials.

Treatment: we may use and disclose your PHI in order to provide, coordinate or manage your health care and any related services. Your PHI may be used or disclosed to our doctors, nurses, employees and other personnel who may be involved in your care. Your PHI may also be disclosed to individuals outside of our facility, such as family members, friends or other caregivers, clergy, nursing homes and other care providers who may be involved in your care.

Payment: we may use and disclose your PHI in order for our doctors and other health care professional to obtain payment for the medical treatment or service they provided you with. For example, obtaining approval for a hospital stay may require your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: we may use and disclose your PHI for our internal health care operations, such as administration, planning, quality improvement, and other activities that help us provide you with quality care. These activities include, but are not limited to, quality assessment activities, sign-in sheets at the registration desk, you may be called by name in the waiting room when your physician is ready to see you, contacting you to remind you of your appointment and with your specific approval, leave information at your home on an answering machine or to a duly authorized person acting on your behalf.

USES AND DISCLOSURES OF YOUR PHI THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will seek your specific written authorization for at least the following information unless the use or disclosure would be otherwise permitted or required by law as described above:

***HIV/AIDS Information**
***Tuberculosis information**
***Mental health information**
***Genetic information**
***Activities where we receive money**
***Sexually transmitted disease information**
***Psychotherapy notes**
***Drug and alcohol information**
***Marketing activities**

WOODBRIDGE INTERNAL MEDICAL ASSOCIATES
NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT
(Page 2)

______________________	______________	______________
Please Print Your Name	**Date of Birth**	**Today's Date**

Right to Inspect/Copy PHI: you have the right to inspect and request copies of your PHI that we maintain. Please contact our Medical Records Department if you would like to inspect or request copies of your PHI from us we will respond in most circumstances within two weeks. We may charge you a reasonable fee for paper copies of your PHI or the amount of our reasonable labor costs for a copy of your Phi in electronic format.

Right to Revoke Authorization: you may revoke this authorization, at any time, in writing to the attention of Privacy Officer, 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.

Right to Notice of Breach: we take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your PHI through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured PHI and inform you of what steps you may need to take to protect yourself.

Complaints: you may contact our Privacy Officer at any time if you wish to obtain any additional information or have questions concerning this notice or your PHI. If you feel your privacy rights have been or may have been violated, you may also contact our Privacy Officer **OR** file a written complaint with the Secretary of the U.S. Department of Health and Human Services.

The notice was published and becomes effective September 23, 2013.

Please answer the questions below and affix your signature acknowledging that you received this Notice of our Privacy Practices and have provided specific direction and authorization in protecting your health information.

- **Who may we provide with your personal health information? (check all that apply)**

  ___ Self ___ Spouse ___ Children ___ Other: ______________________
  (Please Specify)

- **My we leave personal health information on your answering machine at home?**

  ___ YES ___ NO

I hereby acknowledge that I have received Woodbridge Internal Medical Associates HIPAA Notice of Privacy Practices:

Signature: ______________________________

Date: ______________________________

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I. Acknowledgement of Privacy Practice Notice

Date: / /

A copy of Woodbridge Internal Medical Associates Privacy Practices Notice, located on the wall in our waiting room will be provided for you at your request. These rights are to inform you of your privacy and quality of care as a patient. **Would you like a copy of this notice?** □ **Yes** □ **No**

_______________ _______________ _______________

Patient's Name | Date of Birth | Signature of Patient/Parent/Guardian

II. Designation of Certain Relatives, Close Friends and Other Caregivers

☐ INITIAL ☐ UPDATE

I agree that Woodbridge Internal Medical Associates may disclose certain portions of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Woodbridge Internal Medical Associates will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Woodbridge Internal Medical Associates making the limited disclosures described above. (I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.)

Print Name: ______________ Phone # ______________ Relationship: ______________

Print Name: ______________ Phone # ______________ Relationship: ______________

Print Name: ______________ Phone # ______________ Relationship: ______________

Print Name: ______________ Phone # ______________ Relationship: ______________

☐ I wish to make no designation at this time

III. Designation of leaving personal health information on your answering machine

☐ YES ☐ NO

_______________ _______________

Signature of Patient/Parent/Guardian | Date

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

- ***CO-PAYMENTS/DEDUCTIBLES*** - By law we **MUST** collect your insurance carrier designated co-pay/deductible. This payment is expected at the time of service. **Please be prepared to pay the co-pay/deductible at each visit, before seeing the physician, otherwise your appointment will be re-scheduled.**
- ***OUTSTANDING BALANCES*** – Woodbridge Medical Associates, P.A. staff will ask for any outstanding balance for which the patient is responsible for within 30 days of billing. Any account that has gone 60 days without payments is subject to immediate collection process. Phone numbers, including cell phones, can be used to contact the patient or guarantor regarding your outstanding bill.
- ***MEDICARE / COMMERCIAL PLANS*** – I represent that I understand that my health insurance company has agreed to pay for services in accordance with their policies and directives whereby I am bound by their decisions pursuant to these policies, directives and procedures. I further understand that not ALL services may be covered by my insurance company in accordance with their aforestated policies, directives and procedures. I hereby authorize Woodbridge Medical Associates, PA to file insurance appeals on my behalf should my insurance company make such a determination that they are unwilling to pay for the services provided, or they apply them to my deductible, I agree to personally pay for the services provided by Woodbridge Medical Associates, PA. I further understand that Woodbridge Medical Associates, PA shall hold me personally responsible to pay for these services should coverage be denied, deemed not essential, not a covered service or applied to my deductible. We ***DO*** participate with Medicare. This means that we will submit your claim to Medicare. The 20% difference between what Medicare "allows" and what Medicare "pays" will be sent to your secondary insurance if you have one, or to you. ***You will also be responsible for payment of your yearly deductible.***
- ***SELF-PAY PATIENTS/NON PARTICIPATING INSURANCES*** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. If we do not participate with your insurance, the bill is your responsibility and is due at the time of service.
- ***APPOINTMENTS/ATTENDANCE POLICY*** – All patients are expected to arrive on time for scheduled appointments. There will be a no show/cancellation fee of not less than $35.00 should a patient fail to no show/cancel three (3) scheduled appointments without 24 hour notice within a year's time. All fees are required to be paid prior to commencing treatment. Woodbridge Medical Associates also reserves the right to refuse to schedule an appointment for any New Patient who no shows/cancels their scheduled appointments (2) two or more times prior to becoming an established patient.
- ***REFERRALS*** – If your plan requires a referral from your primary care physician, (other than WMA) it is **YOUR** responsibility to obtain it prior to your appointment with Dr. Webber and have it with you at the time of your visit. If you do not have your referral, you will be personally responsible for that day's service.
- ***RETURNED CHECK FEE -*** Our bank charges us a fee for any check that is returned for "insufficient funds" and this will be added to the patient's bill if this occurs.

☐ **Woodbridge Internal Medical has informed me that most insurance plans only cover one (1) "Annual Routine Physical" during a 12 month period. Should this visit be denied due to maximum benefits reached, the practice will transfer the financial responsibility to me. I hereby agree to pay for this visit in full since I requested to have a second "Annual Routine Physical" within 12 months.**

In the event that your account is placed with an attorney or a collection agency because of an unpaid balance remaining on my account, I hereby agree and promise to pay interest of 1.5% per month of the outstanding balance to be calculated starting from my last date of service. In addition, I also agree and promise to pay a collection fee of $75.00 or 25% of the total balance due, whichever is greater, upon placement with an attorney or collection agency because of an unpaid balance remaining on my account.

----WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS OR DISCOVER CARD -----

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

____________________________ ____________________
Patients Name Date of Birth

____________________________ ____________________
Responsible Party Signature Today's Date

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Welcome to Woodbridge Internal Medical Associates!
Please take a few moments to help us review your medical history.

Name (print) ______________________________ DOB: ______________

Previous or current PCP: ______________________________ Visit Date ______________

Who referred you to our practice? ______________________________

Do you have any of the following conditions? (Please circle and elaborate if possible)

- □ Heart Disease
- □ High Blood Pressure
- □ Seasonal Allergies
- □ Hypothyroidism
- □ Acid Reflux
- □ Anemia
- □ Arthritis
- □ Peripheral Vascular Disease
- □ Congestive Heart Failure
- □ Sinus Congestion
- □ Hyperthyroidism
- □ Irritable Bowel Syndrome
- □ Neuropathy
- □ Heart Murmur
- □ Emphysema
- □ Kidney Failure
- □ Gastric Ulcer Disease
- □ Acne
- □ Psoriasis
- □ Leg Swelling
- □ Asthma
- □ High Cholesterol
- □ Cancer
- □ Diabetes (Type 1) (Type II)

Other medical problems? ______________________________

Have you ever had any surgery? If so please explain.______________________________

____

Date of last Tetanus shot: ______________ Date(s) of any Pneumonia vaccine(s):______________

Date of Covid Vaccine(s)? ☐ Moderna ☐ Pfizer ☐ Janson: ______________________________

Date of Last Mammography? ______________Facility Name? ______________

Date of Last Colonoscopy? ______________ Facility or Physician? ______________

Do you smoke cigarettes? No / Yes: _______ packs/day Former Smoker? No / Yes: Quit Date: ______________

Do you drink alcohol? No / Yes: ________oz. per day

Do you have any allergies to food or medication? ☐None ☐ Yes: ______________________________

Do you currently take any medications, supplements, vitamins, or herbal preparations? MEDICATION NAME	DOSE	HOW OFTEN	REASON FOR TAKING

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS
Father	☐ Age _______ ☐ Deceased	☐ Heart Disease ☐ Hypertension ☐ High Cholesterol ☐ Cancer ☐ Stroke ☐ Diabetes Mellitus	**Sibling**	☐ M ☐ F		
Mother	☐ Age _______ ☐ Deceased	☐ Heart Disease ☐ Hypertension ☐ High Cholesterol ☐ Cancer ☐ Stroke ☐ Diabetes Mellitus	**Grand-parent**	☐ M ☐ F		

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Patient Name: ______________________________ D.O.B. / /

Dear Patient: **Coordination of care is very important to us! Please take a moment to update us on the other physicians you may be seeing.**

ENDOCRINOLOGIST:

Name: ______________________________ Phone: ____________________

Street Address: ______________________________ Last Visit Date: ____________

City: ____________________ State: __________ Zip Code: __________

EYE DOCTOR::

Name: ______________________________ Phone: ____________________

Street Address: ______________________________ Last Visit Date: ____________

City: ____________________ State: __________ Zip Code: __________

GYNECOLOGIST:

Name: ______________________________ Phone: ____________________

Street Address: ______________________________ Last Visit Date: ____________

City: ____________________ State: __________ Zip Code: __________

CARDIOLOGIST:

Name: ______________________________ Phone: ____________________

Street Address: ______________________________ Last Visit Date: ____________

City: ____________________ State: __________ Zip Code: __________

OTHER PHYSICIANS: *(i.e. Gastroenterologist, Urologist, Nephrologist)*

Name: ______________________________ Phone: ____________________

Street Address: ______________________________ Last Visit Date: ____________

City: ____________________ State: __________ Zip Code: __________

☐ **No Specialists Seen**

Patient Signature: ______________________________ 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 -