Jefferson Comprehensive Epilepsy Center
Jefferson Hospital for Neuroscience
909 Walnut Street, 2nd Floor COB
Philadelphia, PA 19107

APPOINTMENT WITH DR. ____

AT____________________ON____.

Dear ____,

Welcome and thank you for choosing Jefferson Department of Neurology for your care! Enclosed for your convenience, you will find a patient registration and history form to be completed. This form should be brought with you at the time of your visit. PLEASE DO NOT MAIL THESE FORMS BACK TO THE OFFICE. Completing these forms prior to your visit will help make your encounter with us as timely and pleasant as possible.

Please bring relevant medical records – MRI and CT Images on a CD and reports, lab results, inpatient hospital and outpatient reports – to this appointment. If your records are being faxed or mailed to us prior to your appointment, **please send them to Attention: Epilepsy Chart Preparation.** Please fax medical records to **(215) 955 0606**.

**Please remember that your most recent EEG results and tracings are important criteria for your new patient appointment. Please contact the hospital where the EEG was done to obtain results and tracings; you can ask for the EEG department.*

In addition, we would like to make you aware of a few office policies. In accordance with insurance company regulations, we are required to collect all necessary co-pays and referrals at the time of service. Please remember to bring your insurance card. Should your referral not be available, you have the option to either reschedule or pay for your visit at the time of service. In order to accommodate the high patient volume in our office, **we require a minimum of 3 days notice if you plan on canceling your appointment.** Failure to provide us with adequate notice may result in our inability to reschedule you.

Our physicians make every effort to see patients within 15 minutes of their scheduled appointment time. To accomplish this, they require that patients arriving more than 15 minutes late for their appointment be rescheduled. We understand that traffic and parking can be difficult; please leave adequate time for unanticipated delays.

Thank you once again for choosing the Jefferson Department of Neurology. We look forward to providing you the care that you expect and deserve!

APPOINTMENT POLICY NOTIFICATION:

Dear Mr./Ms. _____________:

You have a **New Patient** appointment with Jefferson University Physicians, Jefferson Neurology Associates scheduled for ______________________ *(date)* at _______ (*time).*

In advance of your appointment, we have sent you information about our scheduling practice, which requests that you attend your appointment as scheduled or notify our Practice **at least three (3) business day prior** to that time if you need to cancel. We do ask that our New Patients understand that if they do not present for their appointment and do not cancel in advance, we will not schedule another New Patient appointment for them.

Please do not hesitate to contact me if you have any questions or concerns on which I may be of further assistance. We look forward to seeing you.

Sincerely,

Russell Starkey, MBA
Director of Operations
Jefferson Neurology Associates

Jefferson™ University Hospitals

Department of Neurology
Clinical Neurophysiology Laboratory

T 215.955.6598 F 215.923.1834

ROUTINE EEG

Patient Name: ____

Date of Appointment: ____________________

Registration Time: ____________________ - Suite 9350 Gibbon, 111 S. 11th Street
Philadelphia, PA 19107

EEG Time: ____________________ - Suite 9350 Gibbon, 111 S. 11th Street

Registration Instructions: ABSOLUTELY NO HAIR PRODUCTS, NO PERFUMES

On the day of your appointment, you will be asked to present a photo ID and your insurance information, which may include referrals and/or authorization numbers. It is your responsibility to check with your insurance company to see what is required by them in order to have this study approved for payment. You will need to present the prescription for your test.

Preparation Instructions for Routine EEG:

We ask that on the day of the study you wash your hair. Do not use gel, mousse, hairspray, etc. The EEG can not be done with hair weaves, braids, or hairpieces.

Please **DO NOT HAVE ANY CAFFEINE** (coke, coffee, tea, or chocolate) **FOR 6-12 HOURS BEFORE THE STUDY, BUT YOU MAY EAT AS USUAL.**

Take your medications as you normally would, unless otherwise instructed by your physician. Please bring a list of your present medications

Please **REFRAIN FROM USING ANY PERFUMES OR COLOGNES** on the day of your appointment. This also applies to anyone accompanying you for your appointment. We have staff and other patients with asthma who may have severe reactions.

Try to get two hours less sleep than usual so you will sleep during the study.
PARENTS: Please wake your child very early on the day of the exam (no later than 6 AM).

The study will take about an hour (in some cases longer) depending on patient cooperation.

Please call us directly at (215) 955-6598 if you have any questions or if you need to reschedule or cancel.

APPOINTMENT CANCELLATIONS REQUIRE AT LEAST 24-HOURS NOTICE

Dear Jefferson Neurology Patient,

We are writing to advise you of our office guidelines regarding form completion. Our practice is experiencing a significant increase in the volume and type of requests for completion of forms and letters by our physicians and staff. These include, but are not limited to the following:

- Disability Forms
- FMLA Forms
- Insurance Forms
- Employment Forms/Letters
- Driving Privileges Forms
- Copies of Office Visits (beyond those for referring/primary care physicians)

*Please note: We are unable to complete forms for patients **who have not been seen** within 9 months (3 months disability forms). In certain cases, a follow-up appointment may be required to ensure the accurate completion of any forms.*

You will be charged $10.00 for a single-page form and $30.00 for each multi-page form (up to 4 pages). Additional pages are $5.00 each up to a maximum form fee of $50.00. The standard turn around time for forms is 12 business days after receipt of payment. An additional fee of $10 is due for any form that needs to be expedited (5 to 12 business days).

The completion of forms is a non-covered benefit as far as your insurance is concerned. The form fee is distinct and separate from any co-pay, co-insurance or insurance fee. Please contact the office if the form fee represents a significant financial hardship. Methods of payment include credit card, cash, money order, or check.

Please enclose payment with your form(s) or call in to pay over the phone by credit card to ensure timely processing. Forms will be completed and released only after receipt of payment. Please Make payment to *Jefferson Neurology Associates*.

The decision to charge for forms was not made lightly, even though many practices in the area charge for completion of forms. Unfortunately, the volume and the time commitment have become overwhelming to our staff.

We appreciate your understanding and thank you in advance for your help and cooperation!

Jefferson Department of Neurology

DIRECTIONS TO: **DEPARTMENT OF NEUROLOGY**
909 Walnut Street, 2nd Floor COB
Philadelphia, PA 19107
Telephone: 215-955-1222

BY CAR

From the Betsy Ross Bridge and points Northeast of Philadelphia

- Take I-95 South to Exit 22 (Central Philadelphia/Independence Hall/Callowhill Street).
- At the end of the ramp, turn right onto Callowhill Street.
- Continue on Callowhill Street to 8th Street.
- Turn left onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10th and Walnut.
- Garage Address: 925 Walnut Street

From points North and West of Philadelphia (76 East)

- Take PA Turnpike to Exit 326 (Valley Forge).
- Take 76 East (Schuylkill Expressway) to Philadelphia.
- Take Exit 344 (Central Philadelphia/676 East) – a left-lane exit.
- Take the Broad Street Exit – a right-lane exit.
- Get into left lane and follow signs for Vine Street.
- Follow Vine Street to 8th Street and turn right onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10th and Walnut.
- Garage Address: 925 Walnut Street

From Northeast Extension of the Pennsylvania Turnpike (Route 476)

- Take Exit 20 and follow signs for Route 476. Take Route 476 to Exit 16A; then take Route 76 East (Schuylkill Expressway) to Philadelphia.
- Take Exit 344 (Central Phila/676 East) – a left-lane exit.
- Take the Broad Street Exit – a right-lane exit.
- Get into left lane and follow signs for Vine Street.
- Follow Vine Street to 8th Street and turn right onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10th and Walnut.
- Garage Address: 925 Walnut Street

From Route 309

- Take Route 309 South to the end of the expressway.
- Turn right onto Route 611 South (Broad Street).
- Continue on Broad Street (approximately six miles) to Vine Street.
- Turn left onto Vine Street
- Follow Vine Street to 8th Street and turn right onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10th and Walnut.
- Garage Address: 925 Walnut Street

From Delaware and points South of Philadelphia

- Take Rt. I-95 North to Exit 22 (Central Phila./Independence Hall/Callowhill St.) – a left-lane exit.
- Stay in right lane and exit onto Callowhill Street.
- Once on Callowhill Street, stay in middle lane and continue to 8th Street.
- Turn left onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10th and Walnut.
- Garage Address: 925 Walnut Street

From the Main Line

- Take Route 476 North to exit 16A (Route 76 East/Schuylkill Expressway) to Philadelphia.
- Take Exit 344 (Central Phila/676 East) – a left-lane exit.
- Take the Broad Street Exit – a right-lane exit.
- Stay in left lane and follow signs for Vine Street.
- Turn left onto Vine Street
- Follow Vine Street to 8th Street and turn right onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10th and Walnut.
- Garage Address: 925 Walnut Street

From New Jersey via Walt Whitman Bridge

- Cross Walt Whitman Bridge. After the toll booth, take I-95 North to Exit 22 (Central Phila./Independence Hall/Callowhill St.) – left-lane exit.
- At the end of the ramp, turn right onto Callowhill Street.
- Once on Callowhill Street, stay in middle lane and continue to 8th Street.
- Turn left onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10th and Walnut.
- Garage Address: 925 Walnut Street

From New Jersey via the Ben Franklin Bridge

- Take bridge and stay in left lane and turn left on 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10th and Walnut.
- Garage Address: 925 Walnut Street

From New Jersey Turnpike

- Take Exit 4 (73 West) off NJ Turnpike.
- Follow 73 West to 38 West.
- Continue on 38 West, following signs for the Ben Franklin Bridge. (38 West will turn into Admiral Wilson Blvd.) Continue to bridge.
- Take bridge and stay in left lane and turn left on 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10th and Walnut.
- Garage Address: 925 Walnut Street

PARKING OPTIONS:

Other Suggested Parking Locations:

A. Downtown Garage - 10th & Sansom Streets
B. Jefferson Hospital For Neuroscience - 9th & Locust Streets
C. Jefferson University Hospital Garage - 10th and Chestnut

PARKING GUIDE: Valet parking is available at the 11th Street entrance of the Gibbon Building (between Chestnut and Sansom Streets) and at the Emergency and Trauma Center entrance on the corner of 10th and Sansom Streets. The University garage is located between Walnut and Locust Streets. Entrances to the garage are on 10th and 11th Streets. If you do not wish to use Jefferson Valet Parking Service, there are a number of parking lots and garages in the area. Patients may be dropped off at either the 11th or 10th Street entrance of the Gibbon Building.

BY PUBLIC TRANSPORATION

From Northeast Philadelphia

- Take westbound Market-Frankford elevated to 8th and Market Streets
- Walk south on 8th
- Turn right onto Walnut
- Go 1 ½ block, entrance to building is on the right

From South Philadelphia

- Take Broad Street subway to Broad and Locust Streets
- Walk east on Locust Street to 9th Street
- Turn left onto 9th and walk North to Walnut Street.
- Turn Left onto Walnut Street
- Go ½ block, entrance to building is on the right

From West Philadelphia

- Take the eastbound Market-Frankford elevated to 8th and Market Streets
- Walk south on 8th
- Turn right onto Walnut
- Go 1 ½ block, entrance to building is on the right

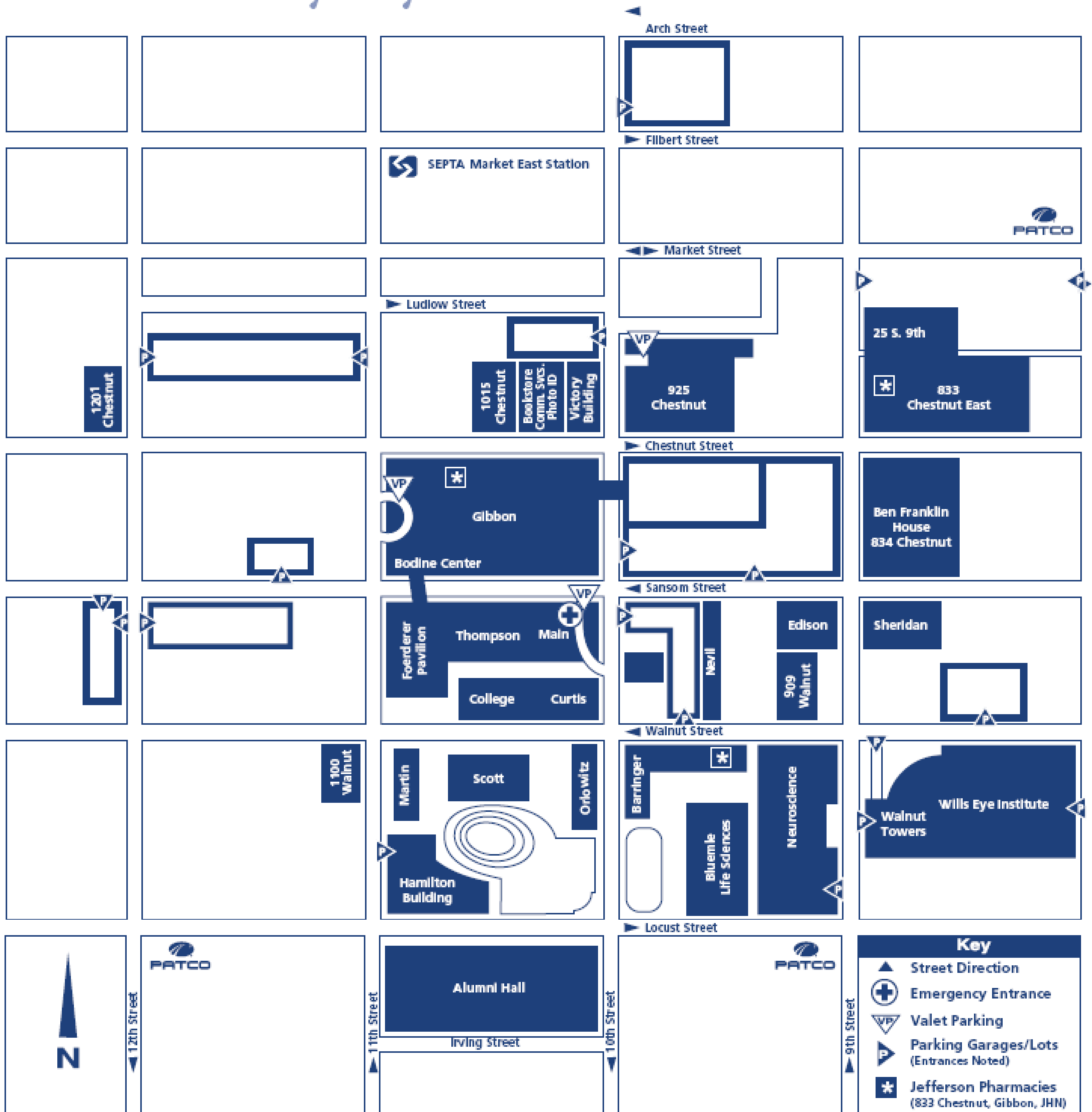
From the suburbs

- Call SEPTA at 215-580-7800 to determine the regional rail line closest to your home
- Take the train to the Market East Station at 11th and Market Streets
- Go right at 9th and Market onto 9th Street. Go to corner of 9th and Walnut
- Turn right onto Walnut
- Go 1 ½ block, entrance to building is on the right

From New Jersey

- Take the PATCO High Speed Line to the 10th and Locust Station
- Follow signs to 9th Street
- Turn left onto 9th and walk North to Walnut Street.
- Turn Left onto Walnut Street
- Go ½ block, entrance to building is on the right

Jefferson™ University Physicians



Please check with individual JUP practices regarding their policy for area parking validation or discounted rates.

JG 08.0154

COMMUNICATION OF PROTECTED HEALTH INFORMATION

I would like Jefferson University Physicians ("Jefferson") to share my protected health information, which includes billing information, with the individuals (e.g., my spouse, parent(s), etc.) listed below.

After providing Jefferson with this completed and signed form, Jefferson agrees to communicate with the individuals listed below unless I provide Jefferson with written notice to no longer do so.

I. Patient Identification

Patient Name: ____ Date of Birth: __________________________

II. Authorization of Communication

I hereby grant Jefferson's Department/Division of ______________________________ permission to communicate my protected health information to the following individuals:

1. Name: ________________________________ Address: ________________________________ ________________________________ Patient Relationship: ______________________________ Telephone No.: (_______) __________ - _____________	4. Name: ________________________________ Address: ________________________________ ________________________________ Patient Relationship: ______________________________ Telephone No.: (_______) __________ - _____________
2. Name: ________________________________ Address: ________________________________ ________________________________ Patient Relationship: ______________________________ Telephone No.: (_______) __________ - _____________	5. Name: ________________________________ Address: ________________________________ ________________________________ Patient Relationship: ______________________________ Telephone No.: (_______) __________ - _____________
3. Name: ________________________________ Address: ________________________________ ________________________________ Patient Relationship: ______________________________ Telephone No.: (_______) __________ - _____________	6. Name: ________________________________ Address: ________________________________ ________________________________ Patient Relationship: ______________________________ Telephone No.: (_______) __________ - _____________

I understand that completing this form is voluntary. I am not required to list any individuals.

Patient's Signature **Date**

____________________________________ ________________________

Witness Date

Everson, Garry; 11/01/53

Jefferson University Physicians

JUP Patient Profile Form

Patient Name: ______________________ **Date of Birth:** ______________
(Please Print)

MRN: ______________________

Associated Providers

Please list any physicians below who should receive information regarding your care/visit.

Primary Care Provider

Name: ______________________ Specialty: ______________

Address: ______________________

City, State: ______________________ Zip: ______________

Phone: ______________________ Fax: ______________

Referring Provider

Name: ______________________ Specialty: ______________

Address: ______________________

City, State: ______________________ Zip: ______________

Phone: ______________________ Fax: ______________

Pharmacy Information

Please complete your pharmacy information below.

Retail Pharmacy

Name: ______________________

Address: ______________________

City, State: ______________________ Zip: ______________

Phone: ______________________ Fax: ______________

Mail Order Pharmacy

Name: ______________________

Address: ______________________

City, State: ______________________ Zip: ______________

Phone: ______________________ Fax: ______________

Laboratory/Radiology Information

Are your laboratory and radiology studies capitated to a specific performing location? ☐ Y ☐ N

Laboratory: ______________________ Radiology: ______________

FORM 81489 (REV. 10/10) JG 11-0872

Jefferson. University Physicians

JUP Medical History Questionnaire

MRN # ______________________

Patient Name *(Please Print)*: ______________________ Date of Birth: ______________

Provider you are seeing today: ______________________ Today's Date: ______________

Please state your problem in your own words as to why you are here today: ______________________

____

____

Did a physician request that you see one of our providers today? ☐ Yes ☐ No If yes, name of physician: ______________________

Past Medical History *(check all that apply)*: ☐ **No Past Medical History**

☐ Acute Myocardial Infarction (Heart Attack)
☐ Anemia (Low Blood Count)
☐ Arthritis
☐ Asthma
☐ Autoimmune Disorder (Lupus/Scleroderma/RA)
☐ Blood Transfusion Complications
☐ Cancer - list type(s):
____
____
____
☐ Chest Pain (Angina)
☐ Chronic Liver Disease
☐ COPD (Chronic Obstructive Pulmonary Disease)
☐ Diabetes Mellitus
☐ Emotional Disturbance
☐ Gastric/Duodenal Ulcer
☐ Heart Disease
☐ Heartburn
☐ Hepatic (Liver) Disorder
☐ Hepatitis
☐ HIV Infection
☐ Hypercholesterolemia
☐ Hypertension
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Lower Back Pain
☐ Mitral Valve Disorder
☐ Murmurs
☐ Obesity
☐ Obstructive Sleep Apnea
☐ Osteoporosis
☐ Peripheral Vascular Disease (Poor Circulation)
☐ Pneumonia
☐ Pulmonary Disease (Lung Disease)
☐ Recent Methicillin-resistant Staph aureus (MRSA)
☐ Rheumatic Fever
☐ Seizure Disorder
☐ Sinusitis
☐ Stroke Syndrome
☐ Thromboembolic Disease (Blood Clot Disorder)
☐ Thrombophlebitis
☐ Thyroid Disorder
☐ Transient Ischemic Attack (Mini Stroke)
☐ Tuberculosis
☐ Other (specify):
____
____
____

Surgery: ☐ No Surgical History

Surgery	Date	Surgery	Date

Family History *(check all that apply)*: ☐ No Family Medical History

	Family Member*		Family Member*
☐ Anemia (Low Blood Count)		☐ Hypercholesterolemia	
☐ Cancer - list type(s):		☐ Hypertension	
		☐ Osteoporosis	
		☐ Pulmonary Disease	
☐ COPD		☐ Renal Disease	
☐ Diabetes Mellitus		☐ Stroke Syndrome	
☐ Emphysema		☐ Thromboembolic Disease	
☐ Heart Disease		☐ Unattainable-Patient Adopted	
☐ Hepatic (Liver) Disorder		☐ Other:	
Family Health Status of Father – Deceased Age:		Cause:	
Family Health Status of Mother – Deceased Age:		Cause:	

Please indicate the family member affected: mother, father, brother, sister, maternal or paternal grandmother/grandfather, etc.

 MRN # ____________

Patient Name: ____________ Date of Birth: ____________

Social History:

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

(check all that apply)

☐ Alcohol Use: Weekly: ____________

☐ Drug Use (Recreational): Explain: ____________

☐ Using Intravenous Drugs: Explain: ____________

☐ Previous History of Smoking: Date Quit: ____________ Packs Per Day ________ Years of Smoking: ________

Attempts to Quit: ________ Methods Used to Quit: ____________

☐ No History of Smoking ☐ Wishing to Stop Smoking

☐ Smoking/Nicotine Substances: ☐ Cigarettes: Packs/Times Per Day: ________ Years ________

☐ Cigars ☐ Chewing ☐ Tobacco ☐ Pipe

☐ Current Diet: Explain: ____________

☐ Exercise Habits: Times per week: ________ ☐ Being Sedentary (Do not exercise) ☐ Sexually Active

☐ Occupation: List All: ____________

☐ Travel: If recently out of the country, where? ____________

Do you have an advanced directive? ☐ Yes ☐ No

Allergies: ☐ No Known Allergies

Allergy	Reaction	Allergy	Reaction

Medications (Include vitamins, herbal supplements and over the counter medications): ☐ No Current Medications

Medications	Dosage	Frequency	Reason for Taking

Have you participated in any clinical trials or used experimental drugs? ☐ Yes ☐ No Explain: ____________

Are you pregnant? ☐ Yes ☐ No Last Menstrual Period Date: ____________

Is there anything else about your medical history that we should know? ____________

____

Patient Signature: ____________ Date: ____________

I certify that I have reviewed the above information with the patient.

Physician Signature: ____________ Date: ____________

AUTHORIZATION TO RELEASE AND/OR COPY HEALTH INFORMATION

Copy of this consent given to patient? ☐ Yes ☐ Patient Refused Copy

Patient Name: ______________________ Date of Birth: ______________________

I authorize the release of health information relating to me as described below:

Physician Office/Department Authorized to Release My Information:

Physician Name: ______________________ Office/Department (*e.g.* Internal Medicine): ______________________

To Whom My Information May be Provided:

Name of Individual (*includes self*) or Organization Receiving Information: ______________________

Address: ______________________
Street *City* *State* *Zip*

Specific Information to be Released: [copying fee may be charged]

- ☐ Summary of Records
  To be prepared by doctor after Patient agrees to additional fees imposed.
- ☐ Entire Record
- ☐ Other (Please Specify): ______________________
- ☐ EKG
- ☐ Progress Notes
- ☐ Imaging Reports
- ☐ Lab Reports
- ☐ Billing
- ☐ History & Physical
- ☐ Pathology Report
- ☐ Immunizations
- ☐ Cardiac Testing

Covering the period(s) of treatment from ______________________ to ______________________

Purpose/Use of Released Information:

- ☐ Personal Use by Patient
- ☐ Workers' Compensation
- ☐ Medical Care
- ☐ Social Security
- ☐ Legal/Litigation
- ☐ Other: ______________________

Authorization Expiration (date or event):

☐ Date from signature : _______/________/____________
(*if not provided, than 180* days)

☐ Date of following event (please specify): ______________________

I understand that information in response to this request may be related to diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, and/or treatment for drug and alcohol abuse. Please check the appropriate box(es) below:

AIDS/HIV Information	Psychiatric Care/Treatment**	Drug or Alcohol Treatment
☐ Yes, disclose	☐ Yes, disclose	☐ Yes, disclose
☐ No, do not disclose	☐ No, do not disclose	☐ No, do not disclose

***I have been informed of my right to inspect my mental health records to be released, subject to the limitations imposed by 55 Pa. Stat. §5100.33*

I understand that if the person or entity receiving my individually identifying information is not a health care provider covered by federal privacy regulations, my information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand authorizing the use or disclosure of the information identified above is voluntary. My refusal to sign this form in no way affects my treatment, payment, enrollment in health plans or eligibility for benefits, unless:

(a) This authorization is for the use or disclosure of health information obtained in a research study. If you do not sign this authorization, you will be ineligible to participate in the research study for which this authorization is being requested.

(b) You have requested a service by Jefferson (for example, a physical examination, a letter about your medical problems, or a medical second opinion consultation) solely to provide the health information related to that service to a third party at your request.

I understand that I may revoke this authorization at any time, except to the extent it has been relied upon. I understand that if I revoke this authorization, I must do so in writing and give my written revocation to my physician's office/department authorized to release the information.

Signature of Patient or Patient's Personal Representative **Date**

Print Name of Personal Representative (*if applicable*): ______________________

Describe Relationship/Authority to act for patient (parent, guardian, etc.): ______________________
(***Please provide necessary documentation proving your authority***)

Verbal Consent (*If the patient is physically unable to provide a signature, two responsible people must sign below*)
The patient understands the nature of this release and freely gives his or her verbal consent, as witnessed by the following responsible individuals. The patient further understands that this verbal consent is subject to revocation at any time except to the extent that it has been relied upon. To revoke this verbal consent, the patient must understand the nature of the revocation and freely give his or her verbal revocation, as verified in writing by two responsible witnesses.

______________________ ______________________ ______________________
Witness 1 Witness 2 Date

REVOCATION SECTION (to be completed and signed by the patient):

This consent has been revoked on ______/______/ ___________ ______________________

Signature of Patient

Jefferson.

STATEMENT TO ACCOMPANY RELEASE OF MENTAL HEALTH, DRUG AND ALCOHOL AND HIV-RELATED RECORDS

Check Applicable Statement(s)

☐ **STATEMENT TO ACCOMPANY RELEASE OF MENTAL HEALTH RECORDS**
"This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains." 55 Pa. Code section 5100.34(d).

☐ **STATEMENT TO ACCOMPANY DISCLOSURE OF CONFIDENTIAL HIV-RELATED INFORMATION**
"This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose." 35 Pa. Stat. section 7607(e).

☐ **STATEMENT TO ACCOMPANY RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS**
"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Jefferson. University Physicians

JUP Patient Registration Form

Today's Date:

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

Patient's Last Name		Patient's First Name	MI
DOB	Sex ☐ M ☐ F	Social Security Number — —	Language ☐ English ☐ Other ______

Race ☐ African American or Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Caucasian or White ☐ Unknown ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown ☐ Declined

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other ______

Address Line 1	Address Line 2	
City	State	Zip
Home Phone	Daytime Phone	Cell Phone
Home E-mail		

Emp Status ☐ Employed Full Time ☐ Employed Part Time ☐ Self-Employed ☐ Unemployed ☐ Active Military ☐ Disabled ☐ Homemaker ☐ Student ☐ Other ______

Employer	Work Phone	
Employer's Address Line 1	Employer's Address Line 2	
City	State	Zip

Please complete if guarantor is other than self. *(Guarantor is the person financially responsible for this patient's bill.)*

Guarantor's Last Name			Guarantor's First Name	MI
DOB / /	Sex ☐ M ☐ F	Social Security Number — —	Patient's Relationship to the Guarantor	Home Phone

Guarantor's Address Line 1	Guarantor's Address Line 2	
City	State	Zip
Guarantor's Employer		
Guarantor Employer's Address Line 1	Guarantor Employer's Address Line 2	
City	State	Zip

Emergency Contact Information

Emergency Contact's Last Name	Emergency Contact's First Name	MI
Patient's Relationship to the Emergency Contact	Daytime Phone	Cell Phone

Please select the source in which you heard of our practice

☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ JEFF NOW® ☐ Mass Mailing ☐ Newspaper/Mag. ☐ Ongoing Care
☐ Patient ☐ Phone Book ☐ Phys. Off./ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other ______

Insurance Information *A separate form is required for workers' compensation, automobile liability, or legal services.*

Primary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#	Subscriber's Employer		
Secondary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#	Subscriber's Employer		

FORM 4734-00 (REV. 03/12) JG 12-1572