Elizabeth Liu, M.D., Ph.D.
60 Essex Street, Suite 202
Rochelle Park, NJ 07662
Phone: (201) 587-8887

Patient Information — Please Print

Last Name ______________________ First Name ______________________ M.I. ______

Address ____ Apt. __________

City ______________________ State ______________________ Zip __________

Social Security # ______________________ Birth Date __________ Age ______

Home Phone # (_____) ______________________ Work Phone #(_____) ______________ Ext. ______

Cell Phone # (_____) ______________________ Pharmacy Phone# ______________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex ☐ Male ☐ Female

Insurance Information - Primary / Secondary / Other

***** Please Give Your Insurance Cards To the Receptionist*****

Is this office visit related to a workman's compensation case? ☐ Yes ☐ No or Motor vehicle accident? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No Copay ☐ Yes ☐ No Amount $ __________

Primary Insurance ______________________ Address ______________________

Policy No. ______________________ Group No. __________

Please indicate the policyholder for the primary insurance: ☐ Self ☐ Spouse

____

Copay ☐ Yes ☐ No Amount $ __________

Secondary Insurance ______________________ Address ______________________

Policy No. ______________________ Group No. __________

Please indicate the policyholder for the secondary insurance: ☐ Self ☐ Spouse

Patient's Employer Information

Employer's Name ______________________ Patient's Occupation ______________________

Address ______________________________________ Telephone # ______________

City ______________________ State __________ Zip __________

Guarantor's Information (if other than patient)

Guarantor's Name ______________________ Guarantor's Birth Date __________

Guarantor's SS# ______________________ Employer's Phone (_______) ______________

Guarantor's Employer ____

Guarantor's Employer's Address ______________________ State __________ Zip __________

Emergency Information

Please list the nearest living relative/friend other than your spouse ______________________

In case of an emergency, we may contact: ______________________ Phone # (_____) ______________

Address ______________________ Relationship to Patient ______________________

Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to Wellness Medical Center LLC, its successors and assigns, or any individual it may designate for services provided.

I hereby agree that I am financially responsible to **Wellness Medical Center LLC,** for all Copays, coinsurances, deductibles and fees for non-covered services which are rendered to me.

____

Signature of Patient or Parent of Minor Date

Authorization for Medicare

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to **Wellness Medical Center LLC,** for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

____

Patient's Signature Date

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Patient Health Questionnaire

Name ______________

Please list all operations you have had:

Please list all pills and medications you take regularly (including over-the-counter medications):

Do you smoke? How much?

Do you drink alcohol? How much?

Do you use recreational drugs?

Please list all allergies (medications, inhalants, foods, contact allergies)

Please describe any other problem which may not have been covered above, and which you would like the doctor to know about:

Relationship/If other than patient

____________________ ____________Signature

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

- Conduct, plan and direct my treatment and follow-ups among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide to such restrictions.

Patient Name: ____

Signature: _______________________________________ Date _____________

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PATIENT HEALTH OUESTIONNAIRE

Patient Name:____ Date:_____________________

Please answer the following by checking "yes or no" to the right of the question.
Do you have any problems relating to:

CONSTITUENTS	Y	N	GENITAL URINARY SYSTEM	Y	N
Fever or Chills, High or Low blood pressure			Frequent urination or Blood in urine		
			Pain upon urination		
HEAD & NECK			Prostate problems		
Double vision, blurred vision			Vaginal discharge or Bleeding or Lesions		
Ear Ache					
Hearing Loss			**MUSCULAR SKELETAL SYSTEM**		
Dizziness			Neck pain or Back pain or Joint pain		
Sinusitis			Deformity in bones or muscles		
Facial Pain			Muscle weakness		
Pain on chewing					
Local Skin Lesions that have changed recently			**SKIN/BREASTS**		
Lumps/Swelling around the head or the neck			Moles or Nevus		
			Rash		
CARDIOVASCULAR SYSTEM			Breast lumps		
Heart Disease			Mastalgia		
. Chest pain/Angina or Palpitation					
Swelling of the ankles			**NEUROLOGICAL SYSTEM**		
Shortness of breath on exertion			Headache		
Heart surgery or Angioplasty or Stent			Stiff neck		
			Weakness or Numbness		
RESPIRATORY SYSTEM			Imbalance		
Hoarseness					
Cough or Chronic cough			**PSYCHOLOGICAL**		
Shortness of breath			Nervousness or Anxious mood		
Pain in chest			Feeling sad		
Chronic bronchitis or emphysema			Hearing voices or Seeing things		
Coughing or Spitting up blood			Insomnia		
History of TB or Lung cancer					
			ENDOCRINOLOGY		
GASTROINTESTINAL			Feeling hot or Feeling cold		
Abdominal pain			Weight gain or Weight loss		
Heart burn or Ulcers			Feeling thirsty often		
Difficult or Pain swallowing					
Jaundice			**HEMATOLOGY & LYMPH NODES**		
Hepatitis			Feeling tired		
Bloody stool			Enlarged lymph nodes		
Diverticulosis					
Diarrhea			**ALLERGY & IMMUNOLOGY**		
Anemia or other blood disorder			Sneezes or Runny nose or Itchy eyes/nose		
Constipation			Immunodeficiency or Autoimmune disease		

WELLNESS MEDICAL CENTER

Suggested wording to meet Compliance

Advance Directive

Do you have Advance Directives / Living Will? (For patient 18 and above)

Yes   No

Cultural/Linguistic Barriers to Care

Do you have any of the following? (Please circle)

Poor Vision   Poor Hearing

Language Barrier   Religious / Cultural Barriers

None of the Above

________________________________   ________________________

Patient Name   Day of Birth

____

Signature

Wellness Medical Center LLC

Consent To Treatment

Patient Name: ________________________________ Date of Birth: __________________________________

SS# : _______________________________________ Today's Date: ___________ Time: _______ AM / PM

I, _________________________ (the _________________ of __________________________), hereby voluntarily consent to outpatient care at Wellness Medical Center LLC, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing, and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physicians' assistants, medical assistants, or their designees as is necessary in the medical staff's judgments.

Release of Information: (a) I authorize Wellness Medical Center LLC to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care. (b) I further authorize the release of medical information about treatment here to my doctors or anyone designated by me.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Wellness Medical Center LLC.

This form has been explained to me and I fully understand this Consent To Treatment and agree to its contents.

Comments: ____

____

Signature of Patient or Person Authorized to consent for patient: ________________________________

Signature of Witness who explained this "Consent to Treatment" form: _________________________

****

If the patient is a minor or is unable to consent, please complete the following:

A. Patient is a minor and is ______ years of age.

Name of Father: ____________________________ Name of Mother: _______________________________

B. Patient is unable to consent because ____

____

Signature of Closest Relative or Legal Guardian: ____

Relationship: ___________________________ Witness to Signature: ________________________________

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FINANCIAL POLICY

Patient must fill out the registration forms completely prior to seeing the doctor. We will request to photocopy your insurance card(s) for your file.

- Non-par ins. and private ins. –– Payment in full is required for all patients with private insurance or carriers we do not participate with. It will be your responsibility to file a claim for reimbursement.
- Co-payments –– we are required by law to collect all co-payments. Please be prepared to pay that co-pay at each visit.
- Primary Care Provider –– if your plan requires choosing a primacy care provider, it is YOUR RESPONSIBILITY to choose Dr. Liu as your primary care provider prior to your visit so that the visit would be covered by your insurance company.
- Medicare –– Dr. Liu is a participating physician with Medicare. We will submit to Medicare for the allowed amount. Patients are responsible for their deductible and the 20% coinsurance, which can be billed to your secondary insurance if you have one we participate with.
- Delinquent Accts –– Accounts 90 days past due will be sent to collection. You will be responsible for all charges incurred and for finance charges.
- Cancellations –– 24-hour notice is required. Failure to do so will result in a $50.00 cancellation fee.

WE ACCEPT CASH, CHECKS.

I HAVE FULLY REVIEWED THIS FINANCIAL POLICY STATEMENT AND AGREE TO HONOR THE TERMS. I FURTHER AUTHORIZE DISCLOSURE OF MY PATIENT RECORDS WHICH ARE REQUESTED BY INSURANCE CARRIER.

____________________________ __________________
RESPONSIBLE SIGNATURE DATE

____
RELATIONSHIP TO PATIENT

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E-PRESCRIBE CONSENT FORM

E-Prescribe is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribe greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) *2003* listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions** — provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Wellness Medical Center, LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Wellness Medical Center, LLC to enroll me in the e-Prescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Consent Accepted: ☐
Consent Denied: ☐

Patient Name:______________________ Date of Birth:_______________

Signature: ________________________ Name:_____________________

Date: __________________ Relationship to Patient:__________________