Welcome!!!

I would like to take this opportunity to welcome you to Hackensack University Medical Center and the John Theurer Cancer Center. My specialty is orthopedic oncology and I treat both pediatric and adult patients with bone and soft tissue sarcomas, as well as other benign and cancerous tumors affecting the musculoskeletal system. My staff & I are here to help you as best we can.

I have two office locations. My primary office is located at Hackensack University Medical Center in Hackensack, NJ and the other in Cedar Knolls, NJ. All appointments, as well as scheduling surgeries, radiological studies and other administrative matters, are handled by my outstanding administrative & medical support staff including: Administrative Assistants: Basmah Allen, Jill Ramsaier and Meredith Kern, Registered Nurse, Helen Wittig, RN; Advanced Nurse Practitioner Connie Chong, RN, ANP; Physician Assistants, Jennifer Kelly, PA-C, Erin Moreau, PA-C and Jill Kossove, PA-C , Medical Assistant, Carlis Mordan and Billing Coordinator, Johnny Rodriguez. We are all here to help you through every aspect of your care!!

Please be sure to complete the following Patient Information form as thoroughly as possible.
There are seven (7) parts to the form that need to be read throroughly and completed:

Part 1: Patient Demographics
Part 2: Additional Personal Physician Information
Part 3: Acknowledgement of Financial Responsibility
Part 4: Assignment of Insurance Benefits from Medicare and private insurance
Part 5: Permission for Electronic Communication
Part 6: Noticy of Privacy Act (HIPAA Forms)
Part 7: Medical History Questionnaire

It is important that we have very accurate information for your medical chart, specifically your physicians' names, addresses and phone numbers as well as **dosages of all medications**, and the **pharmacy name**, address and phone number.

Please complete prior to your appointment, print out and bring on the day of your appointment.
In addition, the Office Information section of this website (www.TumorSurgery.org) has handy, printable checklists to help make the process of your first appointment, a biopsy and/or surgery easier. In addition to patient information & patient education sections, my website, www.TumorSurgery.org has specifics about office policies, scheduling surgeries as well as other pertinent information regarding your care.

My team and I look forward to taking extraordinary care of you.

Sincerely,

James C. Wittig, MD
Vice Chairman, Orthopedic Surgery
Chief, Orthopedic Oncology & Sarcoma Surgery
Director, Skin & Sarcoma Division

Dr. Wittig's Staff Contact Information

Main Office
Hackensack University Medical Center
20 Prospect Avenue
Suite 501
Hackensack, NJ 07601

Morristown Office
Tri-County Orthopedics
197 Ridgedale Avenue
Suite 300
Cedar Knolls, NJ 07927

Phone: 551-996-2533
Fax: 551-996-0877

Please note: For emergency & urgent matters, please call the office.

Email communication with staff to be used strictly for non-urgent/non-emergency matters.
If you do not receive a reply within 1 business day,
please verify with the office that your email was received.

Any email received from a patient will be considered an inferred consent to communicate by email.

Thank you.

Basmah Allen
Administrative Assistant
ballen@HackensackUMC.org

Jill Ramsaier
Administrative Assistant
JRamsaier@HackensackUMC.org

Meredith Kern
Administrative Assistant
mkern@HackensackUMC.org

Helen Wittig, RN
Nurse Clinician
hwittig@HackensackUMC.org

Connie Chong, ANP
Advanced Nurse Practitioner
cchong@HackensackUMC.org

Jennifer Kelly, PA-C
Physician Assistant
jrkelly@HackensackUMC.org

Carlis Mordan
Medical Assistant
CMordan@HackensackUMC.org

Johnny Rodriguez
Billing Coordinator
JRodriguez-Beato@HackensackUMC.org

Part 1: Patient Demographics

Name: Date of Birth

Address

Address

City State Zip Code

Phone Number Cell Number Age

***Email address** Work Number

SSN Occupation

Driver's License Number

Emergency Contact Relation to patient

Work Number Home Number Cell Number

☐ ***By checking the box here, you agree to receive our electronic e-newsletter and important office updates via e-mail.**

Responsible party if different than patient

Name Date of Birth

Address

City State AL Zip Code

Home Phone Cell Number Work Number

Occupation Relationship to patient

Legal Guardian: Copy for Chart:

HEALTH CARE PROXY: ◯ Yes ◯ No

If Yes, Name of Health Care Proxy:

Home Phone: Cell Number:

Patient Signature

Part 2: Additional Personal Physician Information

Name: Date:

Whom may we thank for referring you to Dr. Wittig?

We will send information about your initial consultation, surgery and follow-up appointments to all physicians listed. Please be sure to contact your physician(s) to get accurate addresses, phone numbers, fax numbers and e-mail addresses so that we can communicate more efficiently. Thank you.

1. Referring Physician/Health Professional:

Address

City State/Zip Phone:

E-Mail: Fax:

2. Primary Care Physician/Health Professional:

Address

City State/Zip Phone:

E-Mail: Fax:

3. Pharmacy:

Address

City State/Zip Phone:

E-Mail: Fax:

4. Orthopaedic Surgeon:

Address

City State/Zip Phone:

E-Mail: Fax:

5. Other Specialist/Physician:

Address

City State/Zip Phone:

E-Mail: Fax:

Do you research on the internet? ☐ Yes ☐ No **Did you reference Dr. Wittig's website?** ☐ Yes ☐ No

Patient/Guardian Signature:

Part 3

FACULTY PRACTICE PLAN
ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Dr. James C. Wittig, Hackensack UMC and Staff are dedicated to assisting you to make sure that your health insurance has all of the information necessary to reimburse for all covered services. Your health insurance may not pay for all of your health care costs; you, your employer and your insurance company largely determine your health benefits. Health insurance only pays for covered items and services when their rules are met.

INSURANCE COVERAGE

- ✓ It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier.

- ✓ We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit and/or surgery, you will be responsible for the entire payment.

INSURANCE CHANGES

- ✓ If you have had any changes in your insurance coverage, please notify us. Failure to do so may result in a claim denial and you will be billed for the entire fee for any and all services.

CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES AND OUT OF POCKET EXPENSES

- ✓ Co-insurance and co-payments are the patient's/guarantor's responsibility. Co-payments are due at the time of the visit.

- ✓ Deductibles and Out Of Pocket expenses (that portion of the bill not covered by your insurance plan) are the patient's/guarantor's responsibility. The deductible and out of pocket payment is determined by the contract you have with your health insurance carrier. Your insurance company's definition of Usual and Customary is arbitrary and may be different or less than Dr. Wittig's Usual and Customary fees. It is the patient's responsibility to determine the insurance plan's definition of usual and customary for each CPT code used to bill for the service/visit/surgery. It is the insurance company's responsibility as well as your employer's (human resources) responsibility to provide you with that information in order to determine your out of pocket expense before surgery. Dr. Wittig's staff will assist you in these matters but it is ultimately the patient's/guarantor's responsibility.

ASSISTANTS DURING SURGERY

- ✓ Assistants are required for your surgery. Surgical assistants help Dr. Wittig during your surgery. They may include physician assistants, nurse practitioners, Professional Surgical Services, LLC or other physicians depending on availability and the complexity of the surgery. Your insurance company will be billed separately for an assistant. You may receive a separate bill and explanation of benefits for the assistant. You may also receive a separate check from the insurance company for the assistant that should be forwarded to Dr. Wittig, Professional Surgical Services, LLC or the respective assistant surgeon.

INSURANCE REQUESTS

- ✓ The patient/guarantor is responsible for responding to insurance company requests for further information. The patient/guarantor agrees to help Dr. Wittig's billing staff with denials and appeals regarding payments made by the insurance company. and provide Dr. Wittig's staff with any and all necessary information

INSURANCE PAYMENTS

- ✓ The patient/guarantor may receive a direct payment from the insurance company for services rendered by Dr. Wittig and /or his assistants. It is the patient's/guarantor's responsibility to immediately forward to Dr. Wittig any and all payments and explanation of benefits (EOB) made by the insurance company for any and all services rendered by Dr. Wittig and/or any of his assistants. I also authorize and assign my benefits directly to Dr. Wittig and instruct my insurance company to issue payment directly to Dr. Wittig for any and all services rendered by Dr. Wittig, his staff, Physician Assistants, Nurse Practitioners and Professional Surgical Services, LLC.

I have read, understand, agree and will comply with the terms of this Financial Responsibility form.

Patient/Guarantor Signature

Date

Patient Name:

Account Number

Part 4: Assignment of Insurance Benefits from Medicare and private insurance

Patient's Name _____ MR# _____

ASSIGNMENT OF BENEFITS

I request that payment of authorized benefits be made on my behalf to James C. Wittig, MD for any and all services furnished to the patient listed above by James C. Wittig, MD and/or any of Dr. Wittig's physician assistants or nurse practitioners, and I assign my right to receive these payments to James C. Wittig, MD. I authorize HackensackUMC and Dr. James C. Wittig to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my Health Insurance Plan does not direct payment to Dr. James C Wittig or HackensackUMC, I agree to forward to Dr. James C. Wittig all health insurance payments, which I receive for the services rendered by Dr. James C. Wittig and/or his physician assistants and/or nurse practitioners.

I authorize HackensackUMC or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

_____

Parent/Person Legally Responsible Relationship to Patient Date

MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf for services furnished to me by my 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 payable for related services.

_____

Parent/Person Legally Responsible Relationship to Patient Date

OTHER HEALTH INSURANCE

I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.

_____

Parent/Person Legally Responsible Relationship to Patient Date

PATIENT RESPONSIBILITY

I acknowledge that I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. To the extent no coverage exists under my Health Insurance Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance. I further agree that, if permissible by law, I will reimburse HackensackUMC and Dr. James C Wittig for all costs, expenses and attorney's fees that may be incurred by HackensackUMC or Dr. James C. Wittig to collect those charges.

_____

Parent/Person Legally Responsible Relationship to Patient Date

Part 5: Permission for Electronic (Email & Text) Communication

Dr. Wittig's office welcomes email /text correspondence relative to your medical matters, however please do not email the office regarding matters that require urgent or emergent attention without making us aware of the email by direct verbal communication to a live person. Please be advised that email and texting may not be a secure method of communicating private health information or other sensitive or confidential information that may be contained and could be misdirected, disclosed to or intercepted by unauthorized third parties.

However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

Please read below and check your preference.

☐ I consent and accept the risk in receiving information via email or text. I understand I can withdraw my consent at any time. My email address is _____

☐ I **do not** consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Print Name _____ Date: _____

_____

Patient Signature

Part 7: Medical History Questionnaire

Patient Name _____ Date 8/4/14

Age _____ ◯ Male ◯ Female Weight _____

HISTORY OF YOUR PRESENT ILLNESS:

Why are you here to see Dr. Wittig? _____

When did symptoms begin? _____

Have the symptoms worsened since they first started? ◯ Yes ◯ No

Do you have a lump, mass, growth or a swelling? ◯ Yes ◯ No

If so, where is it located? _____

If so, has it been getting bigger? ◯ Yes ◯ No How much bigger? _____

Have you ever been diagnosed with a tumor or cancer? ◯ Yes ◯ No

If so, where was the tumor or cancer? _____

Have you ever been diagnosed with an infection? ◯ Yes ◯ No

If so, where? _____

Do you have pain? ◯ Yes ◯ No If so, where? _____

Do you have pain at night? ◯ Yes ◯ No If so, does it keep you awake? ◯ Yes ◯ No

Are you taking any medication to relieve your pain? ◯ Yes ◯ No

If so, what is the name of the pain medication? _____

Does the pain medication relieve your pain? Partially - % of relief _____

Do you have any of the following:

Fevers ◯ Yes ◯ No

Night Sweats ◯ Yes ◯ No

Weight Loss ◯ Yes ◯ No

Do you have numbness or tingling in your arms, hands, legs, feet? ◯ Yes ◯ No

If so, where is the numbness or tingling? _____

Signature of Physician: _____

Patient Name _____ Date _____

CURRENT MEDICATIONS AND DOSAGES THAT YOU ARE TAKING:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Maalox ◯ Yes ◯ No Advil ◯ Yes ◯ No Aspirin ◯ Yes ◯ No Laxatives ◯ Yes ◯ No
Mylanta ◯ Yes ◯ No Tylenol ◯ Yes ◯ No Alleve ◯ Yes ◯ No Vitamins/Supplements ◯ Ye s ◯ No

Names of Vitamins / Supplements: _____

ALLERGIES

Food: _____ Shellfish: ◯ Yes ◯ No Iodine: ◯ Yes ◯ No

Medication: _____ Sulfa: ◯ Yes ◯ No Penicillin: ◯ Yes ◯ No

Other: _____

SOCIAL HISTORY

Primary language? _____ Born in the US: ◯ Yes ◯ No

◯ Married ◯ Divorced ◯ Single ◯ Widowed

Do you live alone? ◯ Yes ◯ No If YES, who is your care provider? _____

Do you have a family? ◯ Yes ◯ No Who is your support system? _____

Who do you live with? _____

Where do you live? ◯ apartment ◯ private residence

Are there stairs required to enter? ◯ Yes ◯ No If yes, how many? _____

Your Occupation _____ If Retired, when did you retire? _____

Do you drink alcohol? ◯ Yes ◯ No How much per week? _____

Do you smoke cigarettes or cigars? ◯ Yes ◯ No If yes, how many packs per day? _____

Have you ever smoked? ◯ Yes ◯ No If yes, how much and for how long? _____

Have you traveled in the last year? ◯ Yes ◯ No If Yes, Where? _____

Do you or have you ever used Drugs? ◯ Yes ◯ No If Yes, what type & how much? _____

Physician's Signature:

Patient Name: _____ Date _____

PAST MEDICAL HISTORY

Any reasons why you may have been to other doctors? _____

Admitted to the Hospital? _____

Evaluated in the Emergency room? _____

Have you ever been diagnosed with Cancer or a Tumor? ☐ Yes ☐ No

If so, what type? _____

How was it treated? _____

Do you have any of the following **MEDICAL CONDITIONS?** (please check Yes or No)

	YES	NO		YES	NO		YES	NO
Alcoholism	☐	☐	Psoriasis	☐	☐	Flu	☐	☐
Asthma	☐	☐	Gout	☐	☐	High cholesterol	☐	☐
Bleeding Disorder	☐	☐	Pseudogout	☐	☐	Depression	☐	☐
Kidney Disease	☐	☐	Sarcoidosis	☐	☐	Anxiety	☐	☐
Kidney Stones	☐	☐	Lupus	☐	☐	Stroke or CVA	☐	☐
Kidney Failure	☐	☐	Multiple Sclerosis	☐	☐	Sexually Transmitted Diseases	☐	☐
Parathyroid Disease	☐	☐	Anemia	☐	☐			
Liver Disease	☐	☐	Diabetes	☐	☐	HIV or AIDS	☐	☐
Cirrhosis	☐	☐	Heart Disease	☐	☐	Prostate Problems	☐	☐
Hepatitis	☐	☐	Congestive Heart Disease	☐	☐	Crohns disease	☐	☐
High blood pressure	☐	☐	Abnormal Heart Beat	☐	☐	Ulcerative Colitis	☐	☐
Tuberculosis	☐	☐	Diverticulitis	☐	☐	Osteoporosis	☐	☐
Pneumonia	☐	☐	Hyperthyroidism(High)	☐	☐	Paget's Disease	☐	☐
Bronchitis	☐	☐	Hypothyroidism(Low)	☐	☐	Multiple Myeloma	☐	☐
Osteoarthritis	☐	☐	Clogged Arteries	☐	☐	Thalassemia or Sickle Cell	☐	☐
Rheumatoid Arthritis	☐	☐	Neurological Disease	☐	☐	Peripheral Vascular Disease	☐	☐

Have you ever been on medication for Tuberculosis? ☐ Yes ☐ No

Please List Any Other Illnesses: _____

Physician's Signature:

Patient Name: Date:

PAST SURGICAL HISTORY

Please list any surgical procedures that you have undergone along with the date or age that the procedure was performed:

Procedure	Date or Age

Have you ever had a tumor or cancer removed? ◯ Yes ◯ No

Have you required general anesthesia? ◯ Yes ◯ No

Did you ever have a problem with general Anesthesia? ◯ Yes ◯ No

If yes, please describe:

Do you have a bleeding problem or bruise easily? ◯ Yes ◯ No

HEALTH MAINTENANCE

Have you ever had a colonoscopy? ◯ Yes ◯ No If yes, when?

Have you ever had a sigmoidoscopy? ◯ Yes ◯ No If yes, when?

Have you ever had a Bone densitometry? ◯ Yes ◯ No If yes, when and what is your bone density?

Females Last GYN exam? Last mammogram?

Males Last prostate exam? PSA level? Last PSA #:

FAMILY HISTORY:

Has anyone in your family had a history of a Cancer, Sarcoma or Benign or Malignant Tumor? ◯ Yes ◯ No

If Yes, What type of cancer or tumor and what family members?

Father Mother

Brother Sister

Brother Sister

Children Grandparents

Physician's Signature:

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS

Do you have any of the following signs or symptoms? (Please check Yes or No)

System	Sign/Symptom	Yes	No
General	Weight change	☐	☐
	Fevers	☐	☐
	Hair loss	☐	☐
	Swelling	☐	☐
	Loss of appetite	☐	☐
	Night sweats	☐	☐
	Change in energy level	☐	☐
	Unable to sleep	☐	☐
HEENT	Vision change	☐	☐
	Blurred vision	☐	☐
	Sinus history	☐	☐
	Difficulty swallowing	☐	☐
	Neck pain	☐	☐
	Double vision	☐	☐
	Hearing loss	☐	☐
	Seasonal allergy	☐	☐
	Dentures	☐	☐
	Trigeminal nerve issues	☐	☐
Resp	Cough	☐	☐
	Shortness of breath	☐	☐
	Shortneess of Breath with Activity	☐	☐
	Shortness of Breath at Rest	☐	☐
Cardiac	Cardiac catheterization	☐	☐
	Atherosclerotic heart disease	☐	☐
	Plaque in your vessels	☐	☐
	Dizziness	☐	☐
	Chest pain	☐	☐
	Medication for feet swelling	☐	☐
	Carotid artery disease	☐	☐
	High cholesterol	☐	☐
	Lightheaded with change in position	☐	☐
Neuro/Mus	Gait disturbance	☐	☐
	Numbness	☐	☐
	Muscle weakness	☐	☐
	Seizures	☐	☐
	Bone or joint pain	☐	☐
	Restricted joint motion	☐	☐
Other			

System	Sign/Symptom	Yes	No
GI	Heart burn	☐	☐
	Reflux	☐	☐
	Ulcer	☐	☐
	Blood in stool	☐	☐
	Black stools	☐	☐
	Constipation	☐	☐
	Diarrhea	☐	☐
	Nausea	☐	☐
	Yellow skin	☐	☐
	Vomiting	☐	☐
	Yellow eyes	☐	☐
	Swollen abdomen	☐	☐
	Incontinence of urine	☐	☐
	Incontinence of stool	☐	☐
	Hernia	☐	☐
Renal/	Urine infections	☐	☐
GU	Stress incontinence	☐	☐
	Frequent urination	☐	☐
	Urgency	☐	☐
	Enlarged prostate	☐	☐
	Testicular pain	☐	☐
	Prostatitis	☐	☐
	Abnormal breast tissue	☐	☐
	Menopause	☐	☐
Endo	Always thirsty	☐	☐
	Hot flashes	☐	☐
Hem/	Anemia	☐	☐
Onc	Iron deficiency	☐	☐
	Easy bruising	☐	☐
	Difficulty healing	☐	☐
	Need for oxygen	☐	☐
	Need for blood transfusion	☐	☐
	Fatigue	☐	☐

Physician's Signature: _____

Last two pages, to be completed by Dr. Wittig

Patient Name: Date

HISTORY OF PRESENT ILLNESS

PHYSICAL EXAMINATION

Vital Signs

Pulse Resp. BP Temp.

General

HEENT

Cardiac

Lungs

Abdomen

Extremities:

Mass/Tumor:

Range of motion of joints:

Motor strength:

Sensation:

Lymph nodes:

Pulses:

Other:

Physician's Signature:

Patient Name: _____ Date _____

RADIOLOGICAL STUDIES & REPORTS TO BE COMPLETED AND REVIEWED BY DR. WITTIG :

X-Ray of Tumor: ◯ Yes ◯ No

CT Scan of Tumor: ◯ Yes ◯ No

MRI of Tumor: ◯ Yes ◯ No

CT of Chest: ◯ Yes ◯ No

Bone Scan: ◯ Yes ◯ No

PET Scan: ◯ Yes ◯ No

Blood Work/Lab Studies: ◯ Yes ◯ No

Pathology Report: ◯ Yes ◯ No

Reports from other physicians: ◯ Yes ◯ No

Findings:

Impression:

Schedule for:

PLAN:

Counseling

Prescriptions:

Coordinator of Care

Long discussion re: Risk/Benefit/Options using models, posters, quoting current literature.

Questions and Answers Addressed; Follow up in: _____ weeks, _____*minutes spent in encounter*

Discussed detail of: _____ (see attached)

I attest that I have reviewed and discussed the entire medical history questionnaire with the patient and/or legal guardian, I reviewed the patient's studies and reports and examined the patient myself.

Physician's Signature: _____

James C. Wittig, MD

Part 6

NOTICE OF PRIVACY PRACTICES RECEIPT
HACKENSACK UNIVERSITY MEDICAL CENTER

MRN# _____

I, _____ acknowledge receiving the Hackensack University Medical Center (HUMC) Notice of Privacy Practices. I also acknowledge that future revisions of this notice will be available on the HUMC website www.HackensackUMC.org or upon request.

This pertains to the **HIPAA-NOTICE OF PRIVACY ACT GUIDELINES.** I have received the privacy act guidelines pamphlet and listed all family members who can actively participate in my care planning. I understand that if I do not list these individuals, my patient information or the planning of my care will not be released or planned without my consent.

		relationship		Phone #
		relationship		Phone #
		relationship		Phone #

Signature: X _____

Date signed: _____

Hospital Witness Name (print) _____

Witness Signature: X _____

Date signed: _____