

THE PREMIER SURGICAL NETWORK

INSURANCE/EMERGENCY INFORMATION

DATE: _____

Name of Patient: _____

Name of Primary Insurance Co.: _____

Insurance Co. Address & Phone#: _____

Policy #: _____ Group #: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Subscriber's SS#: _____

Name of Secondary Insurance Co.: _____

Insurance Co. Address & Phone #: _____

Policy #: _____ Group #: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Subscriber's SS#: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

PATIENT INFORMATION

Patient's Name: _____

(Last) (First)

Address: _____ City: _____ State: _____ Zip _____

Home Phone: (____) _____ Cell Phone :(____) _____

Work Phone: (____) _____ Email: _____

Do you accept our office's use of your email? Please initial: Yes _____ or No _____

Age: _____ Sex: _____ Ethnicity/Race: _____ Date of Birth: _____

Social Security #: _____ Married: ___ Single: ___ Widowed: ___ Divorced: ___ Partner: ___

Occupation: _____ Employer: _____

Business Address: _____

Spouse or Parent's Name: _____ SS#: _____

Spouse or Parent's Employer: _____

Employer's Address: _____

Person Financially Responsible: Patient _____; Parent _____; Other _____ Name _____

Address of Person Financially Responsible: _____

Nearest relative not living at same address: _____

Relative's address: _____ Phone: (____) _____

Family Physician: _____ Phone: (____) _____

Other Physician(s) you have seen in the last year: _____

Name of person or physician who referred you to this office: _____

Reason for visit: _____

Have you consulted other physicians about the reason for your visit today? Yes _____ or No _____

If yes, please list their names: _____

ALLERGIES TO MEDICINE Yes _____; No _____ **Please list:** _____

Allergies to other substances: _____

Allergies to Latex? Yes _____; No _____

MEDICAL HISTORY

General State of Health: Good _____; Fair _____; Poor _____

Height _____ Weight _____

Seriuos illness, please list: _____

Is there any risk of pregnancy at this time? Yes _____ No _____

Previous Surgery (Please list):

<u>Operation</u>	<u>Year</u>	<u>Hospital</u>	<u>Surgeon</u>	<u>Anesthesia (Local or General)</u>	<u>Outcome</u>
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Have you had significant complications or after effects from any of these operations? No _____ or Yes _____

If "Yes", please explain: _____

Family History:

	<u>Age</u>	<u>State of Health</u>	<u>Has any relative had:</u>			
Mother			Tuberculosis	No ___ Yes ___	Lung Disease	No ___ Yes ___
Father			Cancer	No ___ Yes ___ List Type? _____	Kidney Disease	No ___ Yes ___
Brother(s)			Diabetes	No ___ Yes ___	Asthma	No ___ Yes ___
Sister(s)			Epilepsy	No ___ Yes ___	Mental Disease	No ___ Yes ___
Children			Heart Disease	No ___ Yes ___	High Blood Pressure	No ___ Yes ___
			Blood or Bleeding Disorders	No ___ Yes ___		
			Chronic Headaches?	No ___ Yes ___		

Pharmacy Name: _____

City: _____

Phone#: _____

Medications, Drugs:

What is your approximate daily consumption of the following:

Caffeine (coffee, tea, etc.) _____; Alcohol _____; Tobacco _____ Other intoxicating or mood/mind altering drugs or drugs to help concentration (specify) _____

Does anyone in your household smoke? No _____; Yes _____ How much? _____

Please list ALL medications, their dosages and the prescribing Physician (including BIRTH CONTROL PILLS, DIURETICS (water pills), BLOOD PRESSURE or HEART MEDICATIONS, TRANQUILIZERS, HORMONE, BLOOD THINNERS, NOSE DROPS and SPRAYS, INHALER MEDICINES, ASPIRIN, and HERBAL SUPPLEMENTS. Please include any over-the-counter medications, nutritional supplements or diet pills:

Pertinent Preoperative Information

Have you had a persistent cough which has lasted for more than two weeks?	No _____; Yes _____	Have you ever had scarlet fever or rheumatic fever?	No _____; Yes _____
Have you ever reacted badly to being put to sleep for surgery?	No _____; Yes _____	Do you bleed or bruise unusually easily (from cuts, surgery, tooth extractions)?	No _____; Yes _____
Has any member of your family ever reacted badly to being put to sleep for surgery?	No _____; Yes _____	Do you occasionally/typically heal with prominent scars or keloids?	No _____; Yes _____
Are you allergic to adhesive tape?	No _____; Yes _____	Do you have any skin disease, hives, eczema or rash?	No _____; Yes _____
Are you on aspirin therapy?	No _____; Yes _____	Do you have frequent infections or boils?	No _____; Yes _____
Are you allergic to Bananas, Kiwi or Chestnuts?	No _____; Yes _____	Have you taken steroid medications, cortisone, or ACTH?	No _____; Yes _____
Do you have high blood pressure?	No _____; Yes _____	Do you have shortness of breath with walking?	No _____; Yes _____
Are you presently on Birth Control Pills?	No _____; Yes _____	Do you have, or have you had any back trouble?	No _____; Yes _____
Are you presently on Estrogen Replacement Therapy?	No _____; Yes _____	Do you have a particular aversion to blood transfusions if medically necessary?	No _____; Yes _____
Are you on any blood thinners?	No _____; Yes _____	Do you have, or have you had any significant emotional problems?	No _____; Yes _____
Do you have any history of migraines or headaches?	No _____; Yes _____	Have you ever had, or been advised to seek psychiatric care?	No _____; Yes _____
		Do you use NSAIDS (Tylenol, Advil, Motrin, Aleve, etc.) regularly?	No _____; Yes _____

Date: _____

Have you ever had any illness or disorder of the following? (Circle if Yes)

- | | | |
|--|-----------------------------------|--|
| (1) Brain (including strokes, epilepsy) | (7) Face (Paralysis) | (14) Blood/Blood Vessels |
| (2) Arms or Legs | (8) Stomach | (15) Liver |
| (3) Nervous System
(including paralysis, numbness) | (9) Bones of Joints | (16) Eyes (including glaucoma, dryness) |
| (4) Intestines/Bowels | (10) Urinary System | (17) Endocrine System or Diabetes |
| (5) Reproductive System | (11) Breasts | (18) Lungs |
| (6) Ears | (12) Nose, Sinuses, Throat | (19) Loss of strength in any part of your body |
| | (13) Heart | |
| | | (20) Loss of feeling, numbness of tingling in any parts of your body. |

If circled, please explain: _____

COMMENTS: (FOR STAFF MEMBERS ONLY)

Personal Medical History:

Mitral Valve Prolapse: Yes No

High Blood Pressure: Yes No

Heart Disease: Yes No

Stroke: Yes No

Diabetes: Yes No

Asthma: Yes No

Cancer: Yes No If yes, what type? _____

Sleep Apnea: Yes No

Low Thyroid: Yes No

Autoimmune Disease: Yes No

Any other significant medical history:

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Premier Surgical Network has my consent to use and disclose my Protected Health Information (“PHI”) to carry out treatment, to obtain payment from third parties and to perform healthcare operations as outlined below. _____(Initial)

I have been given a copy of the HIPAA Notice of Privacy Practices (“HIPAA Notice”) which contains a complete description of PHI. _____(Initial)

I have the right to review, and to the extent I desire to do so, I have reviewed the HIPAA Notice prior to signing this Consent form. _____(Initial)

I authorize Premier Surgical Network to use and disclose my PHI in the following manner:

1. Transmit my PHI through the following means in order to carry out treatment, obtain payment from third parties and perform healthcare operations:
 - a. Cell Phone Number: _____
 - b. Home Phone Number: _____
 - c. Email Address: _____
 - d. Mailing Address: _____
 - e. Fax Number: _____

2. Disclose my PHI to the following family members in order to carry out treatment, obtain payment from third parties and perform healthcare operations:
 - a. Name: _____ Contact Information: _____
 - b. Name: _____ Contact Information: _____
 - c. Name: _____ Contact Information: _____

OR I do *not* authorize disclosure of my PHI to anyone other than myself. _____(Initial)

3. Transmit my PHI to other health care providers as well as my health insurance carrier in order to carry out treatment, obtain payment and perform healthcare operations _____(Initial)

By signing this form, I consent to Premier Surgical Network use and disclosure of my PHI as outlined above: I, _____, acknowledge that I have read and understand the

above.	
Patient Signature (or authorized representative)	Date

I may revoke my consent in writing except to the extent that Premier Surgical Network has already made disclosures in reliance upon my prior consent. If I do not sign this Consent, Premier Surgical Network may decline to provide treatment.

If you have any questions about the HIPAA Notice, please contact our office at 609-204-5357 and ask to speak with the Office Manager.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this would be:

- the coordination of your health care with all of your health care physicians.
- contacting you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization reviews. Examples of this would be, the use and disclosure of your health information:

- on a bill for your visit sent to your insurance company.
- about you for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

Public Health Risk means disclosure of your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability to the public.

Required by law means we may use and disclose your health information about you:

- when required by State and Federal law.
- to authorized federal officials for intelligence, counterintelligence, and other National Security activities as authorized by law.
- when required by the Secretary of Health and the Department of Health and Human Services for the purposes of investigating or determining compliance with the privacy law.
- to a health oversight agencies for activities, authorized by law, for the government and certain private health oversight agencies to monitor the healthcare system, government programs and compliance with civil rights.
- to law enforcement officials, if required by law, or where permitted by law, or in response to a valid subpoena.
- to a court or administrative agency when a judge or agency orders us to do so and in legal

proceedings, such as in a response to a discovery request, subpoena, court order, etc.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to our Privacy Officer:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of PHI.
- The right to obtain and we have the obligation to receive written acknowledgment that you have read a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

This notice is effective as of January 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Service, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Privacy Officer
TPSC
535 Sycamore Avenue
Shrewsbury, NJ 07702
(732)741-0970

For more information about HIPAA or to file a complaint:

The U.S. Department of Health &
Human Services of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257 Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

I have been presented with a copy of Premier Surgical Network's Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

PATIENT'S NAME (Print)

PATIENT OR LEGAL GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT: (if other than self)

DATE SIGNED

I wish to place the following restrictions on disclosure of my health information:

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

A PATIENT'S BILL OF RIGHTS ACT

YOU have the right to be treated respectfully.

YOU have the right to be informed about your diagnosis, to know what your treatment options are, and to know what the potential outcomes of each treatment may be.

YOU have the right to know the names of those treating you.

YOU have the right to refuse treatment, as permitted by law. You can refuse treatment and still receive alternative care.

YOU have the right to privacy. No medical practitioner should ever release information about your condition or treatment to anyone, unless you give express consent to release such information.

YOU have a right to review your medical records, and if necessary have the information explained to you.

YOU have the right to know what your anticipated cost of treatment may cost you.

YOU are responsible for providing all information about your current condition, prior procedures, illnesses and medications. This info is necessary to determine the best treatment for you.

YOU are responsible for being considerate of the needs of others in the office.

YOU are responsible for providing all insurance information when requested, and following the requirements for your individual insurance plan for seeking treatment with the doctor.

Signed: _____ Date: _____

Print Patient's Name: _____

(To be placed in patient's permanent file.)

ASSIGNMENT OF BENEFITS

1. Assignment of Right to Reimbursement and Payment. Pursuant to N.J.S.A 26:2S-6.1(c) and the common law, I hereby assign any and all of my rights to receive payments to any and all benefits under my insurance policy to my medical provider, Premier Surgical Network, relating to and/or arising out of any and all medical treatment provided by Premier Surgical Network to me, including, but not limited to, major medical, personal injury protection (PIP), and workers' compensation benefits otherwise payable to me, regardless of whether Premier Surgical Network is a participating or non-participating provider of my health insurance carrier.

2. Irrevocable Assignment of All Benefits and Legal Rights. I hereby irrevocably assign to Premier Surgical Network any and all of my legal rights, benefits, and claims relating to and/or arising out of my health insurance policy/policies and the medical treatment provided by Premier Surgical Network to me; the assignment to Premier Surgical Network includes, but is not limited to, any and all of my legal rights to major medical, personal injury protection (PIP), and workers compensation benefits, and includes, but is not limited to, my assignment of any and all legal rights to file and prosecute my legal rights and benefits to any and all appeals, claims, and litigation against my health insurance policy/policies relating to and/or arising out of the aforesaid. I hereby name Premier Surgical Network as my Designated Authorized Representative and further authorize any plan administrator or fiduciary, insurer, and my attorney to release to Premier Surgical Network any and all plan documents, insurance policy and/or settlement information upon written request from the Premier Surgical Network in order to assert any and all of my legal rights relating to and/or arising out of my health insurance policy and the medical treatment provided by Premier Surgical Network to me in order to prosecute any and all claims for such medical benefits, reimbursement, and any and all applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

3. Waiver and Release of HIPPA. I hereby authorize my insurance carrier, the plan sponsor, and/or any employer and/or plan administrator to release all of my medical information under HIPPA to Premier Surgical Network, relating to and/or arising out of any and all determinations of any claims for medical services provided by Premier Surgical Network to me.

This assignment shall be binding on and inure to the benefit of Premier Surgical Network, its successors, assigns and its legal representatives.

A photocopy of this assignment is to be considered as valid as the original. I expressly acknowledge and agree that I have read and fully understand this Assignment of Benefits and expressly acknowledge and agree that by executing this Assignment of Benefits below I agreed to its terms herein.

Signature of Insured/Guardian

Date

Print Name of Insured/Guardian