Seashore Plastic & Hand Surgery Center
Michael J. Pecoraro
Patient Profile

PLEASE PRINT

1. PATIENT INFORMATION Today's Date_____ Date injured_____

Patient Last Name_____First Name_____MI____

Address_____City_____

State_____Zip_____Age_____ Sex M or F Birth Date_____

Phone_____Relationship to insured_____Marital Status_____

Place of Employment_____

Address_____Work Phone_____

How did you hear about us?_____

SS#_____Email Address_____

2. GUARANTORS INFORMATION

Guarantors Last Name_____First Name_____MI_____

Address_____City_____

State_____Zip_____Age_____ Sex M or F Birth Date_____

SS#_____Phone#_____Marital Status_____

Employer_____Employer Phone_____

3. PRIMARY INSURANCE (if any)

Carrier_____

ID#_____Group#_____

Insurance Claims Address_____

4. SECONDARY INSURANCE (if any)

Carrier_____

ID#_____Group#_____

Insurance Claims Address_____

****PHARMACY NAME_____ PHONE_____ FAX _____**

5. FAMILY PHYSICIAN_____PHONE_____
6. REFERRING PHYSICIAN_____PHONE_____
7. NEAREST RELATIVE_____PHONE_____

As a patient of Dr. Pecoraro's, I understand I am responsible whether or not Dr. Pecoraro is a Participating provider with my insurance company at the time services are rendered. I am fully responsible for my outstanding bills unless otherwise arranged with the office. I will provide the office with all my medical and hospital insurance information to insure proper billing and care. I authorize payments of these benefits to Dr. Pecoraro. I also authorize the release of any medical information necessary to process these claims to any insurance company involved. **I UNDERSTAND MY INSURANCE COMPANY DOES NOT GUARANTEE PAYMENT ON CONSULTS AND SURGERIES. I AM RESPONSIBLE FOR ANY OUTSTANDNG BALANCES NOT PAID BY MY INSURANCE COMPANY. I AM RESPONSIBLE FOR ALL REFERRALS.** I understand there will be a 1 and a half percent interest rate for unpaid balances after 90days. I understand that should my account go to collections, I will also be responsible for the fifty-dollar service charge.

Patient/ Guardian
Signature_____Date_____

Seashore Plastic and Hand Surgery
Michael J. Pecoraro, M.D.
450 Jack Martin Blvd., Brick, NJ 08724

Acknowledgement of HIPPA Privacy Notice
And Designation of Disclosure

I. Acknowledgement of Practice's Notice of HIPPA Privacy:

I have received a copy of the Notice of HIPPA Privacy for Physician Practice.

Name of Patient _____ Date of Birth _____ Signature of Patient/Parent/Guardian _____

II. Designation of Certain Relatives, Close Friends and other Caregivers:

A. I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care of payment relating to my healthcare. In that case, thephysician Practice 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 wish to be contacted in the following manner (check all that apply):*

Home Telephone Number: _____

___ OK to leave message w/detailed information

___ OK to leave message with call back numbers only

Work Telephone Number: _____

___ OK to leave message w/ detailed information

___ OK to leave call back numbers only

Written Communication:

___ OK to mail to my home address

___ OK to mail to my work address

Fax Communication:

___ OK to fax to this number_____

___ OK to fax test results to other Dr.'s

___ other: _____

B. I designate the following persons listed below as persons involved w/ my health care or payment relating to my health care for the purpose of the practice 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: _____ Tel # _____ last 4 digits of his/her SS # (required)_____

Print Name: _____ Tel # _____ last 4 digits of his/her SS # (required)_____

Print Name: _____ Tel # _____ last 4 digits of his/her SS # (required)_____

C. The following person(s) are not authorized to receive my patient health information:

Print name: _____ Print name: _____

_____ _____

Signature of Patient/Parent/Guardian *Date*

III. The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, Patient Health Information to the minimum necessary to accomplish the inteded purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided below will constitute an adequate record. Uses and disclosures for Treatment, Payment, and Health Care Operations may be permitted without prior consent.

Date of request	Disclosed to whom; Address/fax#	Description of Disclosure	Purpose of Disclosure	Dates of Service of Disclosure	Person Completing Request	Date Completed

HISTORY INTAKE FORM

Patient Name: _____ Birth Date: _____

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Age _____ Sex _____ Height _____ Weight _____ Occupation _____

Race (please circle one): American Indian or Alaskan Native (I) Asian (A) Black (B) Caucasian (C) Other (E) Pacific Islander (P) Declined (7)

Ethnicity (please circle one): Hispanic (H) Non Hispanic (N) Declined (7)

Language: _____

Smoking (amount per day) _____ If former smoker, date quit: _____

Alcohol (type and amount per week): _____

Drug Allergies: _____

_____

List previous surgeries or major illnesses and dates:

_____

_____

List of Medications you are currently taking, including non-prescription drugs, vitamins, and herbals: _____

_____

_____

FAMILY HISTORY:

Has any blood relative ever had the following:

Breast Cancer...	Yes	No	High Blood Pressure...	Yes	No	Kidney Disease...	Yes	No
Melanoma	Yes	No	Heart Disease....	Yes	No	Depression...	Yes	No
Stroke.....	Yes	No	Diabetes....	Yes	No	Skin Cancer...	Yes	No

PAST MEDICAL HISTORY:

Have you ever had the following:

Heart Disease...	Yes	No	Cancer ...	Yes	No	Stomach Ulcer...	Yes	No
Arthritis...	Yes	No	Glaucoma...	Yes	No	Kidney Disease...	Yes	No
Rheumatic Fever..	Yes	No	Asthma...	Yes	No	Thyroid Disease..	Yes	No
Anemia...	Yes	No	Aids or HIV+..	Yes	No	Bleeding Tendency...	Yes	No
Tuberculosis...	Yes	No	Stroke...	Yes	No	Mitral Val Prolapse...	Yes	No
Diabetes...	Yes	No	Melanoma...	Yes	No	High Blood Pressure..	Yes	No
Hepatitis...	Yes	No	Skin Cancer...	Yes	No	Breast Cancer...	Yes	No
Pre-Cancer Skin Lesion...	Yes	No	History of Infected Skin Lesion...	Yes	No			

Please turn over to complete

Review of Syster

Please circle if you are presently experiencing the following conditions:

CONSTITUTIONAL SYMPTOMS: fever, chills, malaise, fatigue, weight loss, weight gain

EYES: blurred vision, cataracts, glaucoma, dry eyes, color blindness

EARS, NOSE, MOUTH, THROAT: hearing problems, ear discharge, ear infection, vertigo, sinus problems, snoring, deviated septum, nasal polyps, septal perforation, bleeding gums, mouth infection, masses on tongue or in mouth, sore throat, earache, tonsillar abscess.

RESPIRATORY: shortness of breath, cough, pneumonia, asthma

CARDIOVASCULAR: chest pain, angina, palpitations, rapid heartbeat, nausea, swollen feet or ankles

GASTROINTESTINAL: jaundice, chronic diarrhea, indigestion, heartbeat, nausea, vomiting, heart burn

GENITOURINARY: painful urination, blood in urine, kidney stones, kidney tumors, kidney infection

MUSCULOSKELETAL: joint pain, muscle pain, bursitis, gout, rheumatism, arthritis, broken bones, ligament sprains or strains, neck pain, back pain, shoulder pain

SKIN AND BREAST: skin rash, skin bleeding, skin masses, itching skin lesions, bleeding skin lesions, changing skin lesions, sunburn, frequent sun exposure, breast lumps, nipple bleeding or discharge, breast pain, breast asymmetry, shoulder grooving, rash underneath breasts

NEUROLOGICAL: numbness or tingling in hands or feet, tremors, speech problems, paralysis, weakness, dizziness, seizures

PSYCHIATRIC: depression, mania, obsessive, compulsive, antisocial, paranoid

ENDOCRINE: increase facial hair – women, increase breast size – men

HEMATOLOGIC/LYMPHATIC: swollen lymph nodes, masses in groin, neck masses, masses in armpits, easy bleeding, easy bruising

ALLERGIC/IMMUNOLOGIC: food allergies, drug allergies, immune disorders

All other systems Negative: YES NO (other symptoms)_____

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient or Parent of Minor Date

HIPAA Notice of Privacy Practices

Effective as of March/1/2010

Seashore Plastic & Hand Surgery Center
450 Jack Martin Blvd, Brick, NJ 08724
(732) 206-1000

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment 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 your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, 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.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Seashore Plastic & Hand Surgery Center Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

Sea Shore

Plastic and Hand Surgery Center

Michael J. Pecoraro, M.D.

Cosmetic, Plastic and Reconstructive Surgery

Adult & Pediatric Hand and Microsurgery

Thank you for choosing Sea Shore Plastic and Hand Surgery Center.

Please be informed that this office is an out-of-network provider with your insurance carrier. If you have out-of-network benefits we will submit the bill to your insurance carrier for you and if there is any balance left, we will balance bill you. Thank you.

I understand I am responsible for any balance not paid by my insurance company. I understand that there will be a 1-1/2% interest rate for unpaid balances after 90 days. I understand that should my account go to collections I will also be responsible for the fifty-dollar service charge.

Patient/Gaurdian Signature:_____Date_____

450 Jack Martin Blvd.
Brick, NJ 08724
(732) 206-1000

Sea Girt Professional Bldg.
Hwy 71, Crescent Place
Sea Girt, NJ 08750
(732) 449-4120

SEA SHORE PLASTIC & HAND SURGERY CENTER

Dear Patient,

We have prepared this letter to help you better understand the complexities of medical insurance as we realize how confusing it can be. To begin, we would like to highlight an often misunderstood: medical insurance was not designed to pay for all medical care. Most medical insurance contracts have limits and/or various degrees of co-payments.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid and have nothing to do with the actual charges. Our fees are based upon a combination of our costs, time, and constant dedication to supplying our patients with the highest quality medical care.

However, please understand that your medical insurance contract is between you and your insurance company, as it is the patient that bears the ultimate financial responsibility.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, feel free to ask any member of our staff for clarification on services, billing, and insurance.

Date _____ Patient Signature _____