PATIENT REGISTRATION FORM

Patient's Name (Last, First, MI)_____ **SS Number**_____

Home Phone Number_____ **Cell Phone Number**_____

Date of Birth: **Age:** **Sex:** Male Female **Marital Status:**

E-Mail Address

Home Address **City** **State** **Zip Code**

Mailing Address if different from home address:

Address City State Zip Code

Employer Name_____ Employer Phone #_____

Employer Address

Emergency Contact_____ Relationship to Patient_____

Address Phone#

Primary Care Physician Name and Phone Number_____

Pharmacy Name **Pharmacy Phone #**

INSURANCE INFORMATION **We will request to scan your ID and insurance card**

Primary Insurance_____ Member ID# _____ Group#_____

Patient is Subscriber/Policy Holder **Yes** **No**

Subscriber/Policy Holder Name_____ Relationship to Patient_____

Address_____

SSN_____ DOB_____ Employer_____

Work Phone

Secondary Ins._____ Member ID# _____ Group#_____

Patient is Subscriber/Policy Holder **Yes** **No**

Subscriber/Policy Holder Name_____ Relationship to Patient_____

Address_____

SSN_____ DOB_____ Employer_____

Work Phone

Responsible Person: (if different from patient)

Last Name_____ MI_____ First Name_____ Relationship_____

Date of Birth_____ Telephone Number _____

Address

How did you hear of our office?

Physician_____ Patient_____ Friend_____ Radio_____

Internet Newspaper Other

Race_____ **Ethnicity**_____ **Preferred Language**_____

Patient/Parent/Guardian Signature X _____ **Date**

MICHAEL J. PECORARO, MD
Sea Shore Plastic & Hand Surgery Center

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

Dr. Pecoraro is an in-network provider with Medicare ONLY. All other insurances will be billed as an out-of-network provider.

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/Guardian Signature:_____ Date:_____

MICHAEL J. PECORARO, MD
Sea Shore Plastic & Hand Surgery Center

MEDICAL INTAKE FORM, pg. 1 **Today's Date:**

Patient Name:_____ **Date of Birth:**_____

Height:_____ **Weight:**_____

Your Doctor's Name: _____ **Phone Number:** _____

Your Pharmacy: _____ **Phone Number:** _____

MEDICAL HISTORY

Have you ever had problems with anesthesia? No Yes Describe problem_____

CARDIOVASCULAR

- ◯ Arrhythmia (A.Fib/SVT/A.Flutter, etc.)
- ◯ Heart Attack, Stroke, TIA
- ◯ High Blood Pressure (HTN)
- ◯ Congestive Heart Failure (CHF)
- ◯ Coronary Artery Disease (CAD)
- ◯ Bleeding disorder
- ◯ Do you bruise easily?
- ◯ Peripheral Vascular Disease?
- ◯ ***Do you take blood thinners? (Aspirin, Coumadin, Warfarin, Plavix, Pletal, Pradaxa, Xarelto, etc...)***

GASTROINTESTINAL

- ◯ Hepatitis, type_____
- ◯ Gallstones
- ◯ Liver Disease
- ◯ Pancreatitis
- ◯ Stomach Ulcer
- ◯ Diabetes, type_____

CONSTITUTINAL

- ◯ Thyroid Disease
- ◯ Significant Weight Gain
- ◯ Significant Weight Loss

SOCIAL HISTORY

- ◯ Children #_____
- ◯ Alcohol Use
  Drinks per day_____
- ◯ Illicit Drug Use
- ◯ Frequent narcotic use
- ◯ Tobacco Use
  Packs per day? _____
- ◯ Nicotine Replacement

_____

UNLISTED MEDICAL CONDITIONS

_____

_____

_____

MICHAEL J. PECORARO, MD
Sea Shore Plastic & Hand Surgery Center

MEDICAL INTAKE FORM, pg. 2 **Today's Date:**

GENITOURINARY

- ◯ Frequent Urination
- ◯ Kidney failure/dialysis
- ◯ Kidney Stones
- ◯ Endometriosis
- ◯ Are you pregnant? N Y

RESPIRATORY

- ◯ Wheezing
- ◯ Short of breath on exertion?
- ◯ Short of breath at rest?
- ◯ Asthma
- ◯ Emphysema or COPD
- ◯ Sleep Apnea

NEUROLOGICAL

- ◯ Seizures
- ◯ Headaches
- ◯ Migraine Headaches
- ◯ History of fainting

PSYCHIARTRIC

- ◯ Dementia
- ◯ Depression
- ◯ Anxiety
- ◯ Other: list_____

_____

DERMATOLOGICAL

- ◯ Rash
- ◯ Acne
- ◯ Rosacea
- ◯ Brown spots/sun damage

CANCER

◯ Type: _____

_____

MUSCULOSKELETAL

◯ Joint pain or arthritis ◯ Other_____

MICHAEL J. PECORARO, MD
Sea Shore Plastic & Hand Surgery Center

MEDICAL INTAKE FORM, pg. 3	Today's Date:

Patient Name:_____ **Date of Birth:**_____

Drug Allergies/Intolerance. *List reactions include metal allergies*	

Current medications with dosages, and Over the Counter and Herbal/Homeopathic

Medication name	Taken to Treat	Medication name	Taken to Treat

SURGICAL HISTORY	

FAMILY HISTORY

	Relationship		Relationship
◯ Heart Disease	_____	◯ Thyroid Cancer	_____
◯ Problems with Anesthesia	_____	◯ Peptic Ulcers	_____
◯ Bleeding Disorder	_____	◯ Kidney Stones	_____
◯ Cancer (specify type)	_____	◯ Pituitary/Pancreas/Adrenal Tumor	_____

Authorization and Release

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary, for my care.

X_____ _____

Patient or Authorized Person Signature Date

HIPAA Notice of Privacy Practices

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 is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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 HEALTH 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. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

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.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

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) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. 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 for the purposes of treatment, payment or healthcare operations. 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. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

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 disclosures, paper or electronic, 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 the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice 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.

MICHAEL J. PECORARO, MD
Sea Shore Plastic & Hand Surgery Center

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of Dr. Michael J. Pecoraro Sea Shore Plastic & Hand Surgery Center's Notice of Privacy Practices pursuant to HIPAA guidelines.

Print Name: _____ **Date:** _____

Patient/Parent Representative **Signature:** _____

Name of Representative, if applicable _____ Relationship: _____

- May we leave a detailed message for you at your home phone number? **YES** **NO**
- May we leave a detailed message for you on your cell phone number? **YES** **NO**

Patient Consent for use Credit Cards, Debit Cards & Financing Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Michael J. Pecoraro, MD and/or Sea Shore Plastic & Hand Surgery Center to disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

Patient Signature: _____ **Date:** _____

Authorization for Release of Information

The Health Insurance Portability Act (HIPAA) regulates how your Protected Health Information (PHI) is "Used and Disclosed." The regulations are being enforced to protect your privacy, and Dr. Pecoraro and his staff are committed to complying with all applicable laws and regulations. By completing the appropriate lines below, you are allowing Dr. Pecoraro of Sea Shore Plastic & Hand Surgery Center to release limited health care information. You may revoke this consent, at any time, in writing, to the practice. I, _____, give my consent to Michael J. Pecoraro, MD and his staff, to speak with family members/spouse regarding office visits, procedures, appointment scheduling, collection of demographic information and billing inquiries.

List the names of people that we are allowed to release information to, and their relationship to you; list as many or as few as you would like. You do not need to name anyone if you do not want to.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Print Patient Name: _____ **Date:** _____

Patient Signature: _____

Witness/Office Staff Signature_____

MICHAEL J. PECORARO, MD
Sea Shore Plastic & Hand Surgery Center

Authorization and Consent for Care

I request care from Michael J. Pecoraro, MD for my medical care condition. This care may include medical tests, exams, or other treatments that are needed for my condition. I agree to this care.

Assignment and Coordination of Insurance Benefits- I agree to provide information regarding all group, hospitalization, health maintenance organization, Worker's Compensation, automobile, and all other health care benefits from insurance plans to which I am entitled. I hereby assign payment(s), if any, from my Insurance Plans(s) to Michael J. Pecoraro, MD and/or Sea Shore Plastic & Hand Surgery Center for services rendered to me. The direct payment hereby assigned and authorized includes any insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to Michael J. Pecoraro, MD and/or Sea Shore Plastic & Hand Surgery Center for services rendered to me during the applicable periods of medical care. I agree to let my doctor submit claims and required treatment information to my insurance company, Medicare, or other third-party payment program for my care, and receive payments directly. I understand I must pay for all charges, co-payments, co-insurances, and deductibles that are not covered by my insurance company, Medicare, or third-party payment program.

Unauthorized, Non-Covered, or Out of Plan Services- I agree to be fully responsible for payment to Michael J. Pecoraro, MD and/or Sea Shore Plastic & Hand Surgery Center, if my Insurance Plan(s) considers this appointment or any services rendered a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge. In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance. I understand my Insurance Company does not guarantee payment or consults and surgeries. I am responsible for any outstanding balances not paid by my Insurance Company. I am responsible for all referrals (if applicable). I understand there will be a 1 ½ percent interest rate for unpaid balances after 90 days. I understand that should my account go to collections, I will also be responsible for all court fees.

For Medicare Recipients Only- I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare Benefits be made on my behalf to Michael J. Pecoraro, MD and/or Sea Shore Plastic & Hand Surgery Center for any services furnished to me. I authorize any holder of medical information about me to be released to Centers for Medicare and Medicaid Services and its agents and any information needed to determine these benefits or the benefits payable for the related services. In case of Medicare Part B benefits, I request payment to Michael J. Pecoraro, MD and/or Sea Shore Plastic & Hand Surgery Center.

Residents, Interns, or Medical Students- I understand residents, interns, medical students and other healthcare professional students may participate, under the supervision of myself, in my care as part of Michael J. Pecoraro, MD education program.

Permission to Communicate with Your Primary Care Physician and/or Other Care Providers- In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, other care providers, and to your insurance company. These communications may include information about your medical treatment. This information is limited to that which is necessary to the determination of coverage for and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or Health Insurance Company.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductible, co-payments, co-insurances, and non-covered services. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorney's fees and collection costs incurred by Michael J. Pecoraro, MD and/or Sea Shore Plastic & Hand Surgery Center. *I understand and agree this document will remain in effect for all future physician office visits, procedures, out-patient services to Michael J. Pecoraro, MD and/or Sea Shore Plastic & Hand Surgery Center, unless specifically rescinded in writing by me.*

Patient/Parent/Guardian Signature: X_____ **Date:** _____

Print Patient Name: _____

Relationship to Patient_____