

THE INSTITUTE FOR  
ADVANCED RECONSTRUCTION

at The Plastic Surgery Center

Date: \_\_\_\_\_

535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

**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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Married: \_\_\_\_\_ Single: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_

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: \_\_\_\_\_

Has anyone in your family been seen or treated at The Plastic Surgery Center: Yes \_\_\_\_\_ or No \_\_\_\_\_

If yes, whom? \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Reason for visit: \_\_\_\_\_

Have you consulted other physicians, including plastic surgeons, 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: \_\_\_\_\_



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## MEDICAL HISTORY

General State of Health: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

If not "Good", please explain and list treating Physician(s) and medications: \_\_\_\_\_

Height: \_\_\_\_\_ Weight \_\_\_\_\_ Weight loss or gain in past year? Loss \_\_\_\_\_ lbs. Gain \_\_\_\_\_ lbs.

Date of most recent check-up: \_\_\_\_\_ EKG \_\_\_\_\_ ; Chest X-Ray \_\_\_\_\_

Serious illness, please list: \_\_\_\_\_

Is there any risk of pregnancy at this time? Yes \_\_\_\_\_ or 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>
------------------	-------------	-----------------	----------------	--------------------------------------	----------------

Have you had significant complications or aftereffects 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 ___	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 ___		

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**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 reacted badly to being put to sleep for surgery? No \_\_\_\_\_ Yes \_\_\_\_\_

Has any member of your family ever reacted badly to being put to sleep for surgery? No \_\_\_\_\_ Yes \_\_\_\_\_

Are you allergic to adhesive tape? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have any Latex allergy? No \_\_\_\_\_ Yes \_\_\_\_\_

Are you allergic to Bananas, Kiwi or Chestnuts? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have high blood pressure? No \_\_\_\_\_ Yes \_\_\_\_\_

Are you presently on Birth Control Pills? No \_\_\_\_\_ Yes \_\_\_\_\_

Are you presently on Estrogen Replacement Therapy? No \_\_\_\_\_ Yes \_\_\_\_\_

Have you ever had scarlet fever or rheumatic fever? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you bleed or bruise unusually easily (from cuts, surgery, tooth extractions)? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you occasionally/typically heal with prominent scars or keloids? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have any skin disease, hives, eczema or rash? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have frequent infections or boils? No \_\_\_\_\_ Yes \_\_\_\_\_

Have you taken steroid medications, cortisone, or ACTH? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have shortness of breath with walking? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have, or have you had any back trouble? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have a particular aversion to blood transfusions if medically necessary? No \_\_\_\_\_ Yes \_\_\_\_\_

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Have you ever taken Accutane for the treatment of Acne? No \_\_\_\_\_ Yes \_\_\_\_\_

Are you presently using Retin A? No \_\_\_\_\_ Yes \_\_\_\_\_

Are you on aspirin therapy? No \_\_\_\_\_ Yes \_\_\_\_\_

necessary? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have, or have you had any significant emotional problems? 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 \_\_\_\_\_

Do you have any history of migraines or headaches? No \_\_\_\_\_ Yes \_\_\_\_\_

## **Have you ever had any illnesses 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<br>(including paralysis, numbness) | (9) Bones or Joints        | (16) Eyes<br>(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 or tingling in any parts of your body. |

If circled, please explain: \_\_\_\_\_

\_\_\_\_\_

## **COMMENTS: (FOR STAFF MEMBERS ONLY)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## FINANCIAL POLICY & PATIENT RESPONSIBILITY

### **Welcome to our office:**

The Plastic Surgery Center ("TPSC") is dedicated to providing the highest level of care. This financial policy has been prepared to make your visit pleasant and informative, as well as to inform you of your financial responsibility to TPSC. Please read carefully, insert your initials at the end of each advisory indicating you have read this information and agree to it, then sign and date at the bottom of the page.

- ❖ Payment for your visit is due at the time service is rendered. If you have insurance or we participate in your insurance plan, we will bill your insurance carrier as a courtesy for you, but we make no assurances about your carrier's decision to make payment. **UNLESS TPSC PARTICIPATES IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED BY TPSC, INCLUDING FOR ALL SERVICES RENDERED BY TPSC PRIOR TO THE DATE OF THIS FINANCIAL POLICY. (Initial: \_\_\_\_\_)**
- ❖ If you have arrived at TPSC for a complimentary cosmetic consultation and during your visit there is a discussion and/or exam concerning a medically necessary condition, we will bill your insurance carrier for the visit and require that payment be assigned to us. If your insurance company makes payment directly to you for services rendered by TPSC, you agree to immediately forward it to us upon receipt. **(Initial: \_\_\_\_\_)**
- ❖ You will receive a monthly statement if your account has any balance due, even if an insurance claim has been filed on your behalf. The date of the insurance submission and any credits to your account will be noted on this statement. **(Initial: \_\_\_\_\_)**
- ❖ A deposit for cosmetic surgery is required at time of scheduling. This is a non-refundable deposit. All cosmetic procedures must be paid three weeks prior to surgery. Please be aware that the surgeon's fee does not include lab fees, the anesthesiology fees, pathology charges, hospital charges or ambulatory surgery center charges (also known as facility fees). There will be a non-refundable surgery fee if surgery is not cancelled within five (5) days of your scheduled date. You agree to a separate cancellation fee of \$50.00 on all credit card refunds. **(Initial: \_\_\_\_\_)**
- ❖ While the medical group's staff makes every effort to assist you with processing your insurance claim any incorrect or incomplete insurance information will usually result in reduced benefits and add to your financial burden. It is your responsibility to understand and know the terms and conditions of your insurance plan, any necessary referrals, pre-authorizations, pre-certifications and all insurance related requirements. **UNLESS TPSC PARTICIPATES IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED BY TPSC, INCLUDING FOR ALL SERVICES RENDERED BY TPSC PRIOR TO THE DATE OF THIS FINANCIAL POLICY. (Initial: \_\_\_\_\_)**

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- ❖ Insurance companies do not pay for cosmetic procedures. If you are having a cosmetic procedure at same time with a non-cosmetic procedure, we will submit to your insurance company only for the non-cosmetic procedure(s). **(Initial: \_\_\_\_\_)**
- ❖ Every insurance company determines it own payment schedule in accordance with plan selected. Please be aware you may have a deductible, co-insurance, out-of-network penalty, an uncovered claim, resulting in payments due from you to TPSC. **(Initial: \_\_\_\_\_)**
- ❖ In the event we do not participate in your insurance plan our fee may be above what your insurance carrier determines to be "reasonable and customary". **UNLESS TPSC PARTICIPATES IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED BY TPSC, INCLUDING FOR ALL SERVICES RENDERED BY TPSC PRIOR TO THE DATE OF THIS FINANCIAL POLICY. (Initial: \_\_\_\_\_)**
- ❖ I understand that a finance charge of (18%) per annum (one and one-half percent (1.5%) per month) will be added to any invoice 30 days past due. I also understand that if the account is placed in the hands of an attorney for collection, I am responsible for collection costs and reasonable attorney's fees. **(Initial: \_\_\_\_\_)**
- ❖ For your convenience, we accept cash, checks, American Express, Visa, MasterCard and Discover. **(Initial: \_\_\_\_\_)**
- ❖ In the event we do not participate and the insurance company sends payment directly to you, you agree to immediately endorse the check to "The Plastic Surgery Center" and send it to us with a copy (front and back) of the Explanation of Benefits provided by your insurance company. **(Initial: \_\_\_\_\_)**
- ❖ Several of our doctors are Medicare Participating Providers which means that Medicare will tell us the amount to charge for our services. Of the amount Medicare allows us to charge, Medicare will pay eighty percent (80%) and you (unless you have supplemental insurance) are obligated to pay the remaining twenty percent (20%). In addition, Medicare has a yearly deductible that you will need to pay before Medicare payments begin/commence. Your co-pay (which is twenty percent (20%) of Medicare's allowed amount) is due at the time of your appointment unless you have a supplemental insurance policy. If you have a supplemental insurance policy, we will file with that secondary insurance carrier after we receive a check or payment from Medicare. We allow sixty (60) days from the date Medicare responds or makes payment for your supplement policy to pay the outstanding balance. After the sixty (60) days expires, the outstanding balance becomes your responsibility. **(Initial: \_\_\_\_\_)**
- ❖ I have received a copy of this Financial Policy & Patient Responsibility, understand the terms stated herein and have voluntarily executed this agreement. **(Initial: \_\_\_\_\_)**

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Should you have any questions or concerns regarding this policy, please feel free to discuss this with your patient coordinator. No changes to the terms set forth in this agreement are binding upon TPSC unless written below and signed separately by both you and an authorized representative of TPSC.

Signature of Patient or Legal Representative: \_\_\_\_\_

If signed by a Legal Representative, relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

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**INSURANCE INFORMATION**

**PLEASE NOTE THAT WE DO NOT PARTICIAPTE IN MOST INSURER'S OR HMO'S NETWORK, IT IS YOUR RESPONSIBILITY TO DETERMINE IF WE PARTICPATE IN YOUR PLAN!!!!**

**Insurance Information:**

Name Of Patient: \_\_\_\_\_ Medicare - ID#: \_\_\_\_\_  
Medicaid - ID#: \_\_\_\_\_

Name of Primary Insurance Co.: \_\_\_\_\_

Address & Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Name of Secondary Insurance Co.: \_\_\_\_\_

Address & Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Please check if applies:

Motor Vehicle Accident (MVA)

Workers' Compensation (W/C)

Adjuster's Name & Telephone #: \_\_\_\_\_

(1) Date of accident/injury: \_\_\_\_\_

(2) Name and address of YOUR automobile insurance company (MVA): \_\_\_\_\_  
\_\_\_\_\_

(3) Name and address of your employer/insurance company (W/C): \_\_\_\_\_  
\_\_\_\_\_

(4) Insurance claim #: \_\_\_\_\_

Is your injury the result of an accident? \_\_\_\_\_ If Yes, describe: \_\_\_\_\_  
\_\_\_\_\_

Are you represented by an attorney? \_\_\_\_\_. If so, Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

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**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, The Plastic Surgery Center ("TPSC") may use and disclose Protected Health Information ("PHI") about me to carry out treatment, to obtain payment and to perform healthcare operations ("TPO"). I have been given a copy of the HIPAA Notice of Privacy Practices which contains a more complete description of such uses and disclosures.

Initials \_\_\_\_\_

I have the right to review the HIPPA Notice of Privacy Practices prior to signing this Consent. TPSC reserves the right to revise its HIPPA Notice of Privacy Practices at any time. A revised HIPPA Notice of Privacy Practices may be obtained by forwarding a written request to the "TPSC Office Manager."

Initials \_\_\_\_\_

**PLEASE INITIAL EACH ITEM THAT YOU WOULD ALLOW US TO DO**

*(If any one item within the sentence is a NO, the whole number is no).*

**With this consent TPSC may:**

\_\_\_\_\_ 1. Call my home or cell phone at \_\_\_\_\_/\_\_\_\_\_ respectively and leave a message on voicemail or speak to any such person that may answer the phone in reference to any items that assist TPSC's healthcare providers or employees in carrying out TPO, including, but not limited to, appointment reminders, insurance items, test results and requests for a call back.

\_\_\_\_\_ 2. TPSC also has my permission to send and request faxes from other health care providers, for items that assist TPSC in carrying out TPO.

\_\_\_\_\_ 3. Mail to my home (or other location designated in writing by me) items that may assist TPSC in carrying out TPO, including, but not limited to, appointment reminder cards and billing statements.

\_\_\_\_\_ 4. Email to this email address ( \_\_\_\_\_ ) items that may assist TPSC in carrying out TPO, including, but not limited to, appointment reminder cards and billing statements.

\_\_\_\_\_ 5. Answer questions about my healthcare and billing with the following family members: \_\_\_\_\_  
\_\_\_\_\_

By signing this form I am consenting to TPSC's use and disclosure of my PHI to carry out TPO.

I \_\_\_\_\_ (patient name) acknowledge that I have read and understand the above.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

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

If you have any questions about our HIPPA Notice of Privacy Practices, please contact the office at (732) 741-0970.

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**ASSIGNMENT OF INSURANCE BENEFITS**

If I am a participant in any insurance plan I request that payment of all benefits be made on my behalf to The Plastic Surgery Center ("TPSC") for any medical services provided to me by TPSC.

\_\_\_\_\_  
**Initials**

I hereby irrevocably assign to TPSC all my right, title, and interest in and to any and all health benefits otherwise payable to me for medical treatment, including major medical, personal injury protection (PIP) and workers' compensation benefits, rendered by TPSC.

\_\_\_\_\_  
**Initials**

I acknowledge that I remain responsible for paying TPSC if my insurance company or plan does not pay TPSC in full for the amount of services.

\_\_\_\_\_  
**Initials**

I authorize the release of any information, including information protected under (HIPAA) to any insurance company, adjuster, attorney, or representative of TPSC.

\_\_\_\_\_  
**Initials**

I authorize TPSC and/or their counsel to initiate legal or administrative proceedings for any reason on my behalf and to formally appeal any outstanding claim issues.

\_\_\_\_\_  
**Initials**

**A photocopy of this Assignment shall be considered as effective and valid as the original.**

Signature of Patient or Legal Representative: \_\_\_\_\_

If signed by a Legal Representative, relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

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**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.

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- 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 acknowledgement 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.

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Please contact us for more information:

Privacy Officer  
The Plastic Surgery Center  
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 The Plastic Surgery Center'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): \_\_\_\_\_

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**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.)