

Seashore Plastic & Hand Surgery Cent
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 _____

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 OUTSTANDING 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 _____

PLEASE TURN OVER TO COMPLETE

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 _____

Smoking (type and 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 any medications you are 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	BleedingTendency....	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		History of infected			
Skin Lesion...	yes no	Skin Lesion...	yes no		

Please turn over to complete.

Review of System

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, heartburn, 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 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.

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 _____