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Automobile Accident Injury Form

"Any person who knowingly and with intent to defraud any insurance company, or other persons, files a statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties."
This statement is required by the New Jersey Fraud Prevention Act of 1983.

Name _____ Home Phone _____ Work Phone _____

Address _____ DOB _____ SS# _____

Date & Time of Accident _____ Place of Accident (Street) _____ City _____ State _____

Brief Description of Accident

_____
_____
_____
_____

Do you or any member of your household own an automobile? □ Yes □ No

Name of Automobile Insurance Company: _____

Were you the driver of the automobile?	□ Yes □ No
Were you a passenger in the automobile?	□ Yes □ No
Were you a pedestrian?	□ Yes □ No
Were you a member of your automobile owner's household?	□ Yes □ No
As a result of the accident, were you injured?	□ Yes □ No

If yes, complete the remainder of this form.

Signature: _____ Date: _____

Describe your injury:

_____
_____
_____

Were you treated by a Doctor?
□ Yes □ No

Doctor's name and address
_____
_____

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If you were treated in a hospital, were you
□ In-Patient □ Out- Patient

Hospital name and address
_____
_____

Amount of medical bills to date:
$_____

Will you have more medical expense
□ Yes □ No

At time of accident were you working
□ Yes □ No

Did you lose wages or salary as a result of Your injury? □ Yes □ No

If yes, amount lost to date: $_____

What is your average weekly wage or salary $_____

If you lost wages: Date disability from work began _____ Date returned to work _____

Have you received or are you eligible for benefit under:

		If yes, Amount per week	Per Month
1. Workers Compensation Law?	□ Yes □ No	$_____	$_____
2. Employees Temp. Disability?	□ Yes □ No	$_____	$_____
3. Medicare?	□ Yes □ No	$_____	$_____

List the name and Address of your Employer and other Employers for one year prior to accident date and give occupation and dates of employment:

Employer Name and address	Occupation	From	To
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature: _____ Date: _____

Do Not Detach

Authorization for Medical Information

This authorization of photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis and progress. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____

Do Not Detach

Authorization for Wage and Salary Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date:_____

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No Fault Authorization for Health Information Disclosure Patient Information

Patient Name: _____ Street Address:_____
City: _____ State: _____ Zip Code: _____ Date of Birth:_____
Claim Number: _____ Date of Injury: _____
I hereby authorize: _____
(Insurance Company Name)

REQUESTOR/RECIPIENT INFORMATION

Please disclose the following protected health information to:

Genesis Regenerative Sports and Aesthetic Medicine
116 S. Euclid Ave, Suite 1
Westfield, NJ 07090
Ph: (908) 588-2311
Fax: (908) 588-2319

Please indicate the information or type of information to be disclosed:
All Independent Medical Examination Reports for Orthopaedic and Pain Management & Rehabilitation.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the Privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released to this authorization. I understand that the information release pursuant to this authorization is subject to redisclosure by the recipient and may not longer be protected by the HIPAA rule. Unless otherwise revoked, this authorization will expire in six months or on the following date:
_____.

I understand that any disclosure of information may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information disclosed. I understand that authorizing this disclosure is voluntary.

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I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization. I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.
IF YOU DO NOT WISH THIS INFORMATION NOTED IN THE PRECEDING PARAGRAPH TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE _____.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Description of Representative's Authority (witness signature required) Signature of Witness

** A photostatic copy of the within authorization shall be as effective and valid as the original.

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New Patient Registration

Date/Fecha _____

Last Name/ Apellido: _____ **First Name/** Nombre: _____ **MI/** I: ___

Date of Birth/ Fecha de Nacimiento: _____ **Age/**Edad: _____

SS Number/Numero de S. Social: _____ **Marital Status/**Estado Marital: **S□ M□ D□**

Address/ Dirección: _____

City/Ciudad: _____ **State/**Estado: _____

Zip Code/ Codigo Postal: _____ **Phone Number/** Telefono: _____

Ethnicity: □ Nonhispanic □ Hispanic □ Other **Race:** _____

Language Spoken: _____

Employer's Name, Address/ Compania de Trabajo, Dirección:_____

Occupation/ Ocupación: _____ **Phone #/** Telefono #:_____

Method of Payment □ **Insurance** □ **Cash**

Primary Insurance Carrier/Seguro Primario: _____

Subscriber ID Number/Numero de Subscriber: _____

Insured's or Responsible Party

Last Name/ Apellido: _____ **First Name/**Nombre:_____

Insured's Email Address/Email del Asegurado: _____

How were you referred to us?/Quien ló refirio a nosotros?_____

Do you have a preferred pharmacy? _____

Do you have a primary care physician? _____

☐ **I give GSAM my permission to check outside sources regarding my prescription history**

☐ **I have received GSAM's HIPAA Compliance Regulations**

Signature/ Firma: _____

Date/ Fecha: _____

Witness Signature: _____ **Date:** _____

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Patient Chief Complaint and History Form

Date: _____ Phone Number: _____

Patient Name: _____ Date of Birth: _____ Age: ____

Address: _____ City, State, Zip: _____

Chief Complaint/ History of Present Illness (What is the reason for your visit today, be specific)

Past Medical History

Have you ever had any of the following?

☐ Anemia	☐ Cancer	☐ Seizures	☐ Asthma
☐ Heart Disease	☐ Gall Bladder Disease	☐ Migraines	☐ Pneumonia
☐ High Blood Pressure	☐ Blood Transfusion	☐ Liver Disease	☐ Diabetes
☐ Thyroid Problem	☐ Kidney Disease	☐ Depression/Anxiety	☐ Sickle Cell
☐ Ulcers	☐ Surgical Operations	☐ Blood Disorder	☐ STD

Are you on any medications? Y☐ N☐ (If yes, list all): _____
Do you have any allergies? Y☐ N☐ (If yes, list all): _____
Please list any hospitalizations or surgeries with dates: _____

Family History

Has any close relative had any of the following listed below?

☐ High Blood Pressure	☐ Kidney Disease	☐ Rare Disorder	☐ Epilepsy
☐ Cancer	☐ Diabetes	☐ Heart Trouble	☐ Stroke

If yes please list which family member: _____

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Social History
Do you smoke? Y☐ N☐
Do you drink alcohol? Y☐ N☐
Do you use any street drugs? Y☐ N☐

Review of Symptoms
Do you currently have any of the following problems? Please check Yes or No

Fever/Chills	Y☐ N☐	Chest pain	Y☐ N☐	Cough	Y☐ N☐
Weight loss	Y☐ N☐	Palpitations	Y☐ N☐	Sleep Apnea	Y☐ N☐
Vision Change	Y☐ N☐	Diff. Breathing	Y☐ N☐	Abdominal Pain	Y☐ N☐
Constipation	Y☐ N☐	Diarrhea	Y☐ N☐	Dizziness	Y☐ N☐
Joint Pain	Y☐ N☐	Muscle Pain	Y☐ N☐	Vomiting	Y☐ N☐

Please note that we trust that all information in this form is true to the best of your knowledge. Proper medical treatment starts with the information the patient provides to the doctor. Also note that the doctor will only discuss complaints that have been listed on this form, anything left out will have to wait for another visit.

This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.

By signing below, I acknowledge that I fully understand everything listed above:

_____
Patient Signature

_____
Witness Signature

_____
Date

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Cancellation Policy/ No Show Policy

For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to seemingly "full" appointment book.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 30 minutes past their scheduled time we will have to reschedule the appointment.

3. Cancellation/ No Show Policy for Procedures

Due to the large block of time needed for surgery and other extensive appointments, last minute cancellations can cause problems and added expenses for the office.

If surgery, concussion, PRP, Lipogems, and BMAC is not cancelled at least 24 hours in advance, or if you are a no-show for your appointment, you will be charged a $150 fee; this <u>will not</u> be covered by your insurance company.

_____ _____

(Signature) **(Date)**

_____

(Printed Name)

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Emergency Contact Information

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Genesis Regenerative Sports and Aesthetic Medicine to disclose your PHI to following individuals.

Name: _____

Relationship to Patient: _____

Telephone: (_____) _____ - _____

Email: _____

Name: _____

Relationship to Patient: _____

Telephone: (_____) _____ - _____

Email: _____

Genesis
Regenerative Sports and Aesthetic Medicine

You authorize **GSA MEDICINE** scheduled charges to your credit card. You will be charged the amount indicated below for any service obtained (Insurance Deductible, Co-pays, Procedures, etc.), in the event not covered by insurance or after payment arrangement made e.g. checks. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize **GSA MEDICINE** to charge my Credit Card
(Cardholder's Name)

indicated below for $_____ on the _____ of each_____.
(Amount) (Day) (Month)

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____
Account/CC Number _____
Expiration Date ____ /____
CVV ____
Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **GSA Medicine** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____

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OPIOID MEDICATION AGREEMENT

Please read through each statement carefully and sign the last page of this packet. By signing this packet, you are agreeing with all terms listed. Should you be prescribed an opioid medication you would be expected to follow all rules listed.

- I understand that my provider may recommend opioid medication to treat my pain.
- I understand that this medication may be prescribed if the provider believes it is needed to treat moderate to severe pain after other treatments are unsuccessful.
- I understand that many medications can have interactions with opioids and may increase or decrease their effect.
- I understand that I must regularly update my current medication list with my provider.
- I will tell my provider the truth about my complete personal drug and/or alcohol history as well as the complete drug and/or alcohol history of my family.
- I understand that the start of an opioid medication is a test. Continuation of this medication is based on evidence of benefit, side effects, and compliance of this medication.
- I have received the opioid information packet informing me of certain risks associated with opioid medication as well as the proper methods of disposal for opioid medications.
- I understand that if I suspect that I may be pregnant, or plan on becoming pregnant, I will notify my provider immediately.
- I understand that there are many non-opioid medications and alternative treatments that do not involve the use of opioids. Having been informed of these non-opioid medications and alternative treatments, I freely consent to the use of opioid medications.
- I understand that I will take my medications only as prescribed and I will not change the amount or dosage frequency without approval from my provider.
- I understand that unauthorized changes to my medications may result in my medications running out early. Early refills may not be allowed.
- I understand that I am responsible for my medication and it may not be replaced if it is lost, damaged, or stolen.
- I understand that if I do not stop my medications correctly, I may have withdrawal reactions that

may include stomach pain, nausea, vomiting, sweating, anxiety, and general discomfort.

- I understand that I will obtain all opioid prescriptions from my provider or, during his or her absence, by the covering provider.
- I understand that I must keep (and be on time for) all of my scheduled appointments with my provider.
- I understand that requests for medication refills must be made Monday through Friday from 8am–4pm, two working days ahead of when my prescription runs out.
- I understand that my provider may request to assess my response to my medication prior to giving a refill.
- I will obtain all controlled schedule medications from one pharmacy. I will notify my provider any changes to my current pharmacy.
- I hereby permit my provider to discuss all diagnostic and treatment details of my condition with all of my other providers and the pharmacists at the dispensing pharmacy.
- I understand that my provider will have access to and frequently check my controlled medication prescription history.
- I understand that I may have to submit random pill counts as well as urine and/or blood drug tests as requested by my provider to monitor my treatment. If I refuse or skip my appointment for drug testing, I understand that my treatment may be stopped.
- I will not share, sell, or otherwise permit others to have access to my medication.
- I will not consume alcohol while taking opioid medications.
- I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do my treatment may be stopped.
- I will always treat the staff respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment may be stopped.
- Upon completion of opioid medication, I will give my left-over medication to the police station or any prescription drug drop box. (for a list of medicine drop box locations please ask the front desk)
- I understand that if I, at any time, do not follow the rules of this contract or I am found to be untruthful about my drug, alcohol, medical, or prescription history, it could result in the

discontinuation of further treatments, discharge from practice, and/or a prompt referral for assessment of addiction or chemical dependency.

We here at GSAM Orthopedics and Medical Associates are committed to work with you in your efforts to get better. To aid in you in this work, we agree that:

- We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointments for any reason, we will make sure you have enough medication to last until your next appointment.
- We will make sure this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.
- We will keep track of your prescriptions and test for drug use every so often to help you feel like you are being monitored well.
- We will help connect you with other forms of treatment to help you with your condition.
- We will help set up treatment goals and monitor your progress in reaching those goals.
- We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.
- We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

- If you become addicted to these medications, we will help you get treatment so you can get off the medications safely.

I have read and understand the terms and conditions in the Opioid Medication Agreement. I have had the opportunity to ask questions. I agree to fill my prescriptions with only one pharmacy. If I need to change pharmacies, I will notify my physician about the change. I understand each of the statements written in the Opioid Medications Agreement and by signing, give my consent for treatment of my pain condition with opioid medications.

Pharmacy Name And Address: _____
Phone number: _____
Fax Number: _____

_____	_____	_____
Patient Signature	Print Name	Date

_____	_____	_____
Patient Signature	Print Name	Date

Genesis
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Financial Policy and Patient Agreement

We understand that choosing a health care provider is an important decision and we appreciate you choosing Genesis – Regenerative Sports and Aesthetic Medicine (GSAM). We are happy to explain our services, our financial policies, and the fees for our services, or the basis for determining the fees to be charged and answer any questions you may have. We will provide a list of our current fees for standard services, upon request.

We do not charge a fee for preparing an insurance claim form on your behalf. We will charge a missed appointment fee if you fail to notify us at least twenty-four (24) hours in advance of your scheduled appointment.

We also know that insurance plans and payments are increasingly complex for our patients. We want you to understand your benefits and the financial arrangements for paying for the cost of your care. We will provide you a list of health insurers with which we are in-network, including Medicare. We do accept out-of-network benefits for all other insurance plans. These out-of-network benefits are different than if you received services from an in- network provider. Your insurance plan may require multiple copays, higher deductibles, and coinsurance. Coverage will depend on the type of plan you have chosen. The amount, or estimated amount, that we will bill you for our services is available to you upon request and will be explained to you prior to providing services.

Financial Responsibility

As used below, “you” and “your” mean the patient/person financially responsible for payment for the patient’s care.

Although you are responsible for the entire bill when the services are rendered, it is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you. While we will make a good faith attempt to verify your benefits prior to the first appointment, this is no guarantee that our services will be completely covered. You are responsible for understanding the details of your health insurance coverage, as well as fulfilling any requirements for coverage, such as pre-authorizations. Required co-payments and estimated co- insurances are to be made as services are rendered.

Arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known.

If any payments of medical benefits are made directly to you for services rendered by GSAM, you must remit such payment directly to GSAM within ten (10) days of receipt. We will ask you to sign an Assignment of Benefits authorizing us to receive payments from your health plan for the services we rendered to you.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for the total amount of your charges if your Workers' Compensation claim is denied.

As a service to you, we will keep a copy of your insurance card on file and will submit an insurance claim on your behalf to your insurance company with the information you have provided us. You must provide accurate information and any updates to your insurance information. Payment options at the time of service include cash, check or credit card. With your authorization, we will charge an approved credit card for the patient balance as determined by the insurance company once we have submitted a claim and received the Explanation of Benefits.

If your medical benefits are not paid within thirty (30) days, the balance will be due in full from you.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees, and reasonable attorney fees, as allowed by law.

Financial hardship should never stand in the way of needed services. A determination of financial hardship can only be made on a case-by-case basis, in compliance with all of the rules applicable to our practice. Upon obtaining necessary information from you, we can make a good faith determination as to whether your circumstances constitute a financial hardship and what payment plan options you may have, including installment payments. Please speak to our patient advocate if you have any questions about our financial hardship policy.

Patient Agreement:

I have been informed if any of the services rendered to me by GSAM will be reimbursed at an out-of-network level. I knowingly, voluntarily and specifically select GSAM as my provider. I have read the

above information and I understand and accept the terms and conditions of the above and I or my Guarantor will be responsible for the payment of my account.

Signature:_____

Date: _____

Please circle one: Patient / Guardian / Guarantor

Print Patient Name:

_____

Print Guardian/Guarantor Name:

_____

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Authorization for Release of Medical Record Information

I hereby authorize _____ to release information from the medical records of:

Patient's First Name: _____Last Name: _____

Patient's Date of Birth:_____ Patient's Phone Number: _____

Patient's Address: _____

The information is to be released to (Name, Address and Phone Number)

_____

For the Purpose of: ____Medical Treatment ____Insurance ____Personal ___Litigation ___Other

Any information including the diagnosis and records of any treatment or examination rendered during the period from _____ to _____, or a specific exam or test listed below:

_____

I understand that if the person or organization authorized to receive this information is not a health plan or heath care provider covered by federal privacy regulations, the released information may no longer be protected by these regulations.

I understand that I may refuse to sign this authorization and that my health care and the payment for my health care will not be affected if I do not sign this form, unless the services to be provided are specifically for the purpose of producing the records the release of which would be authorized by my signing this form.

I understand that I will receive a copy of this form, and may request and will receive a copy if I am not given a copy.

Additional authorization is required when medical records contain the following information:
(Please check the space below if any of the following information is contained in your medical record and I authorize the release thereof :)

_____HTLV-3 or HIV Testing (Results Positive)- AIDS diagnosis and treatment- Drug/Alcohol treatment or History- Psychiatric (Mental Health Evaluation/treatment history)- Sexually Transmitted Disease.

I understand that my records are protected under confidentiality regulations and policies and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except that action has been taken in reliance on it and that on any event; this consent automatically expires 180 days from the date of signature or _____. I understand that I may revoke this authorization at any time by notifying the providing organization in writing by mailing or delivering the notice of revocation to the Director of Medical Records, but if I do, it won't have any effect on any actions they took before they received the revocation. I will still be able to obtain all other health care to which I am entitled and payment for my health care will not be affected. I have read this form or have had it read to me and I understand its contents.

_____ _____
Signature of patient or (representative - relationship) Signature of witness

_____ _____
Patients Name (Please Print) Date of Signature

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ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

By completing this form, you will help ensure payment to GSAM for services under your health insurance policy or benefit plan.

I hereby assign to GSAM my right to receive reimbursement for health care services provided to me and/or to any beneficiary under my health benefits plan and assign my legal claim to benefits under the plan, including but not limited to, my right to appeal and sue for each reimbursement and benefits. This assignment applies to all medical benefits, i.e., Medicare, private insurance, major medical benefits, Worker's Compensation, and any other health plans to which I or my beneficiary am entitled. I hereby authorize GSAM to file claims with all such plans and carriers for services rendered to me and/or my beneficiary and further authorize and direct my insurance benefits to be paid directly to GSAM. I understand and agree that, if a reimbursement check is made payable to GSAM and me, that I promptly will take such action as requested by GSAM to endorse the check so that GSAM can be paid for services rendered.

I understand that I am financially responsible for payment for all services rendered and I agree to pay all charges denied or not covered by my insurance carrier. This assignment and authorization in no way releases me from this responsibility and imposes no obligation to GSAM to collect money on my behalf.

I hereby authorize GSAM to release to my insurer, health plan, and/or any authorized employee or agent of same such of my medical information and records necessary to ensure payment for services rendered.

I have read, understand, and agree to above. A photocopy of this agreement shall be considered as effective and valid as the original. This Assignment of Benefits will be effective until revoked by me in writing. Any revocation shall have a prospective effect only.

Patient's Name: _____

Patient/Guardian Signature: _____

Primary Insured's Signature (if different): _____

Patient's Social Security # (last four digits only): _____

Insurance Company: _____

Claim Number: _____

Date of Accident: _____

Date: _____

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Acknowledgement

Date: _____

I acknowledge that I was provided with a copy of the Genesis – Regenerative Sports and Aesthetic Medicine's (GSAM) Notice of Privacy Practices.

_____ _____
Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____
Personal Representative (Print) Personal Representative Signature

_____
Relationship

For GSAM use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of GSAM's Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign
☐ Patient unable to sign
☐ Other _____

_____ _____
Employee Name Date

This form should be placed in the patient's medical record

Genesis
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At Genesis – Regenerative Sports and Aesthetic Medicine ("GSAM"), we understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by GSAM, whether made by GSAM personnel or your personal physicians and allied health practitioners. Your personal doctors and allied health practitioners may have different policies or notices regarding their use and disclosure of your medical information created in their offices or clinics.
This notice will tell you about the ways in which we may use and disclose medical information about you, referred to below as protected health information ("PHI"). We also describe your rights and certain obligations we have regarding the use and disclosure of PHI.

Uses and Disclosures for Treatment, Payment and Health Care Operations. GSAM may use or disclose your PHI for the purpose of treatment, payment, and health care operations, described in more detail below, without obtaining written authorization from you. In addition, GSAM and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to carry out their treatment, payment and health care operations related to the organized health care arrangement.

For Treatment. GSAM may use and disclose PHI in the course of providing, coordination, or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide you health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to use/ disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

For Payment. GSAM may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, GSAM may need to give PHI to your health plan in order to be reimbursed for the services provided to you. GSAM may also disclose PHI to its business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. GSAM may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations. GSAM may use and disclose PHI as part of its operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you, patient surveys, provider training, underwriting activities, compliance and risk management activities, planning and development, and management and administration. GSAM may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes, to help make sure GSAM is complying with all applicable laws, and to help GSAM continue to provide health care to its patients at a high level of quality. GSAM may also disclose PHI to other health care providers and health plans for such entity's quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance, provided that such entity has, or has had in the past, a relationship with the patient who is the subject of the information.

For Sharing PHI Among GSAM and Its Medical And Allied Health Professional Staff. GSAM and the physicians and other health care providers who are members of the GSAM medical staff work together in an organized health care arrangement to provide medical services to you when you are a patient at GSAM. GSAM and the members of its medical staff will share with each other PHI that they collect from you at GSAM as necessary to carry out their treatment, payment and health care operations relating to the provision of care to patients at GSAM.

Other Uses and Disclosures for Which Authorization is not Required. In addition to using or disclosing PHI for treatment, payment and health care operations, GSAM may use and disclose PHI without your written authorization under the following circumstance:

As Required by Law and Law Enforcement. GSAM may use or disclose PHI when required to do so by applicable law. GSAM also may disclose PHI when ordered to do so in a judicial or administrative proceeding, to identify or locate a suspect, fugitive, material witness or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, the location of the crime or victims, or the identity, description, or location of a person who committed a crime, or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. GSAM may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect, or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities. GSAM may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. GSAM may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Organ, Eye and Tissue Donation. GSAM may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

Research. Under certain circumstances, GSAM may use and disclose PHI for medical research purposes.

To Avoid a Serious Threat to Health or Safety. GSAM may use and disclose PHI, to law enforcement personnel or other appropriate persons, to prevent or lesson a serious threat to the health or safety of a person or the public.

Specialized Government Functions. GSAM may use and disclose PHI of military personnel and veterans under certain circumstances. GSAM may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the president or other authorized persons or foreign heads of state or to conduct special investigations.

Workers' Compensation. GSAM may disclose PHI to comply with Workers Compensation or other similar laws. These programs provide benefits for work-related injuries or illnesses.

Fundraising Activities. Your PHI may be used to contact you in an effort to raise money for GSAM. Your PHI may be disclosed to a foundation related to GSAM. Such disclosure to contact information, such as your name, address and phone number and the dates you required treatment or services at GSAM. The money raised in connection with these activities would be used to expand and support GSAM's provision of health care and related services to the community. If you do not want to be contacted as part of these fundraising activities, please notify GSAM marketing department in writing.

Appointment Reminders: Health-related Benefits and Services. Marketing: GSAM may use and disclose your PHI to contact you and remind you of an appointment at GSAM, or to inform you of treatment alternatives or other health-related benefits and services that maybe of interest to you, such as disease management programs. GSAM may use and disclose your PHI to encourage you to purchase or use a product or service through a face-to face communication or by giving you a promotional gift of nominal value.

Disclosures to You or for HIPAA Compliance Investigations. GSAM may disclose your PHI to you or to your personal representative, and is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. GSAM must disclose your PHI to the Secretary of The United States Department of Health and Human Services ("The Secretary") when requested by the Secretary in order to investigate GSAM's compliance with privacy regulations issued under the federal health Insurance Portability and Accountability Act of 1996("HIPAA")

Uses and Disclosures To Which You Have an Opportunity to Object. You will have the opportunity to object to these categories of uses and disclosures of PHI that GSAM may make:

Disclosures to Individuals Involved in Your Health Care or Payment for Your Facility. Unless you object, GSAM may disclose your PHI to a family member, other relative, friend or other person you identify as involved in your health care. GSAM may also notify those people about your location or condition.

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Other Uses and Disclosures of PHI For Which Authorization is Requires. Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations you have the right to revoke in writing.

Regulatory Requirements. GSAM is required by law to maintain the privacy of your PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this notice. GSAM reserves the right to change the terms of this notice and its privacy policies, and to make the new terms applicable to the entire PHI it maintains. Before GSAM makes an important change to its privacy policies, it will promptly revise this Notice and post a new notice in the Admissions Areas. You have the following rights regarding your PHI:

You may request that GSAM restrict the use and disclose of your PHI. GSAM is not required to agree to any restrictions you request, but if GSAM does so it will be bound by the restrictions to which it agrees except in emergency situations.
You have the right to request that communications of PHI to you from GSAM be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, instead of your home address. Your requests must be made in writing and sent to the responsible GSAM Department Director. GSAM will accommodate your reasonable request without requiring you to provide a reason for your request. Generally, you have the right to inspect and copy your PHI that GSAM maintains, provided that you make your request in writing to the Medical Records Custodian. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30 days), GSAM will inform you of the extent to which your request has or has not been granted. In some cases, GSAM may provide you a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, GSAM may impose a reasonable fee to cover copying, postage, and related costs. If GSAM denies access to your PHI, it will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If GSAM does not maintain the PHI you request and if it knows where that PHI is located, it will tell you how to redirect your request. If you believe that your PHI maintained by GSAM contains an error or needs to be updated, you have the right to request that GSAM correct or supplement your PHI. Your request must be made in writing to the Medical Records Custodian, and it must explain why you are requesting an amendment to your PHI. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), GSAM will inform you of the extent to which your request has or has not been granted. GSAM generally can deny your request if your request relates to PHI : (i) not created by GSAM; (ii) that is not part of the records GSAM maintains; (iii) that is not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, GSAM will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) If you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and GSAM's denial attached; and (iii) complain about the denial. You generally have the right to request and receive a list of the disclosures of your PHI GSAM has made at any time during the 6 years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). The list will not include disclosure for which you have provided a written authorization, and does not include certain used and disclosures to which this notice already applies, such as those: (i) for treatment, payment, and health care operations; (ii) made to you; (iii) for GSAM's patient directory or to persons involved in your health care; (iv) for national security or intelligence purposes; or (v) to correctional institutions or law enforcement officials. You should submit any such request to the Medical Records Custodian, and within (60) days of receiving your request (unless extended by an additional thirty (30) days), GSAM will respond to you regarding the status of your request. GSAM will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of $10.00 finder's fee plus $1.00 per page for each additional request. You have the right to receive a paper copy of this notice upon request. You may complain to GSAM if you believe your privacy rights with respect to your PHI have been violated by contacting our Privacy Officer at 116 South Euclid Ave, Suite 1, Westfield NJ 07090 and submitting a written complaint. GSAM will in no manner penalize you or retaliate against you for filing a complaint regarding GSAM's privacy practices. You also have a right to file a complaint with the Secretary of the Department of Health and Human Services.

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Notice of Nondiscrimination and Accessibility
DISCRIMINATION IS AGAINST THE LAW

Genesis Regenerative Sports and Aesthetic Medicine complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Genesis Regenerative Sports and Aesthetic Medicine does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Genesis Regenerative Sports and Aesthetic Medicine provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters;
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Genesis Regenerative Sports and Aesthetic Medicine provides free language services to people whose primary language is not English, such as information written in other languages.

If you need these services, contact Genesis Regenerative Sports and Aesthetic Medicine Compliance Officer.
Name: Laura Chantre-Melicio
Mailing Address: 116 S. Euclid Ave, Suite 1, Westfield, NJ 07090
Phone: 908-588-2311
Fax: 908-588-2319
Email: manager@gsamedicine.com

If you believe that Genesis Regenerative Sports and Aesthetic Medicine has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Genesis Regenerative Sports and Aesthetic Medicine's Compliance Officer. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Genesis Regenerative Sports and Aesthetic Medicine's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD).
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si usted habla español, le avisamos que tenemos servicios lingüísticos gratuitos a su disposición. Llame al: 1-212-606-1760, TTY: 1-800-676-3777.

注意：如果您講中文，可向您提供免費語言服務。致電 1-212-606-1760，TTY: 1-800-676-3777。

Внимание: Если Вы говорите по русски, примите к сведению, что Вы можете воспользоваться бесплатными услугами переводчика. Звоните по номеру: 1-212-606-1760, TTY: 1-800-676-3777.

ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis asistans nan lang ki disponib pou ou gratis. Rele nan 1-212-606-1760, TTY: 1-800-676-3777.

알려드립니다: 귀하께서 한국어를 하시는 경우, 무료로 언어 도움 서비스를 이용하실 수 있습니다. 1-212-606-1760 (TTY: 1-800-676-3777) 번으로 전화하십시오.

ATTENZIONE: se parli italiano sono disponibili servizi di assistenza linguistica gratuiti. Chiama il numero 1-212-606-1760, TTY: 1-800-676-3777.

1-212-606-1760 רופט .אפצאל פון סערוויסעס פריי הילף דא צו באקומען שפראך אייך פאר זענען ,אידיש עדט איר רעב אויב :אכטונג,TTY: 1-800-676-3777.

দৃষ্টি আকর্ষণ: যদি আপনি বাংলায় কথা বলেন, তাহলে আপনি বিনামূল্যে ভাষাগত সহায়তা পরিষেবা পেতে পারেন। ফোন করুন: 1-212-606-1760, TTY: 1-800-676-3777

UWAGA: Jeżeli mówi Pan/Pani po polsku, dostępne są dla Państwa bezpłatne usługi pomocy językowej. Proszę zadzwonić pod numer 1-212-606-1760, TTY: 1-800-676-3777.

ملاحظة: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات مساعدة لغوية بالمجان. اتصل على
1-212-606-1760، هاتف نصي (TTY): 1-800-676-3777.

VEUILLEZ NOTER: Si vous parlez français, des services d’assistance linguistique gratuits, sont à votre disposition. Appelez le 1-212-606-1760, TTY: 1-800-676-3777.

فرمائیں توجہ: اگر آپ اردو زبان کی آپ تو ہے کے لیے زبان میں معاونت فراہم کرنے والی سروسز (سروسز اسسٹنس لینگوئج) بلامعاوضہ دستیاب ہیں کال کریں 1-
212-606-1760 TTY: 1-800-676-3777-

PAUNAWA: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-212-606-1760, TTY: 1-800-676-3777.

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, διατίθενται δωρεάν υπηρεσίες γλωσσικής βοήθειας για εσάς. Καλέστε το 1-212-606-1760. TTY: 1-800-676-3777.

VINI RE: Nëse flisni shqip, keni në dispozicion shërbime ndihme për gjuhën pa pagesë. Telefononi 1-212-606-1760, TTY: 1-800-676-3777.