NORTHEASTERN
PLASTIC SURGERY

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Age _____ Birthdate _____ Height _____ Weight _____ Gender [ ] Female [ ] Male

Marital Status: S M D W Children Y N Ages _____ Occupation _____

Purpose of Visit:

_____

Previous Surgeries with Dates: (including cosmetic)

_____

_____

Health Problems Past & Present: (mark all that apply)

[ ] Diabetes
[ ] Easy Bruising
[ ] Cancer
[ ] Hay Fever/Allergies
[ ] Sinus Problems
[ ] High Blood Pressure
[ ] Lung/Breathing Problems/Asthma
[ ] Psychiatric/Depression
[ ] Headache/Migraine
[ ] Other: _____
[ ] Heart Problems
[ ] Bleeding/Clotting Problems
[ ] AIDS/HIV
[ ] Hepatitis

Please explain all positive responses: _____

_____

Family History: (mark all that apply)

[ ] No Relevant Family History
[ ] Colon Cancer
[ ] High Blood Pressure
[ ] Lung Disease
[ ] Premature Coronary Heart Disease
[ ] Unknown/Adopted
[ ] Diabetes
[ ] High Cholesterol
[ ] Malignant Melanoma
[ ] Skin Cancer
[ ] Autoimmune Disorders
[ ] Glaucoma
[ ] Liver Disease
[ ] Obesity
[ ] Thyroid Disease

Do you smoke? [ ] No [ ] Yes, How many packs a day? _____
Do you have a history of drug abuse? [ ] No [ ] Yes
Do you have a history of alcohol abuse? [ ] No [ ] Yes

Medications: (including all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly)

_____

_____

Drug or Latex Allergies: (please indicate if none)

_____

_____

Primary Physician _____ **Phone**_____

Date of Last Physical: _____

The above information is accurate and complete to the best of my knowledge

Signature _____ **Date** _____

NORTHEASTERN
PLASTIC SURGERY

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Whom may we thank for referring you?

_____

Race: _____ Ethnicity: _____ Preferred Language: _____

Age _____ Birthdate ___/___/___ SS# ___-___-_____ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Ins Co. Adress _____

Name of Insured _____ SS# _____ DOB _____

Relationship to patient: _____

Name of Employer _____ Work Phone _____

I hereby authorize Dr. Joseph P. Fodero to examine, diagnose, and treat me. A copy of this authorization shall be as valid as the original.

Dr. Fodero is an out-of-network provider and only partcipates with Medicare.

Signature _____ **Date** _____

220 Ridgedale Avenue, Florham Park, NJ 07932 Office 973.295.6565 Fax 973.295.6567
www.northeasternplasticsurgery.com

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NORTHEASTERN
PLASTIC SURGERY

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand that as part of my healthcare, Joseph P. Fodero, MD originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for the future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A means of communication to my insurance company regarding the proper payment of my claim and/or appealing their decision,
- A source of information for applying my diagnosis and surgical information to my bill, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have read and/or been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent,
- The right to object to the use of my health information for directory purpose, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Joseph P. Fodero, MD is not required to agree to the restrictions requested. I understand that I may revoke this contract in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Joseph P. Fodero, MD reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Joseph P. Fodero, MD change their notice, they will send a copy of any revised notice to the address I've provided.

I wish the following restrictions to the use or disclosure of my health information.

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept / decline the terms of the consent.

Patient's Signature: _____ Date: _____

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FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physician which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. Self-pay patients are expected to pay the agreed amount. I understand that Dr. Fodero is a non-participating provider, and that I am responsible for all non-covered charges, not paid by my insurance.

ASSIGNMENT OF BENEFITS

I hereby assign benefits to be paid on my behalf to Northeastern Plastic Surgery, my admitting physician, or other physicians who render service to me. The undersigned individual guarantee prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I understand that in the event that I receive payment for services rendered by Dr. Fodero and/or the Center, such payment will be immediately forwarded to 220 Ridgedale Avenue, Florham Park, NJ 07932. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERESHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform surgeries/procedures at Northeastern Plastic Surgery may have an ownership interest in Northeastern Plastic Surgery. The physician has given me the option to be treated at another facility/Center which I have declined. I wish to have my procedure/services performed at Northeastern Plastic Surgery.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patients demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding Northeastern Plastic Surgery policies pertaining to ADVANCED DIRECTIVES prior to the date of the procedure. ADVANCED DIRECTIVES will not be honored within the Center.

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

_____ _____

Signature of Patient or Responsible Party | Print Name

_____ _____

Relationship to Patient | Date Signed

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Advanced Beneficiary Notice (ABN)

Patient Name: _____

Medicare ID #: _____

Note: If Medicare doesn't pay for (D) (item, test, service, procedure, supply, etc) listed below, you may have to pay.

(D) Service or supply: _____
(E) Reason Medicare may not pay: _____
(F) Estimated cost: _____

What you need to know:

- Read this notice, so you can make an informed decision about your care.
- Ask any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) listed above.

Note: If you choose option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

□**Option 1**: I want the (D) listed above. You may ask to be paid now, but I also want Medicare to be billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that it if Medicare doesn't pay, you will refund any payments I made to you, less co-pays or deductibles.

□**Option 2**: I want the (D) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

□**Option 3**: I do not want the (D) listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information: This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice of Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below indicates that you have received and understand this notice. You also receive a copy.

(I) Signature: _____

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NORTHEASTERN
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NO-SHOW POLICY

In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment.

Please be aware that failure to do so could result in a missed appointment fee of $25.00.

We value our patient/doctor relationships and will do everything we can to accommodate you. Your communication and compliance are very much appreciated.

I understand the terms of this form. I realize that I am financially responsible for charges incurred from no shows.

Signature: _____ **Date:** _____

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Patient's Rights for Northeastern Plastic Surgery

The following list of rights and responsibilities does not presume to be all-inclusive, but is intended to show our concern for you and to emphasize the need for observance of these rights and responsibilities.

As a patient you have the right to...

- Considerate and respectful care provided in a safe environment, free from all forms of abuse, harassment or discrimination.
- Participate in the development and implementation of your plan of care and actively participate in decisions regarding your medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Be well informed about your illness, possible treatments, and likely outcomes of care (including unanticipated outcomes) and to discuss this information with your doctor. In an emergency, when you lack decision-making capacity and the need for treatment is urgent, the information is made available to another person on your behalf.
- Have an advance directive (such as health care proxy, organ donation or living will) and the expectation that Northeastern Plastic Surgery will honor the intent of the directive to the extent permitted by law and hospital policy.
- Upon your request, have a family member, chosen representative and/or your own physician notified promptly of your admission to the hospital.
- Access to people outside the hospital by means of visitors and by verbal or written communication.
- Expect effective pain management to include the following:
    - Express your pain and have that expression accepted and respected as the most reliable indicator of pain,
    - Have your pain assessed systematically and thoroughly,
    - Have your pain managed according to the most currently accepted methods,
    - Receive prompt response to unrelieved pain, and
    - Be informed and involved in all decisions regarding all aspects of your pain care.
- Not undergo any procedure unless your or your legally authorized representative gives voluntary, competent and understanding consent.
- Remain free from seclusion or restraints of any form that are not medically necessary or are used as means of coercion, discipline, convenience or retaliation by staff.
- Expect that those proving care will protect your privacy and support your personal dignity.
- Have your cultural, psychosocial, spiritual and personal values, beliefs and preferences respected.
- Have access upon request to pastoral/spiritual services.
- Expect that treatment records are confidential unless you have given permission to release information or reporting is required or permitted by law. When the hospital releases your records to others, such as insurers, it emphasizes that the records are confidential.
- Review your own medical record and to have the information explained within a reasonable amount of time, except when restricted by law.
- Expect that Northeastern Plastic Surgery will make a reasonable response (to the best of its ability) to a patient's request for medically indicated care. Treatment, referral or transfer may be recommended. If your transfer is recommended or requested, you will be informed of risks, benefits and alternatives. You will not be transferred until the other institution agrees to accept.
- Leave the hospital even against the advice of your physician.
- Know the name of the physician who has primary responsibility for coordinating your care and if Northeastern Plastic Surgery has relationships with outside parties that may influence your treatment and care.
- Be told of alternatives when hospital care is no longer appropriate.
- Be informed by your physician of the continuing healthcare requirements following your discharge from the hospital.
- Know about hospital rules that affect your treatment and about hospital charges and payment methods.

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- An itemized and detailed explanation of your complete hospital bill, regardless of the source of payment for your care.
- Communicate concerns/grievances regarding your care to a patient representative.
- Receive answers to ethical questions that may arise in the course of your care or access the Ethics Committee.
- Receive assistance in accessing protective services.
- Access to an interpreter or translator if necessary.
- Expect that medical information disclosed about you and your rights and our obligations regarding the use and disclosure of your medical information is done in accordance with our Notice of Privacy Practices.
- Access, request amendment to and receive an accounting of disclosures regarding his/her own health information as permitted under applicable law.

I, _____, hereby acknowledge receipt of the Notice of My Patient Rights has been given to me.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

STAFF MEMBER WITNESS SEEKING ACKNOWLEDGEMENT DATE

NORTHEASTERN PLASTIC SURGERY

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.

1. Our Duty to Safeguard your Protected Health Information

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper copies of this Notice of Privacy Practices for Protected Health Information available upon request to our Privacy Officer.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment or due to a legal requirement.

2. How We May Use and Disclose Your Protected Health Information

For use and disclosures relating to treatment, payment or healthcare operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for an orthopedic problem and need to make sure you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, for Medicare or an insurance company to pay for treatment, we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills. You may instruct us not to disclose your health information to your insurance company for payment or operations purposes, but we are only required not to so disclose if you pay for the medical services you receive from us in full out-of-pocket at the time services are rendered.

For health care operations: We may use and/or disclose your medical information during operating our practice. For example, we may use your medical information in evaluating the quality of services provided or disclose your medical information to our accountant or attorney for audit purposes.

In addition, we may use your health information to send you appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you, provided we do not receive financial remuneration from a third party for purposes of making such communication.

3. Use and Disclosure without an Acknowledgement, Authorization or Opportunity to Object.

We may use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons or similar process.
- We may disclose information where a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections.
- We may disclose information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.
- We may use or disclose to a business associate or institutionally related foundation your demographic information, dates of care, department of service information, treating physician, outcome information and health insurance status for fundraising activities. You have the right to opt out of receiving such communications by contacting our Privacy Officer at the contact information below.

4. Use and Disclosure Requiring Patient Opportunity to Object

Under HIPAA, we are permitted to disclose your health information without your written consent or authorization to a family member, other relative, close friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or payment for your care. We may also use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for coordinating with such entities the use or disclosure to your family, relatives, friends or others identified by you. If you are able and available to agree or object, we will give you the ability to object prior to making this notification. If you are unable or unavailable to object, our health care professionals will use their best judgment in communication with your family and others.

5. Use and Disclosures Requiring Patient Authorization

There are certain use and disclosures of your protected health information that require your written authorization. We must obtain your authorization to use or disclose protected health information for purposes of marketing activities, unless such activities involve face-to-face communications made by us to you or a promotional gift of nominal value provided to you by us. Refill reminders or communications about a drug or biologic that is being prescribed for you are not marketing activities that require your authorization, unless we receive, remuneration for such communications that is not reasonably related to our cost is making the communication. Further, communications regarding case management or care coordination or to direct or recommend alternative treatments, therapies, health care providers or settings of care do not require your authorization, unless we receive financial remuneration in exchange for making the communication.

We must obtain your authorization for any disclosures that constitute the sale of protected health information. Other use and disclosure of protected health information not covered in this notice or the laws that apply to us will be made only with written authorization from you. If you provide permission to use and disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosure we have already made with your permission and that we are required to retain records of the care that we provide to you.

6 Your Rights Regarding Your Medical Information

You have rights about your health information. If you wish to exercise any of these rights, please contact the Center. Specifically, you have the following rights:

- You have the right to request that we limit how we use or disclose your medical information for treatment, payment and healthcare operations. We will consider your request but are not legally bound to agree to the restriction, unless it relates to the nondisclosure of certain health information to your insurance company for payment or operations purposes that relates solely to medical services we provide and that you pay for in full. In all other cases, we will agree to your request if it is reasonably feasible for us to do so. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. Your request, however, must specify how or where you wish to be contacted. If we agree to a requested restriction, it is binding on us.
- With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have the right to inspect and obtain a copy of your own health information if you put your request in writing to us. We must respond to your request within 30 days. If we deny you access, we will give you written reasons for the denial and explain any right to have the denial reviewed. To the extent we maintain your health information in one or more designated record sets electronically and you request a copy of your health information, we must provide you access to the information in the electronic form and format requested by you, if it is readily producible in such electronic form and format, or, if not, in a readable electronic form and format as agreed to by us. We may charge you a reasonable fee for a copy of your health information. You have the right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- If you believe that there is a mistake or missing information in our record of your medical information, you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial by us will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.
- You have the right to be notified in the event of a breach of your unsecured protected health information.
- You have the right to receive an accounting of certain disclosures made by us of your health information during the past six years and, of disclosures made through an electronic health record (EHR), during the past three (3) years. You may request an accounting of disclosures for a shorter period. All requests should be made in writing directed to our Privacy Officer at the contact information set forth below. We may provide you with an accounting for disclosures made by our business associates, and we may provide you with an accounting of disclosures made by us and a list of our business associates. There will be no charge for one such list each year. There may be a charge for more frequent requests.

7. Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.
If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office.

We will take no retaliatory action against you if you make any complaints, whether to the Department of Health and Human Services or us. We support your right to the privacy of your health information.

If you have questions about this Notice or any complaints about our privacy practices, please contact our Privacy Officer either by phone or in writing at:

NORTHEASTERN PLASTIC SURGERY
220 Ridgedale Ave. Suite C1 Florham Park, NJ 07932
P: 973.295.6565/ F: 973.295.6567

Effective Date: This Notice is effective on January 17, 2021

Northeastern Surgery Center, PA
Joseph P. Fodero, MD

Member of the
American Society
Of Plastic Surgeons

220 Ridgedale Ave
Florham Park, N.J. 07932
(973) 295-6565
Fax: (973) 295-6567
www.northeasternplasticsurgery.com

Certified by the American Board of Plastic Surgery

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, authorize Dr. Joseph Peter Fodero, MD PA and/or **[his/her/their]** representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for marketing purposes.

Additional Comments:

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Fodero and/or Northeastern Plastic Surgery in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Northeastern Plastic Surgery; for which Dr. Fodero may be receiving direct or indirect renumeration.

2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides or videotapes may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to **Dee Lopez** at **220 Ridgedale Avenue Suite C1 Florham Park, NJ 07932**. A revocation shall not affect any release of information made prior to revocation in reliance upon Authorization.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Fodero and/or Northeastern Plastic Surgery.

5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

6. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Fodero and/or Northeastern Plastic Surgery from all liability, including liability for negligence that in any way arises out of:

Any and all rights that I have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization;

Any claim that I may have or may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and certifies that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides or videotapes, I can contact **Dee Lopez** at **973-295-6565.**

Patient is a minor years of age, and we, the undersigned, are the parents or guardian of the patient and do hereby consent for the patient.

Signature: _____ Date: _____

Witness: _____ Date: _____