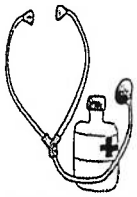

PREMIER SURGICAL & PREMIER VEIN CENTER LLC

INITIAL VISIT

Patient Name:_____ Date:_____

Age:_____ Race:_____ ☐ Male ☐ Female

Patients chief complaint:_____ Date of Onset:_____

Symptoms:_____ Location:_____ Frequency:_____

Severity of symptoms on scale of 1-10 (10 being the worst) 1 2 3 4 5 6 7 8 9 10

_____

_____

_____

_____

Please check if you currently have or have had within the past six (6) months;

☐ FEVER	☐ CHEST PAIN	☐ DVT/SVT
☐ CHILLS	☐ SHORTNESS OF BREATH	☐ PHLEBITIS
☐ HEADACHE	☐ CHRONIC COUGH	☐ BLEEDING
☐ LOSS OF SLEEP	☐ COUGHING UP BLOOD	☐ BRUISING
☐ SWEATS	☐ BLOATING	☐ BLOOD TRANSFUSION
☐ WEIGHT LOSS/GAIN	☐ DIARRHEA	☐ PLATLET TRANSFUSION
☐ LOSS OF HEARING	☐ CONSTIPATION	☐ HIV
☐ NOSE BLEEDS	☐ BLOOD/BLACK TARY STOOL	☐ HEPATITIS
☐ SINUSITIS	☐ BOWEL CHANGES	☐ CMV/EBV
☐ DIFFICULTY SWALLOWING	☐ RECTAL BLEEDING	☐ TB
☐ STROKE	☐ NAUSEA	☐ MRSA
☐ TIA	☐ VOMITING	☐ STAPH
☐ SEIZURES	☐ INDIGESTION/REFLUX	"FOR FEMALE PATIENTS"
☐ DEPRESSION	☐ LAST RECTAL EXAM	☐ LAST SELF BREAST EXAM DATE:
☐ ANXIETY	☐ DATE OF COLONOSCOPY	☐ LAST MENSTRUAL PERIOD DATE:
☐ SCHIZOPHRENIA	☐ BLOOD IN URINE	☐ LAST PAP SMEAR DATE:
☐ EATING DISORDER	☐ PAIN DURING URINATION	☐ LAST MAMMOGRAPHY DATE:
☐ RASH	☐ FREQUENT URINATION	☐ NUMBER OF PREGNANCIES
☐ MOLES	☐ INCONTINENCE	
☐ SKIN CANCER	☐ HEAT/COLD INTOLERENCE	
☐ NON-HEALING SORE(S)	☐ INCREASED URINATION	

Patient Name:_____ Date:_____

Please list all current medical conditions; **Please list all current medications;**

Please list all previous operations; **Please list all allergies;**

Social History;

Are you a current smoker:_yes/no how many pack(s)_____per day for_____years
Previous smoker: yes/no Quit_____months/years, smoked_____pack(s)_____years
Alcohol Intake:_____ Drug use:_____
Marital Status:_____ # Of Children_____ Occupation:_____

Family History;

□ Breast Cancer_____
□ Colon Cancer_____
□ Other Cancer(s)_____
□ Diabetes_____
□ Arthritis_____
□ Kidney Disease_____
□ High Blood Pressure_____
□ Cardiac_____

Please list all doctors that you see;

NAME/SPECIALTY	ADDRESS	PHONE NUMBER

JARROD P. KAUFMAN, MD FACS
General & Advanced Laparoscopic Surgeon

NJ State Chair: Commission on Cancer of the American College of Surgeons

Emeritus Chair: Melanoma Workgroup: NJ Governor's Task Force on Cancer Prevention, Early Detection & Treatment

Founding Director of the Cutaneous Oncology and Melanoma Program @ Centrastate Medical Center, Emeritus

Specializing In:
General Surgery, Surgical Oncology, Advanced Laparoscopy, Surgical Endoscopy, Ultrasound, and Endovenous Surgery

Board Certified:
American Board of Surgery

Fellow:
American College of Surgeons:
ACS NJ State Chair, Commission on Cancer

Surgical Procedures:
Laparoscopic Hernias
Complex Recurrent Hernias
Abdominal Wall Reconstruction
Laparoscopic Antireflux Surgery
Incisionless Hiatal Hernia Repairs
Laparoscopic Cholecystectomy
Laparoscopic Colonic Resection
Laparoscopic Adrenalectomy
Laparoscopic Splenectomy
Laparoscopic Appendectomy
Laparoscopic Bowel Obstruction
Laparoscopic Ultrasonography
Laparoscopic Cancer Staging
Robotic Surgery
Breast Surgery
Melanoma Surgery
Sentinel Node Biopsy
Lymph Node Biopsy
Soft Tissue Tumor Resection
Thyroid and Parathyroid Surgery
Endovenous Surgery: Varicose Vein Laser and Radiofrequency Ablation
Trivex Ambulatory Phlebectomy
Vena Cava Filters

Diagnostic Studies:
Ultrasound Procedures for the Diagnosis and Treatment of Breast, Thyroid, and Venous Disease, Radiofrequency and Laser Closure of Varicose Veins.
Ultrasound Guided Breast Biopsy and Fine Needle Aspiration of Thyroid
Abdominal Ultrasound
Lymph Node Ultrasound

Location:
525, Route 70, East
Suite 1B
Brick, NJ 08723.

Office (732)-262-1600
Fax (732)-262-1606

PREMIER SURGICAL & VEIN CENTER LLC

General & Advanced Laparoscopic Surgery

CONSENT TO RELEASE RECORDS

Date:_____/_____/_____

Patient Name:_____

DOB:_____/_____/_____

Home Address:_____

_____

I hereby authorize;

_____
Facility Name Fax #

to release my entire medical record pertaining to my care and

treatment from:_____ to _____

Please ( ) Fax ( ) mail my medical records to:

Premier Surgical & Vein Center LLC
Fax # 732-262-1606

I release Premier Surgical & Vein Center LLC from all legal responsibility that may arise from this authorization.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

PREMIER SURGICAL & PREMIER VEIN CENTER LLC

JARROD P. KAUFMAN M.D. FACS

DESIGNATION OF CERTAIN RELATIVE, CLOSE FRIENDS AND OTHER CAREGIVERS;

I agree that the practice may disclose certain health information to a family member, close personal friend or other caregiver, since such person is involved with my healthcare or payment relating to my healthcare. In that case the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare. I wish to be contacted in the following manner (check all that apply);

HOME TELEPHONE NUMBER:_____

_____OK to leave message with detailed information

_____Leave message with call back numbers only

WORK TELEPHONE NUMBER:_____

_____OK to leave message with detailed information

_____Leave message with call back numbers only

OTHER/CELL NUMBER:_____

_____OK to leave message with detailed information

_____Leave message with call back numbers only

I designated the following person(s) listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at anytime in writing.

NAME:_____ NAME:_____

_____ _____

Signature of patient/guardian Date

PREMIER SURGICAL & VEIN CENTER

ASSURANCE OF PRIVACY FOR OUR PATIENTS

Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of health information. As part of this plan we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation properly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information is protected for privacy. The "Privacy Rule" provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment or health case operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments, or objections to the privacy policies in this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our entire notice of privacy policies upon request.

*Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name:_____ Patient Signature:_____

Date:_____

If minor, Signature of Parent or Guardian:_____

PREMIER SURGICAL & VEIN CENTER LLC

Financial Policy:
We are committed to providing you with the best possible care. We also look forward to assisting you with realizing your maximum allowable insurance benefits. It is imperative that you understand your responsibilities under your insurance coverage with respect to obtaining referrals, your deductible, co-pay & co-insurance. Should we participate with your insurance provider, we will bill your insurance company in accordance with the guidelines of our contract with that provider. We require that all co-pays and/or deductibles be paid at the time services are rendered. For our patients convenience we accept personal checks, cash, credit/debit cards. **Please note that any returned checks will be subject to any bank fees and a additional $25.00 service fee.** We will gladly discuss your proposed treatment and answer any questions relating to your insurance coverage. All billing questions should be directed to our billing department @ 888-877-0401.

Missed Appointments:
Should you be unable to keep your scheduled appointment we require 24 hours advanced notice of your cancellation. Without proper notification you will incur a $30.00 fee.

Account Balances:
All outstanding balances will be billed a 1.5% monthly finance charge. Any account balance which is 90 days past due will be sent to collection unless there is a payment arrangement made in writing by our office. The patient understands that he/she will be responsible for any collection fees, legal fees and costs incurred by Premier Surgical & Vein Center LLC if the account is placed in collection.

I have read the Financial Policies and Procedures of Premier Surgical & Vein Center LLC. I understand and agree with this policy. I hereby assign benefits to Premier Surgical & Vein Center LLC for all claims submitted to my insurance company on my behalf.

Patient Signature:_____

Assignment & Release

Patient Name:_____

Insurance Co.:_____ID#_____Group#_____

I hereby instruct and direct_____to make payment directly to;

Premier Surgical & Vein Center LLC, Jarrod P. Kaufman M.D FACS

525 Route 70 East, Suite 1B, Brick, NJ 08723

For the professional/ medical expense benefits and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay in a current manner any balance of said professional service charges over and above this insurance payment. A copy of this assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster, collection agency or attorney involved in this case/claim.

_____ _____ _____

Policy Holder Signature | Patient Signature (if not policy holder) | Date