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

CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

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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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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 $50.00 for follow-up visits and $100.00 for consults.

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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AESTHETICIAN CANCELLATION POLICY

For all plastic surgery and injectable patients:

The doctor may recommend you make an appointment with our Aesthetician Jessica following your procedure. Please read and fill out the following form.

I, _____ understand the appointments I make are special times, just for me, that are booked in advance to ensure proper treatment and attention. I understand that it is my responsibility to cancel my appointment **no later than 72 hours prior** to the actual date and time of my appointment. A respectable fee of $50 will be charged to my credit card number specified below to reserve this appointment. This fee will be applied as a credit to my bill for services performed that day or refunded back to my credit card if I cancel my appointment in the appropriate amount of time. I understand that if I do not show for my appointment or cancel with at least **72 hours' notice**, this fee is not refundable.

I understand that if I reschedule my appointment more than 3 times in a row, a full, non-refundable payment for service will be required in order to book another appointment.

I, _____ give Northeastern Plastic Surgery permission to charge $50 to my credit card number below if I do not cancel my appointment **at least 72 hours before** the actual date and time of my appointment.

_____

PRINT NAME ON CARD

_____ _____ _____

CREDIT CARD NUMBER EXP. DATE CODE (3 OR 4 DIGIT)

_____ _____

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…

1. The patient shall be informed verbally and in writing of his/her rights in before their procedure, in terms that the patient can understand. A signature acknowledging receipt of verbal and written notification of these rights shall be obtained on the day of the procedure; and will be obtained by the patient and or legal guardian and placed in the patient's chart as part of the permanent medical record.
2. The patient will be informed of the services offered at the Center, the names of the professional staff and their professional status of who is providing and/or responsible for their care, including information on the Center's provisions for emergency and after hours and emergency care.
3. The patient will be informed if requesting information of the fees and related charges, including the payment, fee, deposit, and refund policy of the Center and any charges not covered by third-party payers or by the Center's basic rate.
4. The patient will be informed of other Health Care and Educational Institutions participating in the patient's treatment.
5. The patient will be informed of the identity and the function of these institutions, and he/she has the right to refuse the use of such institutions.
6. The patient will be informed, in terms that the patient can understand, of his/her complete medical/health condition or diagnosis, the recommended treatment, treatment options, including the option of no treatment, risks of treatment, and expected results. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, then the information will be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly will be documented in the patient's chart.
7. The patient will participate in the planning of his/her care, and has the right to refuse such care and medication. Upon refusal, it will be documented in the patient's chart and witnessed.
8. The patient will be included in experimental care if the patient has agreed to such and gives written and informed consent to such treatment, or when a guardian has consented to such treatment. The patient also has the right to refuse such experimental treatment, including the investigation of new drugs and medical devices.
9. The patient has the right to voice grievances or recommend changes in policies and services to the Center personnel, the Governing Authority and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination, or reprisal.
10. The patient will be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a Physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of the Center's personnel.

11. The patient will be assured of confidential treatment of information about him/herself. Information in the patient's medical record shall not be released to anyone outside the Center without the patient's approval, unless another Healthcare Center to which the patient was transferred requires that information, or unless the release of the information is required or permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the State Department of Health for statutorily authorized purposes. The Center may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.
12. The patient will receive courteous treatment, consideration, respect and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when Center personnel are discussing the patient.
13. The patient will not be required to work for the Center unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules.
14. The patient has the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient.
15. The patient has the right to expect and receive appropriate assessment management and treatment of pain as an integral component of that person's care.
16. The patient has the right to information regarding the Credentialing process of Health Care Professionals at the Center.
17. The patient shall be informed verbally and by written notice on date of the procedure, of his/her Physicians financial interest or ownership in the Center; The signed copy of patient acknowledgement and notification of the Physician financial interest or ownership will be placed in the patient's chart as part of the permanent medical record.
18. The patient shall be informed verbally and offered written notice on the date of the procedure, information on the Center's policy on Advance Directives, including a description of applicable State and safety laws and, if requested, official State Advanced Directive forms. The signed copy of patient acknowledgement and notification of the Center policy on Advance Directives will be placed in the patient's chart as part of the permanent medical record.
19. The patient has the right to refuse any treatment and research, except as otherwise provided by law.
20. The patient will not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the Center.
21. The patient has the right to change their Healthcare Provider and reschedule their procedure.
22. The patient has the right to be informed about procedures for expressing suggestions, including complaints and grievances, including those regulated by State and Federal regulations.
23. The patient has the right not to be misled by marketing or advertising regarding the competence and capabilities of the Center.
24. The patient has the right to be provided with appropriate information regarding the absence of malpractice insurance coverage.

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25. The patient has the right to receive care in a safe setting free from all forms of abuse and harassment.
26. A patient is responsible for reporting unexpected changes in his or her condition to the Health Care provider.
27. A patient is responsible for reporting to the Health Care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
28. A patient is responsible for following the treatment plan recommended by the Health Care provider.
29. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the Health Care provider or Health Care Center.
30. A patient is responsible for his or her actions if he or she refuses treatment or does not follow the Health Care provider's instructions.
31. A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
32. A patient is responsible for following Health Care Center rules and regulations affecting patient care and conduct.
33. A patient is responsible to provide complete and accurate information about his/her health, any medications, including herbals and over the counter supplements and any allergies or sensitivities.
34. A patient is responsible to follow the treatment plan prescribed by his/her Provider.
35. A patient is responsible to provide a responsible adult to transport him/her home from the Center (if the patient is receiving anesthesia) and remain with him/her for 24 hours if required by his/her provider.
36. A patient is responsible to inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
37. A patient is responsible to be respectful of all the Health Care providers and staff, as well as other patients.
38. If a patient is adjudged incompetent under applicable State laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.
39. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law

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

_____ _____

PATIENT SIGNATURE DATE

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Financial Disclosure for Northeastern Plastic Surgery Center

Public law/rule of the State of New Jersey Board of Health mandates that a Physician, Podiatrist and all other licensees of the NJDOH inform patients of any significant financial interest held in a health care service Center.

Please take Notice that Provider

Joseph P. Fodero, MD

Have a financial interest in referring to:

NORTHEASTERN PLASTIC SURGERY CENTER

And the below are members with a financial interest in the Center.

NAME: Joseph P Fodero

ADDRESS : 220 Ridgedale Ave. Suite C1

Florham Park, NJ 07932

Your Physician may also have a financial interest in the professional component of intraoperative monitoring that is provided during selected surgical procedures, as well as in companies that provide implants for certain surgical procedures.

You have the right by law to choose the provider of your health care services as well as the option of utilizing an alternate medical facility, monitoring or implant company.

You will not be treated differently by your Physician if you choose to obtain health care services at another facility, or to utilize another monitoring or implant company, if applicable. We welcome you as a patient and value our relationship with you.

If you have any questions concerning this notice, please feel free to ask your Physician.

By signing and reading this Disclosure of Financial Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your Physician has a financial interest in the listed Center.

Patient Signature/Patient Representative _____

Date:_____