Jersey Shore Advanced Surgical Associates

Dr. Carney T. DeSarno M.D.

PATIENT INFORMATION - ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Name (including middle initial) _____ Birth Date_____ Age_____ ☐ Male ☐ Female

Check appropriate box: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unreported/Refuse to Report

Language: ☐ English ☐ Spanish ☐ Other If other, please specify_____

Race: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaskan Native

☐ White ☐ More than one race ☐ Unreported/Refused to Report

Covid Vaccine : ☐ Have updated Booster ☐ Have 1st Booster ☐ Did not get any booster ☐ Did not get the vaccine

SS#_____ Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____Email_____

Patient's or Parent/Guardian's Employer_____

Business Address_____Business Phone_____

Spouse or Parent's/Guardian's Name_____

Name of Referring Doctor_____

Pharmacy Name_____Pharmacy Phone_____

Emergency Contact_____Relationship_____Phone_____

INSURANCE INFORMATION - PLEASE GIVE US YOUR INSURANCE CARD TO PHOTOCOPY

Primary Carrier_____Address_____

Subscriber's Name_____SS#_____Birth Date_____

Policy Number_____Group Number_____

Secondary Carrier_____SS#_____Birth Date_____

Policy Number_____Group Number_____

IF AUTO OR JOB RELATED PLEASE FILL OUT BELOW

Date of Accident_____ ☐ Auto Related ☐ Job Related

Adjuster_____ Phone Number_____ Claim #_____

Name/Address of Insurance Co_____

IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US FOR SERVICES COVERED UNDER YOUR POLICY WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER. I HEREBY AUTHORIZE RELEASE OF INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE CARRIER AND ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL.

I AGREE THAT IF MY ACCOUNT IS REFERED TO AN OUTSIDE AGENCY OR ATTORNEY FOR COLLECTION, I WILL BE RESPONSIBLE FOR AN ADDITIONAL COLLECTION FEE OF FIFTY DOLLARS ($50.00) OR 20% OF THE BALANCE OWED, WHICHEVER AMOUNT IS GREATER.

YOU AGREE, IN ORDER FOR US OR YOUR AGENTS AND VENDORS TO SERVICE OUR ACCOUNT OR TO COLLECT ANY AMOUNTS YOU MAY OWE, WE MAY CONTACT YOU BY POSTAL ADDRESS, EMAIL ADDRESS, OR TELEPHONE AT ANY NUMBER ASSOCIATED WITH YOUR ACCOUNT, INCLUDING WIRELESS NUMBERS, WHICH COULD RESULT IN CHARGES TO YOU. METHODS OF CONTACT MAY INCLUDE USING PRE-RECORDED/ARTIFICIAL VOICE MESSAGES/ TEXT MESSAGE/ E-MAIL/ MOBILE APPLICATION AND/OR USE OF AN AUTOMATIC DIALING SERVICE, AS APPLICABLE. I UNDERSTAND I MAY OPT-OUT OF RECEIVING TEXT MESSAGES BY NOTIFYING YOU IN WRITING. I/WE HAVE READ THIS DISCLOSURE AND AGREE THAT THE PRACTICE/OFFICE MAY CONTACT ME/US AS DESCRIBED ABOVE.

PATIENT'S SIGNATURE_____**DATE**_____

Jersey Shore Advanced Surgical Associates

Dr. Carney T. DeSarno M.D.

PATIENT NAME_____ DATE OF BIRTH_____ AGE_____

Please answer ALL of the following questions to the best of your ability. If you don't understand a question or need help, please ask for assistance. Feel free to use the back of this form if you need additional space for your answers.

Briefly describe the reason for your office visit_____

How long have you known about this condition?_____ Have you seen another physician for this? Yes No

Have you had any tests done or treatments for this? Yes No If so, what?_____

How often do you have symptoms? Constantly Frequently Daily Weekly Monthly Rarely Never

Do you have pain with this condition? Yes No If so, describe it: Mild Moderate Severe Dull Sharp Achy Burning

Do you have any other associated symptoms? Yes No If so, what? _____

What makes your symptoms better, if anything?_____

What makes your symptoms worse, if anything?_____

Do you have any other known medical conditions? Yes No If so, please circle all that apply, or list:

High blood pressure Heart disease Stroke Diabetes Asthma Cancer (type?)_____

Other:_____

Have you ever had surgery in the past? Yes No If so, please circle all that apply, or list:

Appendix Gallbladder Stomach Intestine Colon Breast Heart Tonsils C-Section Hysterectomy

Other:_____

Do you take any medications on a regular basis? Yes No If so, please circle all that apply, or list:

Coumadin Aspirin Motrin Plavix Insulin Prednisone Prevacid

List all Others:_____

Do you have any allergies? Yes No If so, please circle all that apply, or list:

Penicillin Sulfa Aspirin IV Dye Shellfish Latex Adhesive Tape Percocet

Other:_____

How often do you drink alcoholic beverages? Never Rarely Occasionally Monthly Weekly Daily

Do you use tobacco? Yes No If so, what? Cigarettes Cigars Chew How much per day?_____

Please circle or list any medical conditions that may run in your family:

High blood pressure Heart disease Stroke Diabetes Asthma Cancer (type?)_____

Other:_____

Family Doctor:

Cardiologist:

Jersey Shore Advanced Surgical Associates

Dr. Carney T. DeSarno M.D.

PATIENT NAME_____DATE OF BIRTH_____AGE_____ Today's Date_____

Please indicate by circling all of the following conditions or symptoms that you may experience on a regular basis, if any:

GENERAL:	Night sweats	Fevers	Poor appetite	Weight loss	Fatigue	Malaise	
EYES:	Redness	Itching	Blurriness	Double vision	Blindness		
ENT:	Ringing in ears	Hearing loss	Sinusitis	Deviated septum	Nose bleeds	Hoarseness	Swallowing Difficulty
HEART:	Shortness of breath	Palpitations	Chest pain	Angina	Swollen ankles		
LUNGS:	Difficulty breathing	Frequent cough	Wheezing	Pain with breathing	Coughing up blood		
GI:	Abdominal pain	Nausea	Vomiting	Diarrhea	Constipation	Heartburn	Blood in stool	Bloating
GU:	Pain with urination	Frequent urination	Difficulty with urination	Blood in urine			
ORTHO:	Arthritis	Chronic neck pain	Chronic back pain	Swollen joints			
SKIN:	Psoriasis	Rash	Hair loss	Ulcerations	Infections		
NEURO:	Seizures	Fainting	Weakness	Migraines	Slurred speech	Tremors	
PSYCH:	Depression	Insomnia	Agitation	Anxiety	Mood disorder		
ENDO:	Weight gain	Excessive sweating	Heat or cold intolerance	Excessive thirst			
HEME:	Bruising	Bleeding	Swollen lymph nodes	Phlebitis	DVT		
IMMUNE:	Seasonal allergies	Skin reactions	Frequent infections	Hives			

ADDITIONAL NOTES:

PLEASE PROVIDE AN UP TO DATE LIST OF YOUR OTHER DOCTORS

DO YOU HAVE AN ADVANCED DIRECTIVE? (LIVING WILL) YES NO

IF YOU HAVE AN ADVANCED DIRECTIVE, PLEASE PROVIDE OUR OFFICE WITH A COPY. THANK YOU.

HIPAA NOTICE OF PRIVACY PRACTICES

Jersey Shore Advanced Surgical Associates
1706 Corlies Avenue, Suite 5
Neptune, NJ 07753
(732)775-5005

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to: your past, present or future physical or mental health or condition and related health care services; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g. name, address, birth date, Social Security Number.) There are no restrictions on the use or disclosure of "De-Identified Health Information". De-Identified Health Information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information; either: 1) a formal determination by a qualified statistician; 2) the removal of specified identifiers of the individual and of the individual's relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
We, as a covered entity, are permitted, but not required, to use and disclose protected health information , without an individual's authorization, for the purposes or situations; 1) To the individual (unless required for access or accounting of disclosures); 2) Treatment, Payment, and Health Care Operations; 3) Opportunity to Agree or Object; 4) Incident to an otherwise permitted use and disclosure; 5)Public Interest and Benefit Activities; and 6) Limited Data Set for the purposes of research, public health or health care operations. Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

To the Individual We may disclose protected health information to the individual who is the subject of the information.

Treatment: A covered entity may use and disclose protected health information for its own treatment, payment, and health care operations activities. We may also disclose protected health information for treatment activities of any health care provider, the payment activities of another covered entity and of any health care provider, or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, if both covered entities have or had a relationship with the individual and the protected health information pertains to the relationship.

Treatment is the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider or another.

Payment: Encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for health care delivered to an individual and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: Are any of the following activities: a) quality assessment and improvement activities, including case management and care coordination; b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; c) conducting or arranging for medical reviews, audits or legal services, including fraud and abuse detection and compliance programs; d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; e) business planning, development, management, and administration; and f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity. A patient has the right to "opt out" of participating in or receiving fundraising communications.

Authorization: We must obtain the individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule. A covered entity may not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization, except in limited circumstances.

Psychotherapy Notes: We must obtain an individual's authorization to use or disclose psychotherapy notes with the following exceptions:

1. The covered entity who originated the notes may use them for treatment
2. A covered entity may use or disclose, without an individual's authorization, the psychotherapy notes, for its own training, and to defend itself in legal proceedings brought by the individual, for HHS to investigate or determine the covered entity's compliance with the Privacy Rules, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight of the originator of the psychotherapy notes, for the lawful activities of a coroner or medical examiner or as required by law.

Marketing: Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service. The Privacy Rule carves out the following health-related activities from this definition of marketing:

1. Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making the communications
2. Communications about participating providers in a provider or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan's enrollees that add value to, but are not part of, the benefit plans.
3. Communications for treatment of the individual; and
4. Communications for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or care settings to the individual.

Marketing is also an arrangement between a covered entity and any other entity whereby the covered entity discloses protected health information, in exchange for direct or indirect remuneration, for the other entity to communicate about its own products or services encouraging the use or purchase of those products or services. Any arrangement for an exchange of health information for remuneration, whether direct or indirect requires your authorization.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, including your right to pay "out of pocket" for treatment and not have the bill for services be submitted to your health plan. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive notification if there is a breach of your protected health information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before September 23, 2013.

Member Authorization Form for a Designated Representative to Appeal Determination

To: _____

_____

_____

Date: _____

Member Name: _____

Member ID #: _____

I hereby authorize Jersey Shore Advanced Surgical Associates to appeal my insurance company carrier's determination concerning any denials of claims or incorrect payment of claims (including delayed payment of claims), on my behalf, as my Designated Representative, as part of the appeal, I hereby authorize my insurance carrier in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

> All medical and financial information contained in my insurance file, including but not limited to treatment for medical status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed and all health care program information.

I understand this information is privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____

Signature of Member or Legal Guardian/ Representative

_____

Signature of Witness___ Designated Representative____

_____

Name of Witness/ Designated Representative (Please print)

Jersey Shore Advanced Surgical Associates

PATIENT NAME_____ DATE OF BIRTH_____ AGE_____

CONSENT FOR DISCLOSURE OF PATIENT INFORMATION

The Privacy Rule that is contained in HIPAA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations (TPO) purposes, except in emergency situations.

The following information must be included in a medical record release form used by the practice to be in compliance with HIPAA requirements.

I understand that by giving consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment; it may also be used for payment and operational purposes. I have the right to review Jersey Shore Advanced Surgical Associates' "notice of privacy practices" before I sign this consent. The provider reserves the right to change the terms of the notice of privacy practice. Change in the privacy practices will be made available to me. I may request additional restrictions on access to this information for treatment, payment, or health care operations purposes. I understand that the provider may not be able to comply with this request. I request the following special instructions:_____

_____

I understand that from time to time my physician and his/her staff may inform me of new drugs, treatments, or other services that may be appropriate for my condition and from time to time may inform me of new services that may be appropriate for a person in my situation (age, sex, etc). I consent to the use of my identifiable patient information to notify me of such new drugs, treatments, or other services that may be necessary for the continuity of my care or which may benefit in maintaining or improving my health with the understanding that the provider will not provide such information to others for marketing, fund-raising, or similar purposed without my specific consent.

I understand that I, or my representative, promptly upon request, may inspect, request correction of and obtain information from my medical record.

I may revoke this consent in writing at any time except to the extent that the provider has already acted in reliance on this consent.

NAME_____ DATE_____

SIGNATURE_____

Jersey Shore Advanced Surgical Associates

Dr. Carney T. DeSarno M.D.

PERSONAL REPRESENTATIVE

I_____, a patient of the above practice, name the below person(s) as a personal representative and allow the release of my protected health information to them. I understand I may revoke this release at any time in the future.

NAME (Please print)	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Signature Date

Jersey Shore Advanced Surgical Associates

Patient Disclosure Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Home Telephone**_____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone**_____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Cell Phone**_____

☐ **Written Communication**

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address
- O.K. to fax to this number_____

☐ **Persons authorized to receive information**

_____
Name

_____
Relationship to patient

_____
Name

_____
Relationship to patient

_____
Name

_____
Relationship to patient

Patient/Parent Signature_____ Date_____

Print Name_____ Birthdate_____