Jersey Shore Advanced Surgical Associates

☐ Carney T. DeSarno, M.D. ☐ Seth M. Kipnis, 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

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_____

Employer_____Business Phone_____

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 TO SERVICE OUR ACCOUNT OR TO COLLECT ANY AMOUNTS YOU MAY OWE, WE MAY CONTACT YOU BY 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 AND/OR USE OF AN AUTOMATIC DIALING SERVICE, AS APPLICABLE. 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

☐ Carney T. DeSarno, M.D. ☐ Seth M. Kipnis, 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

Other:_____

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:_____

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PATIENT NAME_____DATE OF BIRTH_____AGE_____

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:

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.

Notice of Privacy

Jersey Shore Advanced Surgical Associates

Notice Of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:
Jersey Shore Advanced Surgical Associates
1706 Corlies Ave
Neptune, NJ 07753

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Jersey Shore Advanced Surgical Associates, 1706 Corlies Ave., Neptune, NJ 07753** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Jersey Shore Advanced Surgical Associates, 1706 Corlies Ave., Neptune, NJ 07753**.
Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Jersey Shore Advanced Surgical Associates, 1706 Corlies Ave., Neptune, NJ 07753** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Jersey Shore Advanced Surgical Associates, 1706 Corlies Ave., Neptune, NJ 07753**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Jersey Shore Advanced Surgical Associates, 1706 Corlies Ave., Neptune, NJ 07753**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Jersey Shore Advanced Surgical Associates, 1706 Corlies Ave., Neptune, NJ 07753**.
7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Jersey Shore Advanced Surgical Associates, 1706 Corlies Ave., Neptune, NJ 07753**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Jersey Shore Advanced Surgical Associates, 1706 Corlies Ave., Neptune, NJ 07753**

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

Carney T. DeSarno, M.D., F.A.C.S.
Seth M. Kipnis, M.D.
General Surgery, Laparoscopic Surgery, and Breast Surgery
Imperial Suites
1706 Corlies Avenue
Neptune, NJ 07753
(732) 775-5005
Fax: (732) 775-0064

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_____