Patient Information

Please answer all questions fully

Date: **07/18/2012**

Account Number:

Premier Urology Group, LLC (USA)
P.O. Box 51079
Newark, NJ 07101-5179
Phone: (908) 654-5100 Fax: (908) 789-8755

Patient						
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Race	Home Phone
Mailing Address	City	State	Zipcode	Marital Status		
Employer	City	State	Zipcode	Work Phone		

Responsible Party				
Name (Last, First ,MI)	Social Security	Birthdate	Sex	Home Phone
Address	City	State	Zipcode	Marital Status
Employer	City	State	Zipcode	Work Phone

Primary Provider	Referring Provider	Referring Address	Phone	Fax

Insurance Information				
Primary Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay
Second Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay
Third Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay

Emergency Contact Information			
Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

Please List Additional Medical Information

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: ________________________ Date: / 7 2012

(Signature of insured or authorized person, patient or parent if minor)

UROLOGICAL SURGICAL ASSOCIATES

PATIENT HISTORY FORM

DATE: ____________________ ACCOUNT #: ____________________

NAME: ____________________ DATE OF BIRTH: ________________ AGE: ________

MEDICAL DOCTOR: ____________________

REASON FOR YOUR VISIT TODAY (HPI)

____

____

FEMALES ONLY

LMP ____________
Paragravida ____________
B.C. ____________
Menopause ____________
Hysterectomy ____________

YOUR SYMPTOMS

DYSURIA
FREQUENCY
INCONTINENCE
SEXUAL PROBLEMS
FEVER
HEMATURIA
NOCTURIA
URGENCY

PAIN: LOCATION ____________
RADIATION ____________
ONSET ____________
INTENSITY ____________

YOUR PREVIOUS UROLOGICAL HISTORY / PROCEDURES

BLADDER ____________
CYSTITIS ____________
HEMATURIA ____________
KIDNEY DISEASE ____________
PROSTATE DISEASE ____________
STONES ____________
UROLOGICAL CANCERS ____________
VASECTOMY ____________

YOUR PRESENT MEDICAL HISTORY

CANCER (NON-URO) ____________
CARDIAC ____________
DIABETES ____________
HIGH BLOOD PRESSURE ____________
MITRAL VALVE PROLAPSE ____________
PACEMAKER ____________
PROSTHESIS ____________
STROKE / MS / SPINAL INJURY ____________
THYROID ____________
OTHER ____________

YOUR HOSPITALIZATIONS / OPERATIONS

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________

MEDICATIONS YOU ARE TAKING

	Medication	Dose	Frequency
1.			
2.			
3.			

YOUR ALLERGIES

1. ____________
2. ____________
3. ____________
4. ____________

DOCTOR'S NOTES

____

____

PLEASE COMPLETE THE REVERSE SIDE OF THIS SHEET

USA 2002

PATIENT HEALTH HISTORY FORM

PFSH

Marital Status:	M	S	W	D
Alcohol Use:	Never	Rarely	Moderate	Daily
Tobacco Use:	Y	N	Stopped	
Caffeine Use:	Y	N	How Much ___________	
Excessive exposure at home or work to:		Fumes	Dust	Solvents

DO YOU HAVE A **FAMILY** HISTORY OF:

	NO	YES	WHO
1. Cancer (Location)	____	____	____
2. Diabetes	____	____	____
3. High Blood Pressure	____	____	____
4. Heart Disease	____	____	____
5. Stroke	____	____	____
6. Thyroid Disease	____	____	____
7. Urological	____	____	____
8. Other	______________		

	Alive	Dead	Cause
1. Father	____	____	____
2. Mother	____	____	____
3. Brother/Sister	____	____	____

REVIEW OF SYSTEMS

GENERAL

Appetite Change
Chills
Fever
Headache
Loss of Weight
____
____

E.N.T.

Ear Infection
Sore Throat
Sinus Problems
____
____

ENDOCRINE

Excessive Thirst
Too Cold
Too Hot
Tires/Sluggish
____
____

EYE

Blurred Vision
Double Vision
Pain
Ringing in Ears
____
____

GASTROINTESTINAL

Abdominal Pain
Appetite Poor
Constipation
Diarrhea
Liver Disease
Rectal Bleeding
____
____

SKIN

Bruise Easily
Hives
Itching
Rash
____
____

CARDIO / VASC

Chest pain
Phlebitis
Poor circulation
Swelling of ankles
Valve Disease
Varicose veins
____
____

MUSCLE, JOINT, & BONE

Arthritis
Back Pain
Joint Pain
Neck Pain
Osteoporosis
____
____

NEUROLOGICAL

Dizziness
Numbness
Parkinson's
Stroke
Tremors
____
____

RESPIRATORY

Asthma
Cough
Shortness of breathe
Tuberculosis
____
____

OTHER

Aids
Chemical Dependency
HIV Positive
____
____

NONE APPLY

REVIEWED______________________________________**MD**

DATE:______________________________________

MEDICATION LIST

PATIENT'S NAME: ___________________________ **DATE:**_________________

PHARMACY: ______________________________________

PHARMACY ADDRESS & PHONE #: ____________________________________

ALLERGIES: ____

MEDICATION:	DOSAGE:	FREQUENCY:

PLEASE LIST ALL OF YOUR CURRENT PHYSICIAN'S:

CARDIOLOGIST:	
PULMONOLOGIST:	
OB/GYN:	
PCP:	
OTHER(S):	

PREMIER UROLOGY GROUP, LLC
Urological Surgical Associates Division

Jerold Grubman MD, FACS
Andrei Kachala MD, FACS
Benjamin Fand MD, FACS
William L. Terens MD, FACS
Joshua L. Wein MD, FACS
Rupa Patel MD, FACS
Neil D. Sherman MD, FACS

10 Parsonage Rd, Suite 118
Edison, NJ 08837
Tel: 732.494.9400
Fax: 732 548 3931

3 Hospital Plaza, Suite 200
Old Bridge, NJ 08857
Tel: 732.679.2010
Fax: 732.679.2077

570 South Ave, Building A
Cranford, NJ 07016
Tel: 908.272.5335
Fax: 908.497.1633

NOTICE OF PRIVACY PRACTICES

UROLOGICAL SURGICAL ASSOCIATES PROVIDES THIS NOTICE TO COMPLY WITH THE PRIVACY REGULATIONS ISSUED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1966 (HIPAA)

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

Please review carefully

Federal law requires this practice to maintain the privacy of your medical and health information

Protected health (PHI) information is information about you, including demographic information, that may identify you and relates to your past, present of future physical or mental health or condition and related health care services. 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. When we use or disclose PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

1. Uses and disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bulls, to support the operation of the physician's practice, and any other user required by law.

TREATMENT:

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with a third party. For example, we could disclose your PHI, as necessary, to the physician who referred you to this office for treatment, a home health care agency that provides care to you, or to a physician we referred you to for further treatment.

PAYMENT:

You PHI will be used, as needed, to obtain payment for your health care services from your health insuror, HMO, or other company (your payor) that arranges or pays the cost of some or all of your health care to verify that your payor will pay for health care. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the Health plan to obtain approval for the hospital admission.

HEALTH CARE OPERATIONS:

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical personnel, licensing, and conducting or arranging for other business activities. For example, we may use or disclose your PHI, as necessary, to contact you to remind you of your appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, E-mail, or otherwise and may involve the leaving of an E-mail, message on an answering machine, or otherwise which could (potentially) be received or intercepted by others.

USE WITHOUT AUTHORIZATION:

We may use or disclose your PHI in the following situations without your authorization. These situations include:

As required by law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal proceedings; Law Enforcement: Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human services to investigate or determine our compliance with health care fraud and abuse issues.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES:

Any other uses and disclosures will be made only with your Consent, Authorization or Opportunity to object, unless required by law. If you are not present or the opportunity to agree or object to as or disclosure cannot be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

2. Your Rights

You have the right to inspect and copy your PHI

You may request access to your medical record file and billing records maintained by us in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your medical records please contact the business office to request a release form and for the current associated costs.

You have the right to request a restriction of your PHI

You may request restrictions on our use and disclosure of any part of your PHI for the purposes of treatment, payment, or health care operations. 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. You 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 the physician believes it is in your best interest to permit use and disclosure of your PHI, your health information will not be restricted.

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.

You have the right to have your physician amend your PHI.

We will comply with your written request for amendment to your records as long as we believe that the amended information is accurate and complete or other circumstances apply.

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

You have the right to file a complaint.

If you desire more information about your privacy rights, are concerned that we have violated yourprivacy rights, or disagree with our decision about access to PHI, you may fi le a written complaint with the Practice or with the Director, Office of Civil Rights, and Department of Health and Human Services. To file a complaint with the Practice, contact our Office Manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.
The Office Manager may be reached at +1.732.494-9400 Ext. 1225
You will not be penalized for filing this complaint.

Effective Date:
This notice becomes effective on or before April 14, 2003
Changes:
We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the date of the last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

PREMIER UROLOGY GROUP, LLC
Urological Surgical Associates, P.A. Division

JEROLD GRUBMAN, M.D., F.A.C.S.
ANDREI KACHALA, M.D., F.A.C.S.
BENJAMIN FAND, M.D., F.A.C.S.
WILLIAM L. TERENS, M.D., F.A.C.S.
JOSHUA L. WEIN, M.D., F.A.C.S.
RUPA PATEL, M.D., F.A.C.S.
NEIL SHERMAN, M.D.

DIPLOMATES
AMERICAN BOARD OF UROLOGY

Permission to Release Medical and/or Payment Information to Designated Relatives, Close Friends and Other Caregivers

I agree that Urological Surgical Assoc., PA may disclose my health information to a family member, close personal friend or other caregiver because such person is involved with my healthcare or payment relating to my healthcare. In that case, Urological Surgical Assoc, PA will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

I designate the following person(s) listed below as person(s) involved with my healthcare or payment relating to my healthcare for the purpose of Urological Surgical Assoc, PA 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 any time in writing.

Can messages be left on patient's answering machine or voicemail?
YES _______ NO ________

________________________________ ________________________
Print Patient's Name **Date of Birth**

X______________________________ ________________________
Signature of Patient **Date**

________________ ________________ ________________
(Print Name of Person) (Relationship) (Phone #)

________________ ________________ ________________
(Print Name of Person) (Relationship) (Phone #)

________________ ________________ ________________
(Print Name of Person) (Relationship) (Phone #)

I DO NOT WISH TO LIST ANYONE: Check box: ☐

Adult and Pediatric Urology • Sexual Dysfunction • Male Infertility • Urinary Incontinence • Urologic Oncology
Laparoscopic Surgery • Robotic Surgery • Radiation Oncology • Stone Disease Management • Pelvic Reconstruction

10 Parsonage Road • Suite 118 • Edison, New Jersey 08837 • Tel: (732) 494-9400 • Fax: (732) 549-3931
3 Hospital Plaza • Suite 200 • Old Bridge, New Jersey 08857 • Tel: (732) 679-2010 • Fax: (732) 679-2077
570 South Avenue East • Building A • Cranford, New Jersey 07016 • Tel: (908) 272-[illegible]335 • Fax: (908) 497-1533

www.UroSurgery.info

Premier Urology Group

Urological Surgical Associates

10 Parsonage Road-Suite 118
Edison, New Jersey 08837
732-494-9400

3 Hospital Plaza-Suite 200
Old Bridge, New Jersey 08857
732-679-2010

Public Law of the State of New Jersey and rules of the Board of Medical Examiners mandates that physicians inform patients of any significant financial interest held in a health care service.

Accordingly, take notice that the practitioners in this office do have a financial interest in the following health care service(s) to which patients are referred.

Same Day Surgery Center of Central New Jersey, LLC

New Jersey Kidney Stone Center, LLC

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

Patient Name Printed: ______________________ Date of Birth: __________

Patient Signature: ______________________

Date: __________

Same Day Surgicenter of Central Jersey ,LLC

POLICY: ADVANCE MEDICAL DIRECTIVES

Patients have the right to develop an Advanced Medical Directive.

PROCEDURE:

A. Prior to the procedure and at the time of registration, the patient will be asked if he/she has an Advance Medical Directive in effect that the Center should be aware of. Advance Medical Directives address such issues as living wills and durable powers of attorney. Patients will be provided, prior to the procedure, information concerning policies on advance directives, including a description of applicable State health and safety laws, and if requested, official State advance directive forms.

B. The existence of such Advance Medical Directives shall be noted on the patient's chart. The Center does not acknowledge Advance Medical Directives. If the patient wishes to have Advance Medical Directives acknowledged, the Center will assist the patient in finding a hospital that will be able to provide the patient care.

C. The Center Administration shall periodically monitor the legal status of Advance Medical Directives with the Center's attorney and track State and Federal Regulations as they are modified.

D. If the patient does not have an Advance Directive then they will be offered information regarding an Advance Directive and may fill one out in the Center, if he/she wishes.

Note: The patient has the right to documentation in a prominent part of the patient's current medical record, whether or not he/she has executed an advance directive.

Advance Directives-Living Wills

New Jersey State law mandates that all health care facilities ask the patient whether he/she has an Advance Directive or Living Will. Medicare has also asked ambulatory surgical centers to provide the patient or the patient's representative with information concerning its policies on advance directives prior to the procedure, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.

If you have an Advance Directive or Living Will, please bring a copy of it with you to the Center on the day of your surgery.

An Advance Directive or Living Will is used by an individual to indicate their voluntary, informed choice of accepting, rejecting, or choosing among alternative courses of medical treatment.

An Advance Directive or Living Will is a document which allows you to give written instruction to those caring for you indicating the type of health care you would wish to receive or reject in the event you

become unable to express these decisions yourself.

There are three different types of Advance Directives:

1. A Proxy Directive:
   This is a document in which a competent adult names a trusted relative or friend to make health care decisions on his/her behalf when he/she is unable to make these decisions.

2. An Instruction Directive:
   In this document, the person writing it provides written instructions concerning the type of medical treatment they want or do not want performed for them and under what circumstances.

3. A Combined Directive:
   In this document, competent adult states his/her general wishes regarding the kind of health care he/she wishes to receive, but appoints a trusted relative or friend to carry them out.

A brochure containing Living will information is available from the Division of Aging. If you wish to receive the brochure, please make your request to the Center or request this information from the address below:

The Division of Aging
101 South Broad Street
CN 807
Trenton, New Jersey 08625

Do you have an Advance Directive or Living Will?

If yes, please send it or bring it to the Center prior to your scheduled procedure.

If no, an Advance Directive/Living Will sample template is available (see attached).

PLEASE NOTE: IT IS NOT THE POLICY OF THE SURGICAL CENTER TO ACKNOWLEDGE ADVANCE DIRECTIVES IN THE CENTER. IF YOU WISH AN ADVANCE DIRECTIVE WILL BE PLACED ON YOUR CHART TO BE USED IN EVENT OF A TRANSFER TO A HOSPITAL WHERE YOUR ADVANCE DIRECTIVE WILL BE ACKNOWLEDGED

Instructions: consult this: Column for guidance

This declaration sets forth decisions regarding my Medical treatment

You have the right to refuse treatment you do not want, and you may request the care you do want

You may list specific treatment you do not want:

- -CPR: Cardiac resuscitation
- -Mechanical respiration
- -Feeding Tubes
- -Intravenous Fluids

your general statement above will suffice

You may want to add: other instructions directing the care you do want pain management to die at home

If you want, you can name someone to see that your wishes are carried out, but you do not have to do this.

Advance Directive/Living Will Declaration

To my family, doctors, and those concerned with my care

I, ____________________, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care. If my death is near and cannot be avoided, or if I become comatose and lose the ability to interact with others and have no reasonable chance of regaining this ability, or if my suffering is intense and irreversible due to my mental or physical condition, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain.

These directions express my legal right to refuse treatment. Therefore, I expect my family, doctors, and everyone concerned with my care to regard themselves as legally and morally bound to act in accordance with my wishes, and in so doing to be free of any legal liability for having followed my directions.

I especially do not want:

____

____

____

____

____

____

____

____

____

Other instructions/comments: ____________________

____

____

____

PROXY DESIGNATION CLAUSE: In order to carry out my instructions as stated above and to interpret them; I designate the following person to act on my behalf: Name: ____________________

Address: ____________________

Home Phone #: ____________________ Work Phone #: ____________________

If the person named above, is unable to act on my behalf, I authorize the Following person to do so: Name: ____________________

Address: ____________________

Home Phone: ____________________ Work Phone #: ____________________

Patient's Signature: ____________________ Witness: ____________________

Date: ____________________ Witness: ____________________

POLICY: PATIENTS' RIGHTS

Patients at the Center have the following rights by state and Federal law and regulations. It is the responsibility of all employees to ensure that the patients' rights are complied with.
Patients are given a copy of the patients'rights prior to the procedure.
The Patient's rights are also posted in the Waiting and Holding Areas in the Center.

The patient or his/her representative, if applicable, has the right to:

- Be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient or the patient representative could understand, prior to the procedure.
- The Center must protect and promote the exercise of such rights. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;
- Be informed, where applicable, of physician financial interests or ownership in the ASC facility. Disclosure of information must be in writing and furnished to the patient prior to the procedure.
- Be provided, prior to the procedure with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and if requested, official State advance directive forms.
- Documentation in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.
- Be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
- Be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment and to change physicians if he or she so wishes;
- Receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s)/outcome(s). This shall occur prior to any treatment being performed. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall 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, shall be documented in the patient's medical record;
- Receive as soon as possible, the services of a translator or interpreter if you need one to help you communicate with the Center's health care personnel free of charge;
- Make informed decisions regarding care.
- Participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;
- Change primary or specialty physicians if other qualified physicians are available.
- Continuity of health care. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements;
- Be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
- Voice grievances or recommend changes in policies and services to facility personnel, the governing authority and /or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;
- Use the grievance procedure to document the existence, submission, investigation, and disposition of a written or verbal grievance to the Center.
- Documentation by the Center of all alleged violation/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse.
- Have all allegations reported to the person in authority of the Center.

- Have substantiated allegations reported to the state authority or the local authority, or both.
- Be provided with timeframes for review of the grievance and the provisions of a response.
- Voice grievances and to investigation of all grievances made regarding treatment or care that is (or fails to be) furnished.
- Written notice of the Centers decision which must contain the name of a facility contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.
- Exercise his/her rights without being subjected to discrimination or reprisal.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Have the person appointed under State law to act on the patient's behalf if the patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction
- 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 facility personnel;
- Appropriate assessment and management of pain. To education, including education for the patient's significant others (if applicable), regarding pain and symptom management in the discharge planning process; To expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care.
- Information regarding credentials of healthcare professionals;
- Confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
- Be treated with courtesy, 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 facility personnel are discussing the patient;
- Privacy and security of individually identifiable health information;
- Receive care in a safe setting and be free from all forms of abuse or harassment.
- Not be required to perform work for the facility 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;
- 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; and
- 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 facility.
- Have his/her rights exercised by the person appointed under State law to act on the patient's behalf.

  If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. 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.
- The administrator shall provide all patients and/or their families upon request with the names, addresses, and telephone numbers of the following offices where complaints may be lodged:

The Office of Acute Care Assessment and Survey
Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
PO Box 358
Trenton, New Jersey 08625-0358
Telephone: (800) 792-9770 (609) 292-9900
State of New Jersey
Office of the Ombudsman for the Institutionalized Elderly

PO Box 852
Trenton, New Jersey 08625-0852
Telephone 1-877-582-6995
www.cms.hhs.gov/center/ombudsman.asp

The Administrator shall also provide all patients and or families upon request with the names and telephone numbers of offices where information concerning Medicare and Medicaid coverage may be obtained. Addresses and telephone numbers shall be conspicuously posted throughout the facility, including, but not limited to, the admissions waiting area or room, the patient service area of the business, office and other public areas. The Center needs the cooperation of its patients to ensure that efficient, safe and considerate care is available to all patients.

Patients are responsible for:

a. Providing physicians, center personnel and healthcare providers with complete and accurate information about their medical history and complete and accurate information related to their condition and care.
b. Informing healthcare providers about all the medications they are taking as well as over-the counter products, herbal remedies, and dietary supplements.
c. Adhering to the treatment plans recommended by their doctors.
d. Arranging for a responsible adult to take them home and remain with them for 24 hours if required by their physician.
e. Telling his/her doctor about any living will, power of attorney, or other advanced directives.
f. Being respectful of healthcare professionals, staff members, and other patients.
g. Being responsible for medical consequences, which result from refusing treatment or not following instructions of physicians and surgery center personnel.
h. Being considerate of the Center's staff that is committed to excellence in patient care.
i. Supplying insurance information and paying bills promptly so that the Center can continue to serve its patients effectively. Agreeing to pay any expenses not covered by his/her insurance.

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Patient Financial Policy

(please read carefully!)

Welcome to our practice! We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care treatment. This is but one component of the integral doctor-patient relationship.

In order for a patient visit be billed to an insurance company, it is the patients obligation to present his current, valid insurance card **each and every time** a service is rendered.

Acceptable payment forms include cash, personal check, Visa or MasterCard.

- We have made prior arrangements with many health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will require you to pay your authorized co-payment at the time of service.
  - Co-payments will be collected upon check in as you arrive for your appointment.
  - MEDICARE 20% coinsurance will be collected at time of service
  - All **patient responsibility for drug therapy costs must be paid at time of service**

- We encourage patients to utilize the Out of Network 'OON" benefits that are frequently associated with your selected insurance program. Our staff will be happy to assist you in navigating the system when dealing with your OON benefits.

- Your health insurance policy is a contract between you and your insurance company. In many instances, the doctor is not involved. Unless either you or your health coverage carriers have made other arrangements in advance, full payment is due at the time of service.

- Your insurance company establishes its own rules for referrals. If you present for a visit without the required referral, you cannot be seen as per **YOUR** insurance company's rule. It is your responsibility to keep track of any required referrals so that you may prevent any disruption of your care.

- Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," **you will be responsible for the complete charge.** Payment is due upon receipt of a statement from our office. This also applies to those diagnoses that an insurance company may deem as a pre-existing condition.

- Our billing cycle is as follows:

  - All co pays and MDCR 20% coinsurance due at time of service