Elite Surgical Specialists

Patient Demographics

Patient Name:				
Last:	First:	Middle:		
Date of Birth:		**SS#:**		
Address:				
Street:	City:	State:	Zip:	
Phone:				
Home:	Work:	Cell:		
Email:				
Marital Status (circle one):				
Single	Married	Divorced	Widowed	Other
Sex (circle one):	Male	Female		
Name of Insurance Subscriber:				
Patient Relationship to Subscriber (circle one):	Self	Spouse	Child	Other
Subscriber's Employer Info:				
Company:		City:		
Supervisor:		Phone #		
Accident Info (if applicable):				
Date of Accident:	Work Related?	Auto?	Other?	

Elite Surgical Specialists

Adult History

Today's Date:_____

Name:	
Date of Birth:	
Referring Provider:	
Primary Care Provider:	

Name of Preferred Pharmacy:	
Phone Number:	

Reason for Visit:

1) Personal Medical History: Conditions - current or treated in the past. (Check all that apply)

❑ Allergies (please list in comments below)	❑ Glaucoma
❑ Anemia	❑ Gout
❑ Anxiety	❑ Heart Attack
❑ Arthritis	❑ Heart Disease
❑ Asthma	❑ Heartburn/Gastric Reflux
❑ Benign Prostatic Hyperplasia	❑ Hepatitis
❑ Bipolar Disorder	❑ High Cholesterol
❑ Blood Clot	❑ HIV

❑ Cancer (add comments below)	❑ Hypertension
❑ Chronic Fatigue	❑ Kidney Disease
❑ Congestive Heart Failure	❑ Kidney Stones
❑ COPD/Breathing Problems	❑ Leg/Foot Ulcers
❑ Coronary Artery Disease	❑ Liver Disease
❑ Cataracts	❑ Obesity
❑ Dementia/Memory Loss	❑ Osteoporosis
❑ Depression	❑ Pneumonia
❑ Diabetes	❑ Seizures
❑ Diverticulosis	❑ Stroke
❑ Eating Disorder	❑ Thyroid Disease
❑ Emphysema	❑ Tuberculosis
❑ Fibromyalgia	❑ Ulcers
❑ None	❑ Urinary Tract Infections

Comments:

2) Medications

List of Medications:	**Dosage:**

3) Allergies

Please List Any and All Allergies:

4) Surgical History (Check all that apply)

❑ Appendectomy	Date of Surgery:
❑ Cardiac Bypass Surgery	Date of Surgery:
❑ Cholecystectomy	Date of Surgery:
❑ Hernia Repair	Date of Surgery:
❑ Tonsillectomy	Date of Surgery:
❑ Skin Lesions Removed	Date of Surgery:
❑ None	

Comments:

5) Smoking Status

❑ Never Smoker
❑ Former Smoker Quit Date if Applicable:
❑ Current Everyday Smoker

6) Alcohol Use

Do you drink alcohol? Yes No

Type:

Drinks / Week:

7) Family History

First Degree Blood Relatives

	Mother	Father	Sister	Brother	Daughter	Son
Arthritis	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Dementia	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑
Diabetes- Type I	❑	❑	❑	❑	❑	❑
Diabetes- Type II	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
High Cholesterol	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Obesity	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Substance Abuse	❑	❑	❑	❑	❑	❑
Cancer (add comments below)	❑	❑	❑	❑	❑	❑

Comments:

8) Review of Systems:

❑ Fevers, Chills, or Night Sweats	❑ Blood in Urine
❑ Weight Loss or Gain	❑ Kidney Stones
❑ Chest Pain	❑ Pain in Calves When Walking
❑ Shortness of Breath	❑ Problems with Clotting
❑ Nausea/Vomiting	❑ Problems with Healing Wounds
❑ Diarrhea	❑ Depression or Anxiety
❑ Blood in the Stool	❑ Skin Rashes
❑ Abdominal Pain	❑ Easily Bruise
❑ Painful Urination	

Comments:

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Elite Surgical Specialists
385 State Route 24, Suite 1B
Chester, NJ 07930

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I hereby give my permission for **Elite Surgical Specialists** (the Practice) to give me medical treatment.

I allow the Practice to file for insurance benefits to pay for the care I receive.
I understand that:

- the Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
  I understand:
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

_____
Signature of Patient or Legal Guardian

Patient Name: _____

Date:_____

HIPAA Privacy Rule of Patient Authorization Agreement Authorization for Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for 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 health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness:_____

Patient Name: _____

Date:_____

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to_____and_____(collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to_____and_____ for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate' (including CH Revenue Management Solutions, LLC and Cohen Howard, LLP) under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name:_____ Date:_____

Patient Signature: _____

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Consent to Share Information with Family Members

I, _____, hereby give Elite Surgical Specialists permission to share my medical information with the following family members:

_____

_____

_____

Name of Patient/Guardian: _____

Signature of Patient/Guardian: _____

Date: _____