# AESTHETIC & RECONSTRUCTIVE SURGEONS, LLC

**PATIENT INFORMATION** This info is requested so that we can keep your records up to date and correct. Please fill in ALL required.

Last Name **(required)** First Name **(required)** ( ) Home Phone# **(required)**

Address **(required)** City State Zip

Social Security # **(required)** Date of Birth **(required)** Sex Age Marital Status Cell Phone#

Driver's License# State Email Address Work Phone#

Name of Employer Address City State Zip

Name of Referring Physician / Phone # **(required)** Primary Care Physician/Phone #

Address / Address

Pharmacy **(required)** Phone Number **(required)**

**EMERGENCY CONTACT INFORMATION**

Last Name First Name Home Phone#

Address Relationship

**INSURANCE INFORMATION** In order to file your insurance claim correctly, please fill ALL required information completely.

Insurance #1

Insurance Company Name **(required)** ID# **(required)**

Address **(required)** Group# **(required)**

City State Zip Group Name

Telephone# Effective Date Relationship to Patient [ ] Self [ ] Spouse [ ] Parent [ ] Child

Print Name of Subscriber **(required)** SS# of Subscriber **(required)** Sub Date of Birth **(required)**

Insurance # 2

Insurance Company Name **(required)** ID# **(required)**

Address **(required)** Group# **(required)**

City State Zip Group Name

Telephone# Effective Date Relationship to Patient [ ] Self [ ] Spouse [ ] Parent [ ] Child

Print Name of Subscriber **(required)** SS# of Subscriber **(required)** Sub Date of Birth **(required)**

I hereby assign the policy rights and benefits to the Doctor, and authorize direct payment for professional services rendered.

I further authorize the attending Doctor to release any information concerning my examination or treatment to my insurance company or any other physicians and medical facilities. I agree to be personally responsible for any unpaid balance or co-payment to the Doctor, and if I receive any payments from my insurance company in error, I will sign them directly over to the doctor.

**Patient Signature**

**Date**

Aesthetic & Reconstructive Surgeons, L.L.C.
113 WEST ESSEX STREET SUITE 202 MAYWOOD, NEW JERSEY 07607
(201) 487-3400 * Fax (201) 487-2481 * www.plasticsurgery-nj.com

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt as of the date set forth below a copy of the Practice's "Notice of Privacy Practices."

**Printed name of patient**

**Patient's Date of Birth**

**Signature of patient (or patient's personal representative)**

**Date**

If a personal representative signs:

Printed name of patient's personal representative

Relationship of personal representative to patient or personal representative's authority to act for the patient, if applicable

Date

AESTHETIC & RECONSTRUCTIVE SURGEONS, L.L.C.
113 West Essex Street , Suite 202, Maywood, New Jersey 07607
(201) 487-3400 ✧ Fax: (201) 487-2481 ✧ www.plasticsurgery-nj.com

Stephanie M. Cohen, M.D.
Richard M. Winters, M.D.

Reconstructive Microsurgery
Surgery of the Hand
Surgery of the Breast
Cosmetic Surgery

NAME:_____

PAST MEDICAL ILLNESS:_____
_____
_____
_____

LAST MENSTRUAL PERIOD:_____

# CHILDREN:_____
# PREGNANCIES:_____

PAST SURGERIES:_____
_____
_____
_____

PRESENT MEDICATIONS:_____
_____
_____
_____

HISTORY OF SMOKING AND ALCOHOL:_____
_____
_____
_____

NAMES OF OTHER PHYSICIANS:_____
_____
_____
_____
_____

ALLERGIES:_____
_____
_____
_____

PHYSICAL CONDITION (ie: exercise, activities):_____
_____
_____
_____

HEIGHT _____ WEIGHT_____

Aesthetic & Reconstructive Surgeons, L.L.C.
113 WEST ESSEX STREET SUITE 202 MAYWOOD, NEW JERSEY 07607
(201) 487-3400 * Fax: (201) 487-2481 * www.plasticsurgery-nj.com

**HIPAA-NJ PRIVACY MANUAL**

# CONSENT FOR USE AND DISCLOSURE FORM
## (For Treatment, Payment and Health Operations)

I _____ understand that in the course of providing care to me the Practice
*(Print Name)*
will receive, create, maintain and disclose information about me for the purpose of the Practice's and the other health provider's provision of treatment, securing payment from me, an insurer, other third-party payer or responsible party, and/or in connection with the health care operations of the Practice and/or the operations other health providers who have treated me and as otherwise required or permitted by State and/or Federal Law. I understand that a further description of these anticipated uses and disclosures of my health information appears in the Practice's Notice of Privacy Practices.

Except for genetic information, I agree to the sharing, utilization, examination and disclosure of any of my health information, including but not limited to known or suspected HIV/AIDS infection, mental health records, communicable diseases, substance abuse and/or treatment, if applicable, as is reasonably necessary by the Practice, its employees and the other members of its workforce for the limited purpose of rendering treatment, securing payment for treatment rendered and conducting the Practice's operations. I further agree to the disclosure by the Practice of such information, as is reasonably necessary, to other health providers involved in my treatment and their employees and the other members of their workforce for treatment, payment and health operations, to any private or governmental insurer, including Medicaid and Medicare and its intermediaries and agents, other third-party payers, or other financially responsible party for the purpose of determining benefits and securing payment, and as otherwise permitted by State and/or Federal Law.

This consent may be revoked at any time but, only to the extent that the Practice has not acted in reliance on it. If not previously revoked, this consent will remain valid as long as I am a patient of the Practice and for such period of time thereafter as is reasonably necessary to serve the purpose for which it was given; namely, the provision of treatment, securing payment for services rendered and conducting health operations.

_____
Date

_____
Signature of patient or legal representative
(if signed by a representative, print title
(e.g., parent/guardian, power of attorney)