LASER & VEIN center of North Jersey™

PATIENT INFORMATION

Patient's Name (Last, First, MI)	S.S.N. - -	Sex F M	Date of Birth	AGE

Mailing Address City State Zip	Email address: ◊ Please check if you do not want to receive promotional offers or discounts

Telephone numbers:

Cell: _____-_____-_____ Home: _____-_____-_____ Work _____-_____-_____ ext _____

Emergency Contact	Relationship	Phone - -

Insurance Carrier	Insurance ID/Policy #

Insurance Policy Holder Name	Mailing Address, if not same as above	DOB / /

How did you hear of our office and/or Services? ☐ Magazine Ad ☐ Email Promotion ☐ Insurance carrier ☐ Doctor ☐ Friend

If Doctor/ Friend, whom may we thank for referring you to Dr. Seaver _____

Communication Privacy Practice

Do we have permission to:

Leave a message on your answering machine/ mobile voicemail? Yes No

Leave a message at your place of employment? Yes No

Discuss your medical information with any member of your household? Yes No If yes, whom, and their relationship. _____

Signature _____ **Date** _____/_____/_____

Insurance Authorization and Assignment

I hereby authorize the release of any medical information that is needed for any utilization to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities.

If applicable, we will file your insurance claim for you. However, you are still responsible for all co-payments and/or balances as required by your specific insurance plan. If your insurance plan requires a referral, it is your responsibility to obtain this from your primary physician prior to your appointment.

I hereby assign the Laser & Vein Center of North Jersey all the payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance or any amount previously arranged with Dr. Seaver. I agree to pay any balance due in full no later than 30 days of statement date, unless prior arrangements have been made.

Signature or Authorized Representative

_____

Date _____/_____/_____

Appointment and Financial Policy

Per the appropriate financial policy, which is posted at the front desk, advance notice is required prior to my appointment for cancellation/postponement of all treatments or procedures; otherwise the applicable charge will be assessed.

- **10 business days notice** (2 weeks) for surgical procedures, CoolSculpting, and/or laser treatments or a **$200** assessment charge will be applied.
  Initials _____
- **2 business days notice** (48 hours) for consults, Sclerotherapy, injectable, and/or skin treatments or a **$75** assessment charge will be applied.
  Initials _____

If I do not cancel within the specified time provided above, I understand I will be charged an assessment fee. I understand that I, as the patient, am ultimately responsible for all fees pertaining to my appointments, treatments, procedures, and diagnostic tests.

I have read and understood the above policy.

Signature or Authorized Representative

_____

Date _____/_____/_____

Medicare Policy Holder

ID#_____

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Laser & Vein Center of North Jersey for services rendered to me by the physician who accepts assignment. I authorize any holder of medical or other information about me to release to the Centers for Medicare and its agents, intermediaries or carriers any information needed for this and/or related Medicare or other insurance claims. I permit a copy of this authorization to be used in place of the original I understand it is mandatory to notify my healthcare provider of any other party who may be responsible for paying my treatment, as mandated in Section 11228B of the Social Security Act and 31 U.S.C. 3801-3812.

Signature or Authorized Representative

_____

Date _____/_____/_____

Patient Name: _____ **Date of Birth:**_____

Race: ( ) Caucasian ( ) African American ( ) Hispanic ( ) Asian ( ) Other: _____

Preferred language:_____

Ethnicity:_____

Do you consume caffeine? Y / N _____cups per day

Do you drink alcohol? Y / N _____(how often)

Do you smoke? Y / N _____packs/day _____number of years Quit _____months / years ago

Do you exercise regularly? Y / N What type: _____

MEDICAL HISTORY

Height:_____ Weight:_____

BP:_____ Pulse:_____

Pneumonia Vaccine Administered: Y / N

Influenza Immunization administered: Y / N

Colorectal cancer screening performed: Y / N

Mammogram performed: Y / N

Please check off the appropriate space next to any condition for which you have a history or are receiving current treatment:

- ☐ **None**
- ☐ Mitral Valve Prolapse
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Chest Pain/Angina
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Pacemaker and/or Defibrillator
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Blood Clots
- ☐ Stroke
- ☐ Bleeding Disorder
- ☐ Blood Vessel Disease (thrombosis/phlebitis)
- ☐ Blood Transfusions
- ☐ High Cholesterol / High Triglycerides
- ☐ Intestinal Problems (colitis, IBS, Crohns)
- ☐ Stomach problems (heartburn / ulcer)
- ☐ HIV / AIDS)
- ☐ Asthma
- ☐ COPD
- ☐ Lung Disease (Bronchitis / Emphysema)
- ☐ Tuberculosis
- ☐ Supplemental Oxygen use
- ☐ Seizures
- ☐ Liver disease / Hepatitis / Cirrhosis
- ☐ Arthritis (Osteo)
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Ulcer
- ☐ Keliod Scarring
- ☐ Scleroderma
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Diabetic Neuropathy
- ☐ Cold Urticaria
- ☐ Paroxysmal Cold Hemoglobinuria
- ☐ Gallstones
- ☐ Back Problems
- ☐ Thyriod disease
- ☐ PCOS (polycycstic ovarian syndrome)
- ☐ Bladder issues (incontinence, infection)
- ☐ Migraine Headaches
- ☐ Cancer (type: _____)
- ☐ Melanoma / Skin Cancer
- ☐ Chemotherapy / Radiation
- ☐ Atypical Moles
- ☐ Porphyria
- ☐ Vitiligo
- ☐ Cold Sores/Fever Blisters
- ☐ Glaucoma
- ☐ Dry Eyes
- ☐ Anxiety / Depression
- ☐ Mental Illness
- ☐ Drug / Alcohol Addiction
- ☐ Raynauds

Other_____

Patient Name: _____ **Date of Birth:**_____

SURGERIES

Please CHECK OFF and/or list all surgeries that you have undergone:

☐ **None**	☐ Lung surgery	☐ Cardiac Bypass
☐ Hysterectomy	☐ Colon Resection / Colostomy	☐ Cardiac Stent / Catherization
☐ Tubal Ligation	☐ Stoma	☐ Heart Surgery
☐ D & C	☐ Thyroid surgery	☐ Abdominoplasty
☐ C-Section	☐ Ulcer	☐ Rhinoplasty
☐ Appendectomy	☐ Prothesis	☐ Face Lift
☐ Tonsillectomy	☐ Plates, pins, screws in bones	☐ Mastopexy / Breast implants
☐ Cholecystecomy (Gallbladder)	☐ Hernia Repair	☐ Blepharoplasty

Other_____

CURRENT MEDICATIONS

(Please include all prescription, over-the-counter medications, vitamins, supplements, and herbal preparations)

Name **Dosage** **Frequency**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

Do you have any food or drug allergies? Y / N If yes, please note _____

Are you allergic to latex? Y / N

Are you Allergic to shellfishor iodine? Y / N

Skin Allergies? Y / N (if yes, please explain: _____

Have you or anyone in your family ever had or have a history of unusual reactions or problems with **LOCAL anesthesia** (dental, freezing), **TOPICAL anesthesia** (anesthetic creams or gels) or **GENERAL anesthesia** (rashes, muscle weakness, jaundice, breathing problems or unexpected fevers)? Y / N

If yes, please explain: _____

Philip R. Seaver Jr., M.D.
Board Certified
248 Columbia Turnpike, Bld 3 Suite 1
Florham Park, NJ 07932
(973) 408-8346

Authorization to Disclose/ Release Protected Health Information (PHI)

_____ _____ / _____ / _____
Patient Name Date

The following individual(s) are authorized to request and receive copies of information within my PHI from LVCNJ:
(If there is no one you wish to authorize disclosure/release of your information, please leave blank)

- _____ _____
(name/relationship) (Telephone #)
- _____ _____
(name/relationship) (Telephone #)
- _____ _____
Primary Care Physician (Telephone #)
- _____ _____
Other Physician (Telephone #)

Authorization is for the disclosure/release of:
☐ Full medical record ☐ Doctor's notes ☐ Venous Doppler Study

The purpose for which disclosure/release is authorized:
☐ Medical Care ☐ Insurance ☐ Benefit Eligibility Other:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care.

I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or consent a claim.

By signing this Authorization, I authorize my Health Care Provider (Dr. Seaver and staff) to disclose my Protected Health Information (PHI). I hereby release LVCNJ, its employees, and physician from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____ / _____ / _____
Signature (Patient or Legal custodian/authorized representative) Date

_____ _____ / _____ / _____
Relationship to Patient (if signed by another party) Date

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Notice of Privacy Practices Patient Consent
For Use and Disclosure of Protected Health Information

_____ _____ / _____ / _____
Patient Name Date

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information (PHI).

I understand that LVCNJ may use or disclose my PHI for treatment, payment or health care operations- which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosure of this information without my authorization.

LVCNJ has a detailed document called the '***Notice of Privacy Practices***'. It contains a more complete description to your rights to privacy and how we may use and disclose PHI.

I understand that I have the right to read the '*Notice of Privacy Practices*' before signing this agreement. If I ask, LVCNJ with the most current copy of *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow LVCNJ to use and disclose my PHI to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that LVCNJ has taken action relying on this consent.

_____ _____ / _____ / _____
Signature (Patient or Legal custodian/authorized representative) Date

_____ _____ / _____ / _____
Relationship to Patient (if signed by another party) Date

You may obtain a copy of our *Notice of Privacy Practices,* including any revisions of our notice at any time by contacting: Laser and Vein Center of North Jersey at (973) 408-8346.

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HIPAA NOTICE OF PRIVACY PRACTICES

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" 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

Uses and Disclosures of Protected Health Information:

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

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to home health agency that provides care to you. For example your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used as needed, to obtain payment for your health care services. 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.

Health Care Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training or medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical-to-medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include; 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: Inmates: 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 the requirements of Section 164.500.

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 indicate in the authorization.

A full version of the HIPAA Notice of Privacy Practices is available in the Front Office and will be provided to the patient upon request.