Atlantic Surgical Group, P.A.

MARK R. SCHWARTZ, M.D., F.A.C.S.
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GENERAL * ADVANCED LAPAROSCOPY * BREAST
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Enclosed please find our patient information packet.

This packet must be completed before you arrive for your appointment.

Please bring the completed forms with you to your appointment - **DO NOT MAIL.**

1. Please **print** neatly in **black ink** only.
2. Please **fill out both front and back pages** of the patient registration form. It is very important for quality care that you answer all questions and check off the appropriate boxes.
3. Please **sign 3 pages** where indicated with an "X".

The following is required at the time of your appointment:

1. **Bring your insurance card(s).**
2. If your insurance requires a co-payment, you will be expected to make that payment at the time of your appointment.
3. If your insurance requires a referral from your primary care physician (PCP), then you **must** bring that referral at the time of your appointment in order for you to be seen (This is a rule that your insurance company insists upon).
4. Please have with you any films or reports that you were instructed to bring.

If you have any questions, please call our office and we will be happy to assist you.

Thank you in advance for your cooperation.

Atlantic Surgical Group, PA

PATIENT REGISTRATION

ATLANTIC SURGICAL GROUP, P.A.

PLEASE PRINT IN BLACK INK CAPITALS ONLY

PLEASE FILL OUT BOTH SIDES

Date_____

Marital Status (x one)

S__ M___ Sep.___ D___ W____

This section refers to **PATIENT ONLY**

First Initial Last

NAME_____

BIRTHDATE ____/____/____ SS#_____/_____/_____

ADDRESS_____

CITY_____STATE_____ZIP_____

SEX _____ AGE_____

HOME PHONE ( )_____

CELL PHONE ( )_____

WORK PHONE ( )_____

EMPLOYER_____

ADDRESS_____

CITY_____STATE_____ZIP_____

OCCUPATION_____

IS THIS JOB RELATED ☐ Yes ☐ No If yes, date_____

IS THIS MOTOR VEHICLE RELATED? ☐ Yes ☐ No

IF YES, DATE OF ACCIDENT_____

This section refers to **SPOUSE** or **SIGNIFICANT OTHER**

NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE ( )_____

CELL PHONE ( )_____

WORK PHONE ( )_____

BIRTHDATE ____/____/____ SS#_____/_____/_____

RELATIONSHIP TO PATIENT_____

OCCUPATION_____

EMPLOYER_____

ADDRESS_____

CITY_____STATE_____ZIP_____

CHECK (ONE) ☐ SPOUSE ☐ PARENT

☐ RELATIVE ☐ CARE GIVER ☐ SIGNIFICANT OTHER

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information for both carriers. Please list all numbers on your card(s). If you have a 3rd insurance please advise receptionist.

Primary Insurance Name_____

Address_____

_____

Phone #_____

Policy Holder/Subscriber

Name_____

Relationship of Patient to Subscriber

Self_____ Spouse_____Child_____Other_____

Insured ID No._____

Group No. & Company Name_____

Policy Holder's Birth Date_____

Secondary Insurance Name_____

Address_____

_____

Phone #_____

Policy Holder/Subscriber

Name_____

Relationship of Patient to Subscriber

Self_____ Spouse_____Child_____Other_____

Insured ID No._____

Group No. & Company Name_____

Policy Holder's Birth Date_____

*** Contact in case of emergency (someone not residing with you):**

Name:_____ **Address:**_____

Phone:_____ **Relationship**_____

I hereby authorize release of information necessary to file a claim / appeal with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand I AM FINANCIALLY RESPONSIBLE for any balance not covered by my insurance carrier. In the event my account is placed for collection with an attorney or agency. I will pay collection fees (33 1/3% of balance)
A copy of this signature is valid as the original.

Signature X_____

6/13 (TURN OVER)

PATIENT NAME _____ DATE _____ REFERRING MD _____

Your Primary Care Physician _____ Phone # _____

Your Cardiologist _____ Phone # _____

***BRIEFLY DESCRIBE REASON FOR YOUR VISIT** _____

Medical History	yes	no
diabetes	❑	❑
high blood pressure	❑	❑
sleep apnea (c-pap)	❑	❑
seizures	❑	❑
pneumonia	❑	❑
asthma	❑	❑
tuberculosis	❑	❑
emphysema	❑	❑
kidney disease _____	❑	❑
hepatitis A B C	❑	❑
liver disease	❑	❑
stomach ulcers	❑	❑
arthritis	❑	❑
anemia	❑	❑
thyroid _____	❑	❑
phlebitis	❑	❑
HIV	❑	❑
diverticulitis	❑	❑
colon cancer	❑	❑
gyn cancer - site _____	❑	❑
melanoma - site _____	❑	❑
other cancer - site _____	❑	❑
mental health _____	❑	❑
dementia	❑	❑

Any other information you feel may be important to the doctor _____

Surgical History	yes	no
gallbladder	❑	❑
appendectomy	❑	❑
hernia repair	❑	❑
hemorrhoidectomy	❑	❑
colon surgery	❑	❑
orthopedic surgery	❑	❑

If yes, body part _____

Titanium or Metal

Other surgery _____

Cardiac History	yes	no	year
cardiac surgery	❑	❑	_____
type			_____
pacemaker	❑	❑	_____
defibrillator	❑	❑	_____
stents	❑	❑	_____
heart attack	❑	❑	_____
heart valve disease	❑	❑	_____
irregular heartbeat	❑	❑	_____
stroke	❑	❑	_____

Social History	yes	no	If yes, amount
cigarette smoking	❑	❑	_____
cigar or pipe smoking	❑	❑	_____
alcohol use	❑	❑	_____

Quit/When _____

Family History	yes	no	Relative
melanoma	❑	❑	_____
diabetes	❑	❑	_____
heart disease	❑	❑	_____
colon cancer	❑	❑	_____
ovarian cancer	❑	❑	_____
breast cancer	❑	❑	_____
uterine cancer	❑	❑	_____

other _____

Female Patients please answer the following:

Date of last menstrual period _____

Date of last breast exam by a physician _____

Date of last mammogram _____

Age of first menstrual period _____

	yes	no
Personal history of breast cancer	❑	❑
Previous breast surgery:	❑	❑
biopsy	❑	❑
lumpectomy	❑	❑
mastectomy	❑	❑
implants	❑	❑

other _____

Please check yes or no for each of the following if you have experienced within the last 2 months

	yes	no		yes	no		yes	no
unexplained weight loss	❑	❑	incontinence	❑	❑	excessive gas	❑	❑
change in a skin lesion	❑	❑	chest pain	❑	❑	hemorrhoids	❑	❑
persistent headache	❑	❑	ankle swelling	❑	❑	indigestion	❑	❑
nosebleeds	❑	❑	palpitations	❑	❑	jaundice	❑	❑
neck pain	❑	❑	difficulty urinating	❑	❑	nausea	❑	❑
chronic cough	❑	❑	blood in urine	❑	❑	vomiting	❑	❑
wheezing	❑	❑	black or tarry stool	❑	❑	dizziness	❑	❑
breast mass	❑	❑	blood in stool	❑	❑	easy bruising	❑	❑
nipple discharge	❑	❑	constipation	❑	❑	back pain	❑	❑
gout	❑	❑	diarrhea	❑	❑			

Immunizations up to date? yes❑ no❑

Pneumonia vaccine? ❑yes ❑ no date _____

Colonoscopy last 5 years yes❑ no❑

Foreign travel within last year? yes❑ no❑

Pregnancy History / number of pregnancies _____

number of live births _____

Atlantic Surgical Group

List Medications /Vitamins/Supplements

(Please Print)

Patient Name_____ **Date:**_____

Local Pharmacy Name_____ **Location**_____

LATEX ALLERGY: Yes or No - If yes: Airborne or Touch **Do you take aspirin or blood thinner? YES NO**

ALLERGIES TO MEDICATIONS_____

Name of Medication (Print)	Dosage	Frequency taken

If you need additional sheets, we will be happy to provide them for you. Please ask the receptionist.

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Patient's Name_____Date_____

E-Mail address_____

What is the best way for us to contact you?

- ❑ home phone
- ❑ cell phone
- ❑ business phone

Do you have a living will?

- ❑ yes
- ❑ no

To comply with federal regulations, we are required to ask you to fill out the following items:

Race

- ❑ Caucasian
- ❑ African American
- ❑ Asian
- ❑ More than one Race
- ❑ other_____
- ❑ Prefer not to disclose

Ethnicity

do you consider yourself

Hispanic / Latino

- ❑ yes ❑ no
- ❑ Prefer not to disclose

Preferred Language (if other than English)_____

NOTICE OF PRIVACY PRACTICES
ATLANTIC SURGICAL GROUP

Effective Date: 10/2013

SUMMARY

WHAT IS THIS NOTICE FOR? This Notice of Privacy Practices (Notice) describes how ATLANTIC SURGICAL GROUP (We or Us) may use and disclose your medical information that we maintain and how you can get access to this information.

WHO ARE WE? ATLANTIC SURGICAL GROUP is a surgical practice which consists of all employed doctors, nurses, employees and other healthcare professionals. This Notice applies to these individuals as well as all services that are provided to you at our facility/any of our facilities.

WHY DO YOU NEED THIS NOTICE? The Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, places certain obligations upon us with regard to how we may use and disclose your ***personal health information*** (PHI). Your PHI includes medical information about you such as your medical record and the care and services you have received. We are committed to **maintaining the privacy** of your PHI. When we need to use or disclose it, we will comply with the full terms of this Notice. Anytime we are permitted to or required to share your PHI with others, we only provide the **minimum** amount of data **necessary** to respond to the need or request unless otherwise permitted by law.

WHEN CAN WE USE/DISCLOSE YOUR PHI? There are certain uses and disclosures of your PHI that we may undertake **without your written or other authorization.** These uses and disclosures may be for purposes such as to provide you with treatment, obtain payment for services we have provided, and other health care operations (such as administration, quality improvement, cost studies and other activities designed to improve the care we provide to all our patients). Some other examples include: PHI made known to your relatives, close friends, or caregivers, public health activities and officials, reporting of abuse or neglect as may be required by law, health oversight activities, judicial and administrative proceedings, law enforcement officials, workers' compensation, and other individuals and activities as set forth in this Notice. Individuals who may have access to your information **without your written or other authorization** may include doctors, nurses, health care students, and other hospital staff.

WE MUST OBTAIN YOUR WRITTEN AUTHORIZATION FOR ANY USE OR DISCLOSURE NOT SET FORTH IN THIS NOTICE. You may revoke this authorization AT ANY TIME. In addition to obtaining your written authorization for uses or disclosures not described in this Notice, we generally will also need to seek your written authorization or approval prior to disclosing the following information:

- HIV/AIDS related information

- Sexually transmitted disease information
- Tuberculosis
- Psychotherapy notes
- Mental health information
- Drug & alcohol information
- Genetic information
- Any information where you, if a minor, sought emancipated treatment (e.g., care related to your pregnancy or child, sexually transmitted diseases, etc)

We will also seek your **written authorization** for any "marketing" activities we may conduct or where we would receive money for providing a third party with your PHI.

WHAT RIGHTS DO YOU HAVE FOR YOUR PHI? You have the right to ask us to limit certain uses and disclosures of your PHI. We will consider ALL requests but may not be *required* to agree to your requested limitations. You also have the right to inspect and receive copies of your PHI, the right to request a change or amendment be made to your PHI, the right to an accounting (a list) of certain disclosures of your PHI, and the right to revoke any authorization you may have made to the extent we have not yet relied upon it. You also have the right to receive a paper copy of this Notice at any time.

CAN WE CHANGE THIS NOTICE? We may change this Notice **at any time.** The revised Notice will apply to all PHI that we maintain. However, if we do change this Notice, we will only make changes to the extent permitted by law. We will also make the revised Notice available to you by posting it in a place where all individuals seeking services from us will be able to read the Notice **as well as on our website at http://atlanticsurgicalgroup.com**. You may obtain the new Notice in hard copy as well from our Privacy Office.

ADDITIONAL INFORMATION/COMPLAINTS. You may contact our Privacy Office if you wish any additional information or have questions concerning this Notice or your PHI. If you feel that your privacy rights have been violated, you may also contact our Privacy Office OR file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. **We will NOT retaliate against you if you file a complaint with us or the Office of Civil Rights.**

Name (please print):_____

Signature:X_____ **Date:**_____

Please only disclose personal medical information to the following person(s):_____

THE ABOVE IS ONLY A SUMMARY OF THE RIGHTS AND OBLIGATIONS WITHIN THIS NOTICE. PLEASE READ CAREFULLY THE ENTIRE NOTICE THAT FOLLOWS. WE WELCOME ANY QUESTIONS YOU MAY HAVE.

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Financial Policy

Welcome to Atlantic Surgical Group. Our office has had a long standing reputation for the caring and sensitive treatment of our patients and their families We are committed to giving you the best care possible. Here is a summary of our financial policies. Please take the time to read this thoroughly.

Insurance Billing

Insurance policies have become increasingly complex over the years and it has become impossible for our office to know each specific plan and their limitations. Your insurance policy is a contract between you and your insurance company. Failure to comply with your insurance company requirements may result in lower or no payment. PLEASE REMEMBER THAT YOUARE RESPONSIBLE TO KNOW YOUR INSURANCE BENEFITS.

1. Co-Pays – a re due at the time of your visit. This is the rule of your insurance company. If you are unable to pay your co -pay at the time of your visit we will reschedule your appointment for the next available office time.
2. Referrals – if required by your insurance company you must have your referral at the time of your visit. If you do not have your referral we will reschedule your appointment for the next available office time.
3. Medicare – we participate with Medicare. We will file to Medicare and your secondary/supplemental plan You will be responsible for any balance due to deductibles, co-insurances, or co-pay that is determined by your plans. If you do not have a secondary/supplemental plan we require the Medicare 20% co-insurance to be paid at the time of visit.
4. In Network Insurance – we will file to your insurance company first. You will be responsible for any balance due to a deductible, co-insurance or co-pay that is determined by your plan. If we do not have a response from your insurance company within 45 days you will be responsible for the balance.
5. Out of Network / Self Pay – Payment in full is due upon completion of the visit. As a courtesy we will file to your out of network insurance for your reimbursement.

Charges / Fees

Appointments– $25.00 service fee will be due if you miss an appointment or do not give the proper notice. W e require 24 hour notice for cancellation and rescheduling of appointments.

Late fee / Collection – $10.00 late fee will be added to your bill if a payment or payment arrangement is not made within 30 days. If you have not made any payments or payment arrangements within 90 days your account will be considered seriously delinquent and will be forwarded to our outside collection agency.

Returned Checks – $20.00 service charge will be added to your bill if a check is returned to us by your bank.

Disability Forms– $10.00 service charge is due for each Disability, Medical Leave, or Supplemental Insurance form filled out. (Not applicable for New Jersey State Disability Forms)

Our office accepts cash, checks, and credit card payments for your convenience. Our office is here to help you. If you have any questions regarding our financial policies please do no hesitate to contact us.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS OF THE ABOVE FINANCIAL POLICY.
A COPY IS AVAILABLE UPON REQUEST. THANK YOU FOR YOUR COOPERATION.

PRINT PATIENT NAME X _____

SIGN PATIENT NAME X _____ DATE _____