WELCOME
MONMOUTH PLASTIC SURGERY
DR. GREGORY A. GRECO

NAME (LAST)_____ (FIRST)_____

ADDRESS_____

CITY_____STATE_____ZIP_____

D.O.B_____-_____-_____ AGE_____ GENDER M / F S.S.#_____-_____-_____

PHONE# (_____)_____-_____ CELL# (_____)_____-_____

EMAIL ADDRESS_____ May we contact you via email? **Y / N**

MARRIED_____SINGLE_____DIVORCED_____WIDOWED_____PARTNERED_____

PARENT/GUARDIAN OF CHILD_____

EMERGENCY CONTACT_____
LAST FIRST

RELATION _____
Phone # (_____) _____-_____

EMPLOYER_____TITLE_____
ADDRESS_____PHONE_____EXT_____

PRIMARY CARE PHYSICIAN_____
LOCATION_____PHONE_____

PHARMACY_____
LOCATION_____PHONE_____

INSURANCE INFORMATION
NAME OF INSURED_____D.O.B._____-_____-_____
CARRIER_____
POLICY #_____GROUP #_____
CARRIER ADDRESS _____
PHONE_____
PLEASE HAVE CARD AVAILABLE FOR PHOTOCOPY

Is your visit related to a car accident or work injury? Yes_____No_____

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier. I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to DR GRECO or the group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. In the event my account is placed in collection with an attorney or agency, I will pay the collection fees (33 1/3 of balance and all court costs incurred by the doctor in addition to my balance.) A copy of this signature is valid as the original.

SIGNATURE_____**DATE**_____

MONMOUTH PLASTIC SURGERY
PATIENT HEALTH HISTORY

HEIGHT _____ WEIGHT_____
ALLERGIES TO DRUGS:_____
TAPE: _____ LATEX:_____

CURRENT MEDICATIONS: _____
VITAMINS: _____
HERBAL MEDICATION / DIET PILLS: _____

DO YOU TAKE MOTRIN, ADVIL OR ASPIRIN REGULARLY? **Y/N**

LAST TETANUS SHOT _____-_____-_____

ARE YOU CURRENTLY OR HAVE YOU EVER BEEN TREATED FOR:

ASTHMA	Y/N	**DIABETES**	Y/N	**HIGH BLOOD PRESSURE**	Y/N
STROKE	Y/N	**CANCER**	Y/N	TYPE_____	
HEART DISEASE	Y/N	**INTESTINAL**	Y/N	**THYROID**	Y/N
VASCULAR	Y/N	**BLOOD D/O**	Y/N	**HEPATITIS**	Y/N
HIV	Y/N	**SKIN DISORDER**	Y/N		
NEUROLOGICAL DISEASE	(MS, Myasthenia Gravis, etc)		Y/N		

Do you have bleeding disorders or do you bruise easily?_____
Have you ever used anabolic steroids or growth hormone? Y / N

SURGICAL HISTORY - *PLEASE LIST ALL PREVIOUS OPERATIONS AND YEAR*

_____
_____
_____

TOBACCO USE Y / N

Cigarettes / Packs per day? _____
What year did you start smoking? _____

ALCOHOL USE Y / N

Frequency:Daily_____ Weekends_____ Rarely_____

FAMILY HISTORY

Cancer_____ Collagen / Vascular Disease_____ Melanoma_____
Hypertension_____ Skin Cancer_____ Other _____

BREAST HISTORY

LAST MAMMOGRAM _____-_____-_____ **RESULT**_____
Lumps/masses?_____ Nipple discharge? **Y / N**
Is there a family history of breast cancer? **Y / N**
Relation to patient: _____
Current breast cup size (if applicable): 30-32-34-36-38-40 A B C D DD DDD

REASON FOR TODAY'S VISIT: _____

IS TODAY'S VISIT A COSMETIC CONSULTATION Y / N

Please list the specific areas you would like addressed in your consultation:_____

How did you hear about us?

Friend_____ Phone book _____ Newspaper_____ Television_____
Facebook_____ Hospital Referral_____ Physician_____ Internet_____
Please list the name of your referral (optional)_____
May we thank them for referring you? Y / N

MONMOUTH PLASTIC SURGERY
DR. GREGORY A. GRECO

CONSENT FOR DISCLOSURE OF PATIENT INFORMATION

The Privacy Rule that is contained in HIPAA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations (TPO) purposes, except in emergency situations.

The following information must be included in a medical record release form used by the practice to be in compliance with HIPAA requirements.

I understand that by giving consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment; it may also be used for payment and operational purposes. I have the right to review Dr. Gregory A. Greco "notice of privacy practices" before I sign this consent. The provider reserves the right to change the terms of the notice of privacy practice. Change in the privacy practices will be made available to me. I may request additional restrictions on access to this information for treatment, payment, or health care operations purposes. I understand that the provider may not be able to comply with this request. I request the following special restrictions:

_____

_____

I understand that from time to time my physician and his/her staff may inform me of new drugs, treatments, or other services that may be appropriate for my condition and from time to time may inform me of new services that may be appropriate for a person in my situation (age, sex, etc). I consent to the use of my identifiable patient information to notify me such new drugs, treatments, or other services that may be necessary for the continuity of my care or which may benefit in maintaining or improving my health with the understanding that the provider will not provide such information to others for marketing, fund-raising, or similar purposes without my specific consent.

I understand that I, or my representative, promptly upon request, may inspect, request correction of and obtain information from my medical record.

I may revoke this consent in writing at any time except to the extent that the provider has already acted in reliance on this consent.

Name:_____ **Date:**_____

Monmouth Plastic Surgery
Insurance Submission and Patient Responsibility

At Monmouth Plastic Surgery we are happy to provide you with the courtesy of submitting all insurance information necessary to process your claim and to receive payment directly from your insurance company. In order for us to provide these services, you must agree to the following:

- **Provide us with current insurance cards and photo ID.**
- **Forward any reimbursement checks and Explanation of Benefits from your insurance company. These items should be forwarded to Dr. Greco upon receipt. Please endorse checks and print "Make Payable to Monmouth Plastic Surgery" on the back.**
- **Pay any difference between the amount billed and the amount paid by the insurance company.**

Please note that all visits related to a surgery or emergency room care are included in a 90 post-operative period. After this time, a claim will be sent to your insurance company for reimbursement towards any new care.

Monmouth Plastic Surgery will estimate, to the best of our ability, the amount of benefit that your insurance company will provide. Monmouth Plastic Surgery is not responsible for any difference between the estimate and the amount that your insurance company actually pays. Each patient is personally responsible for the payment of his/her balance if the insurance benefit does not cover services in-full.

Our office will submit all necessary forms and information required to process your claim, and in some cases contact your company in an attempt to obtain your rightful benefits under your policy. You may be responsible for negotiating with your insurance company in the event of a disputed claim. We can provide you with any information or advice necessary if you need to make an inquiry to your health insurance provider.

Please sign below to indicate that you have READ, UNDERSTOOD and AGREE to the above policy.

Name: (Please Print)_____

Signature:_____ Date:_____

Witnessed by: _____

Monmouth Plastic Surgery

Dr. Gregory A. Greco

Notice of Privacy

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information" or PHI. It includes information that can be used to identify you that we have created or received about your past, present, or future health condition, the provision of care to you, or the payment of this healthcare. We must provide you with this notice about our privacy practices that explains how, when, and why we used and disclosed your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use and disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies we will promptly change this notice and post a new notice in the main reception area. You can also request a copy of this notice from the contact person listed in Section IV below at any time.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures we need your prior consent or specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Require Your Written Consent.

We may use and disclose your PHI with your consent for the following reasons:

1. **For treatment**. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.

2. **To obtain payment for treatment**. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.

3. **For health care operations**. We may disclose your PHI in order to operate this practice. For example, we nay use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. Exceptions to consent requirements for treatment, payment, and health care operations. Although your consent is required for numbers 1-3 of this section, above, we may disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment as long as we try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) and we think you would consent if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent

We may use and disclose your PHI without your consent or authorization for the following reasons:

1. When a disclosure is required by federal, state, or local law, judicial, or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or when ordered in a judicial of administrative proceeding.

2. For public health activities. For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

3. For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

4. For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

5. For research purposes in certain circumstances we may provide PHI in order to conduct medical research.

6. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

7. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

8. For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.

9. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

C. Use and Disclosure Where You to Have the Opportunity of Object:

   1. Disclosure to family, friends, or others. We may provide your PHI, to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. All Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures to the extent that we haven't taken any action relying on authorization.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You may have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request we will put any limits in writing and abide by them except in emergency situations. You may not limit that uses and disclosures that we are legally required or allowed to make.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, email instead of regular mail). We must agree to your request so long as we can easily provide it in that format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30

days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have a denial reviewed.

If you request copies of your PHI, we will charge you $1.00 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections and law enforcement personnel, or before April 1, 2003.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $10.00 for each additional request.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of information is missing you have the right to request that we correct the existing information or add the missing information. We will respond within 60 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct (ii) not created by us (iii) not allowed to be disclosed, or (iv) not part of our records.

Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the changes to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get this Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W., Room 615F, Washington, D.C. 20201. We will take no retaliatory action against you and your benefits will not be affected if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please call the Office of Civil Rights at 866-627-7748.

Signature_____ **Date**_____