



Name: _____

Date of Birth: _____

Today's Date: _____

Please explain in your own words what brings you to our office today to see Dr. Spiro:

Have you ever tested positive for COVID? _____

If yes, please provide the date(s) _____

Have you been vaccinated against COVID? _____

If yes, please provide the date(s) _____



Patient Information

Today's Date _____

Patient Name: _____

Home Address: _____

City, State, Zip Code: _____

Date of Birth: _____ Age: _____ Social Security # _____

E-mail Address: _____ Marital Status: Married _____ Single _____ Others _____

Cell Phone: _____ Home Phone: _____

Patient's Occupation: _____ Employer: _____

Business Address: _____

Business Phone: _____

Significant Other's Name: _____ Significant Other's Occupation: _____

Internist/Primary Care Doctor (Name and Phone Number): _____

Internist/Primary Care Doctor Address: _____

Purpose of Initial Consultation (Please check the procedure(s) that you are interested in):

- | | | | | |
|---|---------------------------------------|---|--|--|
| <input type="checkbox"/> Brow Lift | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Fat Grafting | <input type="checkbox"/> Breast Reconstruction | <input type="checkbox"/> CoolSculpting |
| <input type="checkbox"/> Face Lift | <input type="checkbox"/> Tummy Tuck | <input type="checkbox"/> Breast Lift | <input type="checkbox"/> Vaginoplasty | <input type="checkbox"/> Ear Surgery |
| <input type="checkbox"/> Eyelid Surgery | <input type="checkbox"/> Gynecomastia | <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Other Body Contouring |

Med Spa:

- Wrinkle Treatment Brown Spot Treatment Acne Treatment Botox
- Fillers (Juvéderm) Microneedling Diamond Glow

Emergency Contact Name/Phone #: _____ Relationship: _____

Injuries: Is your consultation related to a work injury, Motor Vehicle Accident (MVA) or other injury? If yes, please explain:

Patient Name: _____ Patient Date of Birth: _____

Insurance – PRIMARY (Please fill out completely)

Primary Insurance Company _____

Claims Address _____

Telephone Number _____

ID # _____

Subscriber/Insured _____

Group Name/# _____

Subscriber Soc Sec # _____

Subscriber Employer _____

Subscriber Birth Date _____

Relationship of Patient to Subscriber _____

Insurance – SECONDARY (Please fill out completely)

Secondary Insurance Company _____

Claims Address _____

Telephone Number _____

ID # _____

Subscriber/Insured _____

Group Name/# _____

Subscriber Soc Sec # _____

Subscriber Employer _____

Subscriber Birth Date _____

Relationship of Patient to Subscriber



How Did You Hear About Us?

Please take a moment to tell us where you heard about our office
Check all that apply. Please remember all information is confidential.

Online Review Sites

- Yelp! Google+ Realself American Society Plastic Surgeons Other: _____

Practice sites online

- Drspiro.com
 Instagram @SpiroPlasticSurgery
 Twitter @DrScottSpiro
 Facebook Spiro Plastic Surgery, LLC.

Print Media, Advertisements, Articles and/or Interviews:

- Suburban Essex Vicinity Magazine Bergen Health & Life NJ Top Docs
 NJ Monthly Morris Essex Health & Life Montclair Magazine Other: _____
- Physician Referral: _____
 Patient Referral: _____
 Friend of a Friend: _____
 Other Source (Please Specify): _____

Which referral / advertisement helped most in making your decision to visit our office?

Patient Name: _____ Patient Date of Birth: _____

Medical History

Height: _____ Weight: _____ Weight change in the past year: _____ Loss/Gain

Date of last physical ____/____/____ Location of last physical _____

Did your last physical include any of the following (please circle): EKG/ Blood work/ Chest X-Ray/ Stress Test/ Other

Pharmacy Information: (for prescriptions) _____

MEDICATIONS: Please list all medications, vitamins, supplements, and herbals that you take daily and as needed**:

Medication Name	Dosage	How Often Taken	Reason for Taking	Prescriber (physician)

**Please attach a separate sheet of paper with additional medications, supplements, vitamins, and herbals as needed.

ALLERGIES: Please list all allergies to any drugs, foods, environmental factors, or others with reactions below:

No Known Allergies

MEDICAL CONDITIONS/ILLNESSES: Have you ever been diagnosed with or had the following (please circle and explain):

Acid Reflux	Bowel Obstruction	High Blood Pressure	MRSA or VRE
Adhesive Allergy	Brain/Neurologic Disorder	High Cholesterol	Other Heart Condition
Anemias	Breast Biopsies	Hormonal Imbalance	Other Skin Disorders
Anxiety	Cancer	Hyperthyroidism	Pneumonia
Arthritis	Chemotherapy	Hypothyroidism	Psoriasis or Eczema
Asthma	Dental problems	Kidney problems	Radiation
Attention Deficit Disorder	Depression	Large Scars or Keloids	Reactions to Anesthetics
Back Problems	Diabetes	Latex Allergy	Reproductive Problems
Bipolar Disorder	Dry Eye	Learning Disorder	Seizures
Bleeding Disorder	Facial Surgery	Liver Disease	Sinus Problems
Blood Clots	Frequent infections	Lung Problems	Stroke
Body Dysmorphic Disorder	Heart Arrhythmia	Mental Illness	Ulcers
Bone or Joint Disease	Heart Attack	Metabolic Issues	Urinary Problems
Bowel Intestinal Disorders	Hernia	Motion Sickness	Vascular Disease

Please Explain: _____

Pertinent Family History: _____

PRIOR SURGERIES AND HOSPITALIZATIONS (please list all, including cosmetic procedures):

DATE	SURGERY OR ILLNESS	HOSPITAL AND PHYSICIAN

Have you ever had a reaction or adverse event related to anesthesia? Yes _____ No _____

If yes, please explain: _____

Have you or a member of your family ever had a history of malignant hypothermia? Yes _____ No _____

MEDICATION/SUPPLEMENT WARNING!

For a minimum of **THREE (3) WEEKS** prior to any surgical procedure, please avoid the following medications, dietary supplements and herbal teas/remedies. Please disclose EVERY prescription/non-prescription medication, supplement, suspension, oil, etc. that you consume.

PLEASE NOTE: If you take aspirin, Lovaza, an antidepressant, or any other medication under the direction of a physician, check with your doctor *prior* to stopping any medication. Do not resume taking these substances after your surgery until approved by the doctor.

PLEASE CIRCLE ANY YOU ARE TAKING

Common Over-The-Counter/
Prescription Pain Relievers

- * Advil
- * Motrin
- * Aleve
- * Aspirin
- * Bufferin
- * Excedrin
- * Ibuprofen
- * Naprosyn
- * Ketaprofen capsules
- * Alka-Seltzer

Common Vitamins

- * Multi-Vitamins
- * Vitamin E

Herbals and Other

- * Alfalfa
- * Appetite Suppressants
-i.e. Phentermine
- * Berdock Tea
- * Bildberry
- * Biotin
- * Chamomile Tea
- * Cayenne
- * CBD Oil

- * Chinese Herbs
- * Chinese Herbal Teas
- * Chinese root extract
- * Coenzyme Q10 (CoQ-10)
- * Colon Cleanse
- * Damiana Tea
- * Dandelion Tea
- * Dong Quai Root
- * Energy Drinks
- * Fennel Tea
- * Feverfew
- * Fish Oil (Alpha Omega)
- * Flax Seed Supplement
- * Garlic (allium sativum)
- * Ginger
- * Gingko
- * Gingkobiloba
- * Glucosamine
- * Goldenseal
- * Green Tea
- * Guarana
- * Hawthorn Tea
- * Herbal Supplements
- * Herbal Teas
- * Holistic Medications
- * Horse Chestnut
- * Hydroxycut

- * Kava Tea
- * Lavender/ Valerian Root
- * Licorice Root
- * Licorice Tea
- * Lovaza
- * Ma Huang (Ephedra)
- * Melatonin
- * Natural Medications
- * Papaya
- * Protein Supplements with
Vitamins in them (without
vitamins is okay)
- * Selenium
- * Seroquel
- * Skull Cap Tea
- * St. John's Wart Tea
- * System Detox
- * Willow Bark
- * Yellow Root
- * Yarrow Tea
- * Yohimbe (The Natural
Viagra)
- * Sumatra Coffee (Starbucks)

Any Additional _____

Aspirin and aspirin-containing products, some dietary supplements, "nutraceuticals", and even teas have all been linked to prolonged bleeding which complicates surgery, delays healing, produces more bruising, and may lead to *emergent re-operation* for continued bleeding after surgical procedures. If you need to take an aspirin-free fever reducer/pain reliever prior to your procedure, we recommend Tylenol, or the generic equivalent Acetaminophen.

Alcohol – Patients should not consume any alcoholic beverages for a minimum of ten (10) days prior to any surgical procedure.

Hormones- Hormones such as estrogen and progesterone from birth control, intrauterine devices, and bioidentical hormones, hormone replacement therapy, selective estrogen replacement modulators, and aromatase inhibitors can increase your risk of blood clots during surgery and contribute to complications like Deep Venous Thrombosis and Pulmonary Embolism. We recommend hormones be discontinued for 4 weeks prior to surgery with the consent of your prescribing physician.

Patient Initials _____

Patient Name: _____ Patient Date of Birth: _____

Pertinent Clinical Information

Do you smoke cigarettes or use a vape? Yes _____ No _____ Quit (date) _____

Do you use nicotine patches, nicotine chewing gum, or nicotine lozenges? Yes _____ No _____

When was your last cigarette or use of nicotine products? _____

Does anyone in your household smoke? Yes _____ No _____

Do you smoke marijuana, use edibles, or vape? Yes ___ No _____ If yes, how often _____

Do you use any other recreational drugs? Yes ___ No ___ If yes, what kind and how often? _____

Caffeine consumption (number of drinks per day): Coffee _____ Tea _____ Soda _____ Energy drinks _____

Alcohol consumption (number of drinks per week and what kind): _____

Do you or have you ever taken steroid medications, cortisone, or ACTH? Yes _____ No _____

Do you use any workout supplements? Yes _____ No _____ If yes, what kind and how often? _____

Do you use any other herbal or nutritional or herbal supplements? Yes _____ No _____ If yes, what kind and how often _____

Have you ever had any psychiatric or psychological care (including therapy)? Yes _____ No _____

If yes, please explain: _____

Do you have any significant emotional problems? _____

Do you have any lifestyle factors that would prevent you from consenting to a blood transfusion? Yes ___ No ___

If yes, please explain: _____

WOMEN ONLY:

How many times have you been pregnant? _____

How many children do you have? _____

How many miscarriages have you had? _____ Have you ever had an ectopic pregnancy? _____

Are you planning more children? _____

Are you pregnant now? _____

Have you breastfed in the past? Yes _____ No _____ When was your last latch? _____

Did you have any complications during your pregnancy? Yes _____ No _____

If yes, please explain: _____

When was your last menstrual cycle? _____

Date of last mammogram? _____ Facility: _____

Are you currently using contraception's? Yes _____ No _____

If so, what kind? IUD _____ Birth Control Pills _____ Other _____

For breast procedures: What size bra are you currently wearing and how do you feel that it fits? _____

Coagulation Questionnaire

Part of the normal healing process after surgery involves an interaction with your coagulation system. It is important that we understand how your coagulation system will respond to surgery. Therefore, please take a moment and complete the following checklist.

- 1) Do you have a history of varicose veins? Yes / No
- 2) Do you have a history of inflammatory bowel disease? (*Not Irritable Bowel*) Yes / No
- 3) Do you currently have swollen legs? Yes / No
- 4) Have you ever been diagnosed with congestive heart failure? Yes / No / NA

If YES, explain _____

- 5) Have you been diagnosed with sepsis within the last 6 months? Yes / No

If YES, explain _____

- 6) Have you been diagnosed with pneumonia within the last 6 months? Yes / No

If YES, explain _____

- 7) Have you ever been diagnosed with abnormal pulmonary function including COPD or emphysema? Yes / No

If YES, explain _____

- 8) Do you have a central venous access port? Yes / No

- 9) Do you have a history of deep venous thrombosis (DVT) or pulmonary embolism (PE), or blood clots anywhere else in your body? **If YES, explain** _____ Yes / No

- 10) Do you have a family history of DVT, PE, or any other clotting issues including excessive bleeding? Yes / No

- 11) Have you ever been diagnosed with any of the following:

Factor V Leiden?	Yes / No	Elevated anticardiolipin antibodies?	Yes / No
Prothrombin 20210A?	Yes / No	Heparin-induced Thrombocytopenia (HIT)?	Yes / No
Elevated serum homocysteine levels?	Yes / No	Congenital or Acquired thrombophilia?	Yes / No
Positive lupus anticoagulant?	Yes / No	Any other type of abnormal clotting?	Yes / No

- 12) Have you had a hip, pelvis, or leg fracture within the last month? Yes / No
- 13) Have you had a stroke or transient ischemic attack within the last month? Yes / No
- 14) Are you currently taking oral contraceptives or hormone replacement therapy? Yes / No / NA
- 15) Have you ever had any miscarriages? How many? _____ Yes / No / NA
- 16) Do you have a history of unexplained stillborn infant, recurrent spontaneous abortion/miscarriage (>3), premature birth with toxemia or growth-restricted infant? Yes / No / NA

- 17) Are you currently taking any medications that are blood thinners, such as aspirin, anti-inflammatory medications, anti-platelet medications, Warfarin, Pradaxa, Aggrenox, Plavix, Pletal, Vitamin E, Herbals, or Homeopathic substances? Yes / No

- 18) Are you currently taking an SSRI or MAOI (anti-depression medication)? Yes / No

- 19) Have you ever required a blood transfusion because of excessive bleeding? Yes / No

- 20) Do you commonly have heavy menses? Yes / No / NA

- 21) Do you experience nosebleeds more often than several times a year? Yes / No

- 22) History of COVID-19? Last known positive test: _____ Yes / No

Patient Name: _____ Patient Date of Birth: _____



Authorization to Disclose Protected Health Information (PHI)

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is also called "protected health information" under HIPAA's Privacy Rule. I understand that if the person or entity receiving this information is not a health plan or health care provider covered by the federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Name of Individual/Company to Whom Disclosures May Be Made To:

Name:	Relationship:	PHI	Financial Information
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Limitations of Disclosure: Please describe any limitations you would like on the disclosure of your PHI and/or Financial Information: _____

I understand that I may revoke this permission, in writing, at any time. Revoking permission, however, does not affect previous disclosures that were made with my consent.

 Print Name Signature of Patient or Legal Guardian Date

Authorization to be Contacted Through Alternate Means

I hereby request to be contacted through alternate means. I understand that in the course of doing so, my PHI may be viewed by individuals I did not intend. I understand that I may revoke this request in writing, at any time. Please describe the specific means you would like employed, including alternate address, phone numbers, e-mail addresses, etc.:

 Print Name Signature of Patient or Legal Guardian Date

Authorization to be Contacted by Text Messaging (data rates may apply) and E-Mail

- I consent to be contacted by e-mail regarding notifications that documents have been uploaded to my patient portal and for promotions/special events within the office.
- I consent to be contacted by text messaging regarding upcoming appointments and rating services.

 Print Name Signature of Patient or Legal Guardian Date



Financial Policy Agreement for Spiro Plastic Surgery

CONSULTATION FEES: Patients who wish to discuss multiple surgical procedures and/or treatment of multiple body regions may be charged an additional fee. Consultations that are functional in nature may be submitted to insurance and subject to deductible, co-insurance, and co-pay. If consultations are both cosmetic and functional, they may be subject to both an out-of-pocket consultation fee as well as a billable charge to your insurance carrier.

- **CONSULTATION CANCELLATION POLICY:** Patients who cancel their consultation within two business days of their appointment will be subject to a pre-payment for rescheduling a future consultation, which will be non-refundable.

ACCEPTED METHODS OF PAYMENTS: for services provided by our office, we accept cash, bank checks, money orders, Visa, MasterCard, Discover, and American Express. Personal checks are only accepted three weeks prior to the date services are rendered. There is a fee of \$30.00 for returned checks.

IN-NETWORK/PARTICIPATING INSURANCE: Dr. Spiro participates with Horizon Blue Cross Blue Shield of New Jersey and all covered services rendered by Spiro Plastic Surgery, LLC will apply toward your in-network benefits. Please note that Dr. Spiro does NOT participate with Horizon NJ Health or Horizon Medicare Advantage Plans. Please advise our front desk staff if you have one of these plan types.

- **COVERED SERVICES:**

- ***Approved Surgeries:*** If you meet the criteria for coverage, we will initiate all pre-certifications/pre-determinations required for medically necessary procedures prior to your surgery and notify you of the outcome. Prior to your approved procedure, we will collect your in-network co-pays, deductible, and co-insurance per the terms of your plan. We will submit all approved procedures to your insurance carrier on your behalf.

- **NON-COVERED SERVICES:**

- ***Non-Covered Surgeries:*** If your procedure does not meet criteria for coverage under your plan provisions, we will collect 100% of the surgical fee in advance of your procedure, due three (3) weeks prior to surgery. Although we may be participating with your plan, this does not mean that all services rendered by Spiro Plastic Surgery, LLC are covered under the terms of your plan provisions. All procedures that are submitted to insurance and denied as a non-covered service will be your financial responsibility.

OUT-OF-NETWORK/NON-PARTICIPATING: Your insurance is a contract between you and your insurance company; our office is not a party to that contract. This contract may include limitations or exclusions of coverage. We strongly recommend that all patients obtain a complete copy of their insurance documents and become familiar with the provisions of their plan. Regardless of whether the services provided by our office are covered by your insurance plan, you are ultimately responsible for 100% of our total billed charges. Our office does not have to accept what your insurance company determines to be the "allowed amount" for a claim. Dr. Spiro is a non-participating provider with all health insurance plans except Horizon Blue Cross Blue Shield of New Jersey. Therefore, any eligible healthcare claims would be processed under the out-of-network provisions of your policy.

- **FEES:** Our fees may not be considered usual, customary and reasonable (UCR) by your insurance company. Dr. Spiro is an experienced surgeon, highly specialized in Plastic and Reconstructive Surgery. Accordingly, his fees may be higher than some providers in the region. We encourage you to contact your insurance carrier to determine approximately what your out-of-pocket expense will be.
- **OUT-OF-NETWORK INSURANCE SUBMISSIONS:** As a courtesy to our patients, our office will submit a letter of pre-determination, initiate a pre-certification, and/or file a claim on your behalf with your commercial/private insurance plan as appropriate. You must provide our office with all necessary information, including demographic information on the patient and the insured party/subscriber, addresses, telephone numbers, a copy of your current insurance identification card, etc. Our office may require your cooperation with obtaining insurance correspondence such as (but not limited to) explanation of benefits and claim submissions.

- **COSMETIC PROCEDURES:** Procedures deemed cosmetic in nature will not be submitted for pre-certifications or pre-determinations to your insurance carrier.
- **MEDICARE:** – Effective April 1, 2011 Dr. Spiro has “opted out” of the Medicare system and may enter into private contracts with Medicare beneficiaries. As such, patients must accept full responsibility for payment of Dr. Spiro’s fees for all services rendered. Medicare limiting charges do not apply to Dr. Spiro’s services. Our office cannot submit claims to Medicare for services provided by Dr. Spiro. Similarly, Medigap plans and other supplemental plans may elect not to make payment for services rendered by Dr. Spiro as he is opted out of Medicare.
- **MEDICAID** – Dr. Spiro does not participate with Medicaid or any Medicaid plans administered through other carriers. Please advise our office if you have a primary or secondary Medicaid plan.

INSURANCE PAYMENTS: Our practice may be notified by your insurance carrier that you have received an insurance check/ACH payment. Should you receive an insurance payment for services rendered by Spiro Plastic Surgery, LLC, you will be responsible for reimbursing our office within seven (7) days of receipt with a copy of the explanation of benefits. If you have not received any insurance correspondence, it is your responsibility to follow-up with the insurance carrier immediately. Non-payment to our practice may result in default of your account and subsequent placement with an attorney or bonded collection agency.

COLLECTIONS: In the event a patient balance exceeds 90 days, the undersigned authorizes Spiro Plastic Surgery, LLC and/or their authorized agent to verify any information provided in the Patient Information Sheet/Online Medical History, now or in the future, and/or obtain additional information by securing data from a credit reporting agency. In addition, the undersigned agrees to pay a thirty percent collection fee in the event of default on their account, if the account is placed with an attorney or bonded collection agency.

CREDIT CARD DISPUTES: If you engage your credit card company by disputing a charge, you are hereby authorizing Spiro Plastic Surgery, LLC to share details regarding appointments, treatments, and purchases with your credit card company, thereby relinquishing your HIPAA rights as it pertains to the financial dispute.

APPOINTMENT SCHEDULING FEES, LATE FEES, AND CANCELLATION FEES:

Spiro Plastic Surgery LLC collects fees for scheduling an appointment. **Scheduling fees** are collected prior to scheduling the appointment and will be applied towards your consultation fee or service fee. Please read the following carefully.

- **SCHEDULING FEE FOR DR. SPIRO:**
 - The scheduling fee for Dr. Spiro is \$200. Balances for consultation fees will be collected at the time of the appointment. **The scheduling fee will be assessed and retained as a cancellation fee** for appointments that are cancelled or rescheduled within two business days of an appointment and “no shows.”
- **SCHEDULING FEE FOR SKIN CARE SERVICES INCLUDING INJECTABLES:**
 - Balances for skin care treatments will be collected at the time of the appointment. **The scheduling fee will be assessed and retained as a cancellation fee** for appointments that are cancelled or rescheduled within two business days of an appointment and “no shows.”
- **SCHEDULING FEE FOR COOLSCULPTING:**
 - The scheduling fee for Coolsculpting treatments is \$250 per treatment cycle. The balance for treatment cycles is due prior to treatment on the day of the appointment. **The scheduling fee will be assessed and retained as a cancellation fee** for appointments that are cancelled or rescheduled within two business days of an appointment and “no shows.”
- **LATE FEES AND CANCELLATION FEES:**
 - We ask that you arrive 15 minutes in advance of your appointment to complete additional paperwork (Privacy Practices, Financial Agreement, and any other applicable consents). A late fee will be assessed for appointments with Dr. Spiro, for skin care services, and for Coolsculpting treatments for patients who do not arrive on time for their appointment. If you are late and we cannot accommodate you, your appointment will be subject to cancellation. **The scheduling fee will be assessed and retained as your late fee charge.**
 - If you are late and our office is able to accommodate you, **the scheduling fee will be assessed and retained as a late fee charge** and **will not** be applied towards the balance of your consultation or treatment. The full amount of the service will be due at the time of the appointment.

PRODUCT REFUND POLICY: If a patient has a documented skin reaction within three weeks of the purchase date of the product, a credit for the product may be issued. Credits may be used towards future products and/or services within Spiro Plastic Surgery, LLC. No credits will be issued after three weeks from the purchase date. All credits expire one year from the date issued.

Patient Name: _____ Patient Date of Birth: _____

By signing below, you are agreeing that you read and understand our financial policy. If you have any questions about our financial policies, please feel free to ask for additional clarification from our Billing Manager, Erika Donadio. We are here to assist you in any way possible. Thank you for choosing Spiro Plastic Surgery, LLC.

Print Name Signature of Patient or Legal Guardian Date



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Any questions or concerns regarding information contained in this document should be directed to:

Marybeth Lascari, Privacy Officer
101 Old Short Hills Road, Suite 510
West Orange, NJ 07052
Telephone (973) 736-5907

We Have a Legal Duty to Safeguard Your Protected Health Information (PHI).

This 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 health care to you, or the payment for this health care. We must provide you with this notice regarding our privacy practices that explains how, when, and why we use and disclose 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 at any time. Any changes will apply to the PHI we already have. We will promptly post the revised policy in our office waiting room. You may also request a copy of this notice from the individual named above at any time.

How We May Use and Disclose Your Protected Health Information:

We use and disclose health information for many reasons. Below we describe the different uses and disclosures. Uses and disclosures which do not require your authorization:

- Treatment - We will use your health information for treatment. We may provide your information to hospitals, anesthesiologists, and other physicians involved in your care, nurses and technicians.
- Payment – We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. A bill may be sent to you, a third-party payer, or collection agency. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis and procedures.
- Health Care Operations – We may disclose your PHI in order to operate this practice. We may use your information in order to evaluate the quality of health care services our office provides. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make certain we are complying with laws that apply to our practice.
- Federal, State, or Local Law, Judicial or Administrative Proceedings, or Law Enforcement – We may disclose your information when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, domestic violence, or when ordered in a judicial or administrative proceeding.
- Business Associates - There are some services provided in our practice through contacts with business associates. Examples include radiology, anesthesiology, laboratory diagnostics, hospital and surgical facilities, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer when necessary. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.
- Public Health Activities – We may report information to government officials in charge of collecting information about various diseases, infections, and medical products. We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls. We may provide coroners, medical examiners, and funeral directors any necessary information.
- Health Oversight Activities – We will provide information to assist the government when it conducts an audit or investigation of a physician or medical practice.
- Tissue/Organ Donation – We may contact tissue procurement organizations to assist them in donations and transplants.
- Research - We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health

information. We will always ask for your specific written permission if the researcher will have access to any information that reveals who you are, such as your name, address or other patient identifying information.

- To Avoid Harm - In order to avoid a serious threat to the health and safety of a person or the public, we may provide your information to law enforcement personnel or persons able to prevent or lessen such harm.
- Specific Government Functions – We may disclose information on military personnel or veterans in certain situations. We may disclose information for national security purposes or conducting intelligence operations.
- Workers' Compensation – We may provide information to comply with applicable workers' compensation laws.
- Appointment Reminders and Health Related Benefits or Services – We may use information to advise you of future appointments, treatment alternatives, or other health care services or benefits we offer.
- Incidental Uses and Disclosures – An incidental use and disclosure is a secondary use that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. Such uses are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your information than is necessary to accomplish the permitted disclosure.

Uses and disclosures where you have the opportunity to object:

Disclosures to Family, Friends, and Others – Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. You may object in whole or in part to these disclosures.

Other uses and disclosures of medical information not covered by this policy or applicable laws will only be made with your prior written approval. You may revoke that permission, in writing, at any time. Revoking your permission does not require us to take back any disclosures we have previously made with your permission.

Your Rights Regarding Your Protected Health Information

Although your health record is the physical property of the healthcare practitioner, the information belongs to you. You have the right to:

- Obtain a copy of the Notice of Privacy Practices upon request.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. This request must be made in writing to the attention of the Privacy Officer and must include what information that patient wants to limit and to whom the limits apply. We will consider your request but are not legally required to accept it.
- Inspect and copy your health record as provided for in 45 CFR 164.524. This request must be made in writing to the attention of the Privacy Officer. We will respond to you within 30 days of receiving your written notice. We may charge a fee for the costs of copying, mailing, faxing, reproducing photographs, or other expenses associated with a patient's request.
- Choose how we send health information to you. You may request that we send information to you at an alternative address or by alternate means.
- Request an amendment of your health record if you feel the information, we have is incomplete or incorrect as provided in 45 CFR 164.528. Requests must be made in writing to the attention of the Privacy Officer and must include a valid reason to support the request. We will respond within 60 days of receiving your written request.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528. This list will not include disclosures you have already consented to such as those made for treatment, payment, or health care operations, or disclosures made prior to the effective date of this policy. This request must be made in writing and must state a period of no longer than six years. We will respond within 60 days of receiving your written request.

For More Information or to Report a Problem

If you have any questions or would like additional information, you may contact Marybeth Lascari, Privacy Officer at (973) 736-5907. If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint. All complaints must be made in writing.

Revisions of Privacy Policy

We reserve the right to change our Privacy Practices at any time and to make the new provisions effective for all protected health information we maintain. You may request a copy of any revisions made to our Notice of Privacy Practices either by mail, telephone, or in person.

Policy Effective Date: July 1, 2018