Scott A. Spiro, MD, FACS

Patient Information **Today's Date** ________________

☐ Mr. ☐ Miss ☐ Dr.
☐ Mrs. ☐ Ms. ☐ Other Patient's Name ____
Home Address____

City, State, Zip Code ____

Social Security # ______/______/______ Marital Status: Married ______ Single ______ Others_____

Date of birth ______/______/______ Age ______ Home Phone ________________________________

Email Address ________________________________ Cell Phone __________________________________

☐ I consent to being contacted by e-mail regarding promotions/ special events within the office

☐ I consent to being contacted by text message regarding upcoming appointments, office promotions and rating services

Patient's Occupation ___________________________ Employer __________________________________

Business Address, City, Zip Code ____

Business Phone _______________________________

Significant Other's Name ___________________________ Significant Other's Occupation _________________

Internist/ Medical Doctor ___________________________ Phone ______________________________________

Medical Doctor Address ____

Purpose of Initial Consultation

Please check the procedure you are interested in:

_____ Brow Lift
_____ Face Lift
_____ Eyelid Surgery
_____ Rhinoplasty
_____ Fat Grafting
_____ Liposuction
_____ Tummy Tuck
_____ Gynecomastia
_____ Ear Surgery
_____ Breast Lift
_____ Breast Reconstruction
_____ Breast Reduction
_____ Breast Augmentation
_____ Vaginoplasty
_____ Other Body Contouring

Aesthetic Medicine (Medical Spa)
_____ Wrinkles _____ Brown Spots _____ Acne _____ Botox _____ Facial Fillers (Juvéderm)

Has this office treated any member of your family? Yes____ No ___ If yes, whom? ______________________________

Emergency Contact

Name ______________________________ Relationship ________________________________

Home Phone ________________________ Phone ____________________________

Injuries

If consultation is related to an injury, date of injury_________ Injury related to: Work MVA Other ________

Name of Hospital ____________________________ Name of Physician _______________________________

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, @ScottSpiroTheArtist, @AlexisParcellsMD

☐ 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?

____

Our office is proud to offer CoolSculpting®!

Discover how to freeze away fat with the world's #1 non-invasive fat reduction procedure*:

- Visible results without surgery and little to no downtime
- Millions of treatments performed worldwide
- FDA-cleared, safe, and effective

Patient Name: ______________________

Date: ______________________

CoolSculpting® can target stubborn fat in the areas that bother you the most.

Indicate below which problem areas would you be interested in treating: (Check all that apply)

- ☐ Under the Chin and/or Jawline — BEFORE / 12 WEEKS AFTER SESSION
- ☐ Upper Arm — BEFORE / 12 WEEKS AFTER SESSION
- ☐ Bra Fat — BEFORE / 8 WEEKS AFTER SESSION
- ☐ Back Fat — BEFORE / 28 WEEKS AFTER SESSION
- ☐ Abdomen — BEFORE / 16 WEEKS AFTER SESSION
- ☐ Flank/Side — BEFORE / 12 WEEKS AFTER SESSION
- ☐ Thigh (inner) — BEFORE / 12 WEEKS AFTER SESSION
- ☐ Underneath the Buttocks (Banana Roll) — BEFORE / 4 WEEKS AFTER SECOND SESSION
- ☐ Distal Thigh — BEFORE / 20 WEEKS AFTER SESSION
- ☐ Thigh (outer) — BEFORE / 19 WEEKS AFTER SESSION

*CoolSculpting® is the treatment doctors use most for non-invasive fat removal.

Individual results and patient experience may vary.

Before and After photos courtesy of (in order of appearance): A. Jay Burns, MD; Jason Rivers, MD; Christine Dierickx, MD; Brian Hass, MD; Grant Stevens, MD; Scott Gerrish, MD; Amy Brenner, MD; Mark Beaty, MD; Innovation Research Center; Premier Plastic Surgery.

Uses

The CoolSculpting® procedure is FDA-cleared for the treatment of visible fat bulges in the submental (under the chin) and submandibular (under the jawline) areas, thigh, abdomen and flank, along with bra fat, back fat, underneath the buttocks (also known as banana roll) and upper arm. It is also FDA-cleared to affect the appearance of lax tissue with submental area treatments. The CoolSculpting® procedure is not a treatment for weight loss.

Important Safety Information

The CoolSculpting® procedure is not for everyone. You should not have the CoolSculpting® procedure if you suffer from cryoglobulinemia, cold agglutinin disease, or paroxysmal cold hemoglobinuria.

Important Safety Information (Continued)

Tell your doctor if you have any medical conditions including recent surgery, pre-existing hernia, and any known sensitivities or allergies.

During the procedure you may experience sensations of pulling, tugging, mild pinching, intense cold, tingling, stinging, aching, and cramping at the treatment site. These sensations subside as the area becomes numb. Following the procedure, typical side effects include temporary redness, swelling, blanching, bruising, firmness, tingling, stinging, tenderness, cramping, aching, itching, or skin sensitivity, and sensation of fullness in the back of the throat after submental or submandibular area treatment.

Rare side effects may also occur. CoolSculpting® may cause a visible enlargement in the treated area which may develop two to five months after treatment and requires surgical intervention for correction.

Please visit coolsculpting.com for full Important Safety Information.

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CSC120018-v2 07/19

Allergan

Patient Name: ________________________

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

Authorization to Release Protected Health Information to Your Health Insurance Carrier

Your authorization is required to perform the following tasks with your health insurance carrier:

- Initiate a request for pre-determination of benefits
- Obtain pre-certification for scheduled procedures
- Submit claims for services to your carrier either electronically or on hardcopy claim form
- Follow up on the status of claims
- Appeal improperly processed claims

Your signature below authorizes the release of demographic, financial and protected health information to the insurance carriers listed above.

Patient Signature ____

If patient is under age 18, Signature of Parent/Guardian____

Patient Name: ________________________

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_____

Patient Name: ________________________

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? ___________

Are you planning more children? ___________

Are you pregnant now? __________

Have you breastfed in the past? Yes_____ No_____ When did you stop? ______________________________________

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 _____

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION OR CONDITIONS NOT LISTED BELOW:

Patient Name: ________________________

Nicotine and Marijuana Policy

Nicotine, marijuana, and marijuana related products negatively impact healing and can cause unwanted and avoidable surgical complications. Because of this, we have a NO NICOTINE and NO MARIJUANA USE POLICY.

Patients must be nicotine and marijuana free for AT LEAST SIX WEEKS PRIOR TO SURGERY.

You must avoid all smoking, vaping, and use of edibles or oils. You may not use any nicotine replacement therapy such as nicotine patches, nicotine chewing gum, nicotine lozenges, vapes, or hookahs. You must refrain from using e-cigarettes and herbal cigarettes, even if they do not have nicotine in them. You must also avoid second and third hand smoke. If you are able to smell it, you must avoid it.

There are medications that can help you quit smoking that we may approve you to use, but these would need to be prescribed from your primary care physician. Please contact us or your primary doctor for more information.

We understand that some patients may have prescriptions for medical marijuana, however it still can negatively impact your surgical outcome. Patients with prescriptions for medical marijuana must let our staff know and will also need to contact their prescribing physician for an alternative.

Please be aware that our office requires random nicotine and THC testing as frequently as once a week. These visits take about 10 minutes to complete. We understand that our patients lead busy lives and we typically will grant our patients 48 hours to comply with a request for an in-office screening, but we do require that you have a scheduled appointment.

If testing is positive, your surgery may need to be postponed to help reduce your risk of complications.

By lack of disclosing nicotine or marijuana use, you are putting yourself at risk for adverse events including the risk of hospitalization and re-operation.

By signing below, you are acknowledging our policy.

Patient/Guardian Name__________________________________

Patient/Guardian Signature_______________________________ Date_____/_____/_____

Medical Record Photographic Consent

I understand that photographs and/or videos will be taken at the time of my consultation, as well as during and after my procedure. I understand that these photographs and/or videos will be **kept strictly confidential** and maintained as a part of **medical records**. Photographs may be submitted to insurance carriers for the purpose of coverage determinations. No further use of my photographs and/or videos will be performed without my written consent.

________________________________ Patient Signature

________________________________ Witness Signature

________________________________ Date

Any questions or concerns regarding information contained in this document should be directed to:
Marybeth Gabriel, Privacy Officer
101 Old Short Hills Road, Suite 510
West Orange, NJ 07052
Telephone (973) 736-5907

Patient Name: ________________________

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**

Patient Name: ______________________

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
* Ketaprofin 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 _________

SPIRO PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

I acknowledge receipt of the Notice of Privacy Practices, amended July 1, 2018.

______________________	______________________________	________________
Print Patient Name	Signature of Patient/Legal Representative	Date

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	Protected Health Information	Financial Information
		☐	☐
		☐	☐
		☐	☐

Limitations of Disclosure: Please describe below limitations you would like on the disclosure of your Protected Health Information 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 Patient Name	Signature of Patient/Legal Representative	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 protected health information may be viewed by individuals I did not intend. I understand that I may revoke this request, in writing, at any time. Please describe below the specific means you would like employed, including alternate address, phone numbers, e-mail addresses, etc.

____

______________________	______________________________	________________
Print Patient Name	Signature of Patient/Legal Representative	Date

101 Old Short Hills Road • West Orange • New Jersey • 07052

Telephone (973) 736-5907 • Fax (973) 736-4987

FINANCIAL POLICY AGREEMENT

SCOTT A. SPIRO, MD, FACS

We are committed to providing you with the best possible patient care and customer service. In order to achieve these goals, we need your assistance and your understanding of our financial policies.

1. Consultation fees will be determined based upon the length of time spent in direct consultation with Dr. Spiro, as well as the scope of procedures patients wish to discuss. Patients who wish to discuss multiple surgical procedures and/or treatment of multiple body regions may be charged an additional fee.

2. Payment for services provided by our office are payable by cash, bank checks, money orders, Visa, MasterCard and American Express. Personal checks are only accepted three weeks prior to the date services are rendered. (Exceptions may be made at the discretion of the Practice Manager.) There is a fee of $30.00 for returned checks.

3. Please be aware of our participation status regarding your insurance coverage.
   - **Commercial/Private Insurance Plans** (including Medicare Supplement Plans) - Your insurance is a contract between you and your insurance company; our office is not a party to that contract. 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. Therefore, any eligible healthcare claims would be processed under the out-of-network provisions of your policy.
   - **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. Patients must understand that no claims may be submitted to Medicare for services provided by Dr. Spiro. Similarly, Medigap plans and other supplemental plans may elect not to make payment for services not paid by Medicare.
   - **Medicaid** – Dr. Spiro does not participate with Medicaid. Please advise the receptionist if you are covered by Medicaid, regardless of whether it is your primary or secondary coverage.

Patient Initial _____________

4. In addition to cosmetic procedures, not all functional and/or medically necessary procedures are covered by all health insurance plans. Health insurance coverage is a "contract" between the insurance company and the insured party. 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.

5. 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. It would be wise to contact your insurance carrier to determine approximately what your out of pocket expense will be. We must emphasize that as a medical care provider, our relationship is with you and not your insurance company.

6. 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. You must provide our office with all necessary information, including demographic information on the patient and the insured party, addresses, telephone numbers, a copy of your current insurance identification card, etc. As non-participating providers, our office may be unable to obtain the status of these submissions. It may therefore be necessary for the patient to follow up with their insurance company as to the status of such requests.

7. 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, 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.

If you have any questions about our financial policies, please feel free to ask for additional clarification. We are here to assist you in any way possible. Thank you for choosing Spiro Plastic Surgery, LLC.

________________________________ __________________

Patient/Guardian Signature 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:
Mary Beth Gabriel, 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 <u>not</u> 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. <u>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.</u>
- *To Avoid Harm* - In order to avoid a serious threat to the health and safety or 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 Veronica DeFranza, 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. <u>There will be no retaliation for filing a complaint.</u> 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

101 Old Short Hills Road, Suite 510
West Orange, New Jersey 07052
Telephone (973) 736-5907 • Fax (973) 736-4987

From Route 280 West

- Take Exit 6A – Laurel Avenue South
- Within half a mile, you will reach a fork in the road. Stay left.
- This road changes times several times (Shrewsbury Dr, East Cedar St)
- At the 5th traffic light, our building is the large 5 story office building on the left hand side, directly across from Saint Barnabas Medical Center
- Our building is called the Atkins Kent Building.

From Route 280 East

- Take Exit 6 – Laurel Avenue
- Turn right at the end of the exit ramp onto Laurel Avenue South
- Within half a mile, you will reach a fork in the road. Stay left.
- This road changes times several times (Shrewsbury Dr, East Cedar St)
- At the 5th traffic light, our building is the large 5 story office building on the left hand side, directly across from Saint Barnabas Medical Center
- Our building is called the Atkins Kent Building

From the Garden State Parkway

- Garden State Parkway to Exit 145
- Stay Left and follow signs for Route 280 West
- Follow directions for Route 280 West

From the George Washington Bridge

- Route 80 West to the Garden State Parkway South
- Follow directions above from the Garden State Parkway

From the New Jersey Turnpike

- Take Exit 15W
- Follow signs for Route 280 West
- Follow directions for Route 280 West

From Route 287 North or South

- Exit at Route 10, take Route 10 East
- At the Livingston Traffic Circle, follow signs for Northfield Road
- At the third traffic light, make a right turn onto Shrewsbury Road.
- At the top of the hill, Shrewsbury Road merges with Old Short Hills Road.
- At the 3rd traffic light, our building is the large 5 story office building on the left hand side, directly across from Saint Barnabas Medical Center
- Our building is called the Atkins Kent Building.

From Route 78 East or West

- Take exit 48
- Take Route 24 West
- Exit at JFK Parkway, follow signs for Livingston
- In approximately 2 miles, you will come to a traffic light at South Orange Avenue. Make a right.
- At the 2nd traffic light, make a left on Old Short Hills Road
- Our building is on the right at the 1st traffic light. It is called the Atkins Kent Building.