

**Riverside Plastic Surgery & Sinus Center**

**Frank J. Scaccia, M.D., F.A.C.S.**

*70 E. Front Street 3 rd Floor*

*Red Bank, New Jersey 07701*

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Welcome to our office. In order to serve you properly, we will need the following information.  
**(Please Print)** All information will be strictly confidential.

**PATIENT INFORMATION**

Full Name of Patient: \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Patient's Date of Birth: Month \_\_\_ Day \_\_\_ Year \_\_\_

Age \_\_\_ Weight \_\_\_ Height \_\_\_ Race/Ethnicity \_\_\_

Married \_\_\_ Widowed \_\_\_ Single \_\_\_ Divorced \_\_\_

Full Street Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Home Telephone Number \_\_\_ Cell # \_\_\_ Work# \_\_\_

Which voice mail#, if any may we leave medical results on? \_\_\_\_\_

Social Security # of Patient \_\_\_ Email address \_\_\_\_\_

Occupation \_\_\_ **Emergency Contact(s)** \_\_\_ **Telephone #** \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Identification Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Policy Holders Date of Birth: \_\_\_ SS # \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Holders Place of Employment: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Policy Holders Date of Birth: \_\_\_ SS# \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Did your Physician refer you? Yes \_\_\_ No \_\_\_

Name, address & phone # of your Primary Care Physician (**Medicare patients must fill out**):

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If no, how did you hear about us?

Are you being seen as a result of an automobile accident? Yes \_\_\_ No \_\_\_

Are you being seen as a result of Workmen's Compensation? Yes \_\_\_ No \_\_\_

1. Chief Complaint: \_\_\_\_\_
2. Do you have any drug allergies? \_\_\_\_\_
3. Have you been treated for Diabetes, High Blood Pressure, Ulcers, Angina, Cancer or recent heart trouble? \_\_\_\_\_
4. Have you had any surgery or other medical problems not mentioned above?  
\_\_\_\_\_  
\_\_\_\_\_
5. Have you ever been or are you currently being treated for psychological disorders?  
\_\_\_\_\_
6. What medications are you currently taking?  
\_\_\_\_\_  
\_\_\_\_\_
7. Have you ever had Hepatitis, HIV or any liver problems?  
\_\_\_\_\_  
\_\_\_\_\_
8. Do you have any history of a bleeding disorder?  
\_\_\_\_\_  
\_\_\_\_\_
9. Do you smoke? \_\_\_\_\_ When was the last time you smoked? \_\_\_\_\_
10. How much alcohol do you drink in one week? \_\_\_\_\_
11. Use of Drugs. Never \_\_\_\_\_ Type/Frequency \_\_\_\_\_
12. Excessive Exposure at home or work to: Fumes \_\_\_\_\_ Dust \_\_\_\_\_ Solvents \_\_\_\_\_  
Airborne Particles \_\_\_\_\_ Noise \_\_\_\_\_
13. **Do you have a living will?** Yes \_\_\_\_\_ No \_\_\_\_\_
14. **Durable Power of Attorney** Yes \_\_\_\_\_ No \_\_\_\_\_
15. **If yes, who** \_\_\_\_\_
16. **Are you an organ donor?** Yes \_\_\_\_\_ No \_\_\_\_\_

**I understand that Advance Directives are not honored here at the Riverside Plastic Surgery and Sinus Center.**

**A copy of The Patients' Rights and Responsibilities has been offered to me.**

**Family Medical History:**

	Diseases	Age
	If Deceased, Cause of Death	
Father _____	_____	_____
Mother _____	_____	_____
Sibling's _____	_____	_____
_____	_____	_____

Patients Signature (or signature of representative)

Representative's relationship to patient: \_\_\_\_\_

Date: \_\_\_\_\_

**Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of Your Protected Health Information**

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Your protected health information will be used by Riverside Plastic Surgery & Sinus Center or disclosed to others for the Purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

**Notice of Privacy Practices**

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You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

**Requesting a Restriction on the Use or Disclosure of Your Information**

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You may request a restriction on the use or disclosure of your protected health information.

Riverside Plastic Surgery & Sinus Center may or may not agree to restrict the use or disclosure of your protected health information.

If Riverside Plastic Surgery & Sinus Center agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

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You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practices**

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Riverside Plastic Surgery & Sinus Center reserves the right to modify the privacy practices outlined in the notice.

**Signature**

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I have reviewed and received a copy of Notice of Privacy Practices. I have reviewed this consent form and give my permission to Riverside Plastic Surgery & Sinus Center to use and disclose my health information in accordance with it.

\_\_\_\_\_  
**Name of Patient (Please Print)**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_

Date

\_\_\_\_\_  
Signature of Patient Representative

**FRANK J. SCACCIA, MD FACS**  
**70 East Front Street**  
**Third Floor**  
**Red Bank, NJ 07701**

## **AGREEMENT TO PAY AND RIGHTS OF EACH PATIENT**

I acknowledge that I am responsible for payment of the fees for medical services rendered by Frank J. Scaccia, M.D. and/or Riverside Plastic Surgery & Sinus Center regardless of any reimbursement to which I may be entitled by reason of insurance or legal claims. I am aware that it is solely my responsibility to know in advance of the services provided both in terms of the benefits/guidelines stipulations of my individual insurance coverage and to know the fees for the consultation and/or recommended procedures/surgery. In addition, it is my responsibility to obtain all necessary insurance referral forms and/or precertification requirements and to confirm with my insurance company whether or not Dr. Scaccia participates with my insurance. Furthermore, I am responsible for deductibles, copays, and remaining balance charges after payment and/or lack of payment from out-of-network insurance providers. If I am a member of an insurance plan of which Frank J. Scaccia, M.D. is a participating provider, the payment guidelines of my plan will prevail.

I authorize Frank J. Scaccia, M.D. and/or Riverside Plastic Surgery & Sinus Center to prepare and submit the appropriate claim forms to my primary and secondary (if any) insurance carriers. I hereby assign all insurance benefits relating to my medical service to Frank J. Scaccia, M.D. and/or Riverside Plastic Surgery & Sinus Center and authorize release of all information necessary to effect payments of those benefits. Even though payment may be sent directly to Frank J. Scaccia, M.D. and/or Riverside Plastic Surgery & Sinus Center, I understand that I am still responsible for any balance remaining and will pay any amount not paid by my insurance. I understand that if I fail to keep any financial agreement I make with Frank J. Scaccia M.D. and/or Riverside Plastic Surgery & Sinus Center, my account will be sent to a collection agency and I will be responsible for not only the remaining balance but also all collection costs and legal fees. I hereby acknowledge that I have been offered a written copy of the "Rights of Each Patient" adopted by the New Jersey Department of Health for ambulatory care facilities and a written and/or verbal explanation of these rights. Furthermore, I acknowledge that I understand the information given to me about my rights and that they are in effect indefinitely with Dr. Scaccia applicable to every future visit and/or treatment.

### **Cancellations of appointments/no-show**

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient, it is very important that you call within 24 hours in advance to cancel your appointment. If for any reason you need to cancel an appointment, please notify our office as soon as possible. On your 2<sup>nd</sup> **no-show** there will be a **\$35** charge to your account.

PATIENT/LEGAL GUARDIAN

DATE

WITNESS

DATE

**Frank J Scaccia MD FACS  
Riverside Plastic Surgery & Sinus Center  
70 East Front Street 3<sup>rd</sup> Floor  
Red Bank, NJ 07701**

**AGREEMENT TO MAINTAIN PRIVACY**

This is an agreement between Dr. Frank J. Scaccia, Riverside Plastic Surgery & Sinus Center, and the below named patient. Our office takes pride in ensuring that your healthcare information is protected and maintained as outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is a United States federal statute enacted by the 104<sup>th</sup> United States Congress signed into law in 1996. It was created primarily to modernize the flow of healthcare information and stipulate how personally identifiable information is maintained by healthcare and health insurance industries.

The purpose of this agreement is to ensure that all care delivered by our office to the below named patient remains confidential and that the patient agrees to refrain from directly or indirectly publishing or airing negative commentary upon Dr. Frank Scaccia and/or his practice or staff at Riverside Plastic Surgery & Sinus Center with the sole exceptions being communication to a confidential medical-peer review body, to another healthcare provider, to a licensed attorney to a government agency, in the context of a legal proceeding or unless mandated by law. Publishing is intended to include the use of the patient's actual name, a relative or friend acting on behalf of the patient, by pseudonym or anonymously. Any public publications by the patient or anyone acting on behalf of the patient will not denigrate, defame, slander or cast aspersions upon Dr. Scaccia and his practice. Examples of where it is forbidden by a patient or patient's representative to publish negative comments include any site on the internet including websites, doctor's reviews and rating sites (i.e., google, ratemds, Healthgrades, Facebook, vials, Yelp, etc.). A negative review/comment by a patient will include posting any rating below five stars and/or any comments that mention any negative criticism about Dr. Scaccia's surgical and/or medical skill, personality, attitude, billing practices, staff members or anything that reflects negativity towards his practice, billing practices, staff members or anything that reflects negativity towards his practice. Patients, however, are encouraged to privately and directly communicate any complaints or criticisms of their care directly to the practice of Dr. Frank Scaccia. It is the goal of Dr. Scaccia and Riverside Plastic Surgery Center to provide the highest quality care for our patients and to continually improve and provide the patient with the best patient experience possible. Privately provided constructive criticism is always appreciated. Surgical patients are all provided with a questionnaire (for our office use only) to be completed at the end of their care and an honest appraisal of their experience with examples both positive and negative are welcomed.

This agreement shall be in force and enforceable indefinitely starting from the beginning of the physician patient relationship. Failure to sign/agree to this agreement does not prevent the patient from initiating or continuing his care with Dr. Frank Scaccia. However, the patient should understand this agreement is encouraged as medical and surgical care is complex and not a perfect science. Patients sometimes do not understand and appreciate and may misinterpret the actions and treatments of the physician whose decision making is in the best interest of the patient. Patients must also understand that defamation of the physician by a patient can have serious consequences to his ability to market and maintain his practice. As a consequence, if the patient breaks this agreement by publishing any negative comments or ratings less than five stars and is discovered by the practice, he/she must immediately delete the comment/rating and owes the practice twelve thousand dollars that must be paid within a seven day period. True defamation as determined by a court verdict will include in addition to the twelve-thousand-dollar penalty an additional amount determined by the court as damages. The patient also agrees to reimburse/pay for any legal fees incurred by Dr. Scaccia while pursuing defamation. These legal fees will apply whether the verdict is in favor of the plaintiff or defendant. By signing this agreement below the patient acknowledges that he agrees to everything stipulated in this agreement. The patient has been given opportunity to ask questions, seek legal advice, and receive satisfactory and adequate explanation to any statements in this agreement.

NAME OF PATIENT \_\_\_\_\_

(Please print)

**SIGNATURE OF PATIENT/GUARDIAN** \_\_\_\_\_

**DATE** \_\_\_\_\_