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

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)**:
_____
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:

	Age	Diseases	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

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

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 or Your Information

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

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

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

Signature

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 2nd **no-show** there will be a **$35** charge to your account.

_____ _____

PATIENT/LEGAL GUARDIAN DATE

_____ _____

WITNESS DATE

Riverside Plastic Surgery & Sinus Center
Frank J. Scaccia, M.D., F.A.C.S. LLC
70 East Front Street 3rd Floor
Red Bank, NJ 07701
(732) 747-5300

I, _____, the Patient/Guardian, authorize the Doctor to deposit checks received on Patient's account when made out to the Patient/Policyholder.

Patient Name: _____

Patient/Guardian Signature:

_____Date: _____

Frank J Scaccia MD FACS
Riverside Plastic Surgery & Sinus Center
70 East Front Street 3rd 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 statue enacted by the 104th 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, vitals, 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_____

Employer Insurance Information Sheet

1) Do you get Insurance Coverage through your Employer?

   Yes / No

   a. If **Yes**, what is your Employer's name, address, phone number, and contact name?

   Employer Name: _____
   Employer Address: _____
   Employer Phone Number: _____
   HR Contact Person (If known)_____

   b. If **No**, do you get Insurance through a spouse or family member's Insurance?
   Yes / No

   Insurance Carrier Name:_____
   Insurance Policy Holder:_____

2) What is your relationship to that spouse or family member and what is your spouse or family member's employer's name, address, phone number?

   Relationship with Spouse or Family Member: _____
   Employer Name: _____
   Employer Address: _____
   Employer Phone Number: _____
   HR Contact Person (If known)_____

3) If you don't have Insurance through any of the above, please explain how you receive medical coverage?

   _____
   _____
   _____
   _____

I, _____(Patient Name), do hereby designate and authorize _____(Provider Name) or their designated legal or other representative to contact the employer shown above and/or the insurance carrier to obtain my health insurance plan documents, and to act on my behalf in connection with any claim, appeal or related right or legal action that I may have under the Plan with respect to any health insurance claim related to my treatment, and which was incurred as a result of the medical services I received.

_____
(Patient Signature)