Gyn Cancer & Pelvic Surgery LLC

Patient Information

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

Last Name:_____ First Name:_____ M.I.:_____ Maiden or Nickname:_____

Address:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Home Phone #: (_____)_____ Work Phone #: (_____)_____ Ext:_____

Cell Phone #: (_____)_____ Email Address:_____

Can we call you at home? Yes / No (Please circle one) If no, call: _____

Marital Status: O Single O Married O Divorced O Widowed O Other _____

Race:_____ Language(s) Spoken:_____ Ethnicity:_____

Patient's Employer Information

Employer's Name:_____ Patient's Occupation:_____

Address:_____ If Student: O Full time O Part time

City:_____ State:_____ Zip:_____

Insurance Information Primary/Secondary/Other

Do you have health insurance? Yes / No (Please circle one)

Primary Insurance Company Name:_____

Who is the Primary Insurance Subscriber? O Self O Parent O Spouse O Other_____

Secondary Insurance Company Name:_____

Who is the Secondary Insurance Subscriber? O Self O Parent O Spouse O Other_____

Spouse's Information or Parent's Information (If Patient is Covered by Parent's Insurance)

Spouse's or Parent's Name_____ Spouse or Parent's Date of Birth:_____

Spouse's or Parent's SS#:_____ Employer's Phone #: (_____)_____

Spouse's or Parent's Employer:_____

Spouse's or Parent's Employer's Address:_____

City:_____ State:_____ Zip:_____

Other

How did you hear about us?_____

Referring Physician:_____ Phone #: (_____)_____

Referring Physician's Address:_____

Primary Care Physician:_____ Phone #: (_____)_____

Primary Care Physician's Address:_____

Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to Gyn Cancer & Pelvic Surgery, LLC, its successors and assigns, or any individual it may designate for services provided.

I further agree to pay all costs of collection, including attorney's fees, associated with collection of any amount due to services rendered and performed, I will pay a ten dollar surcharge for every month a balance is due. I understand that I am financially responsible to Gyn Cancer & Pelvic Surgery, LLC, its successors and assigns and any individual it may designate for any balance not covered by insurance.

_____

Signature of Patient or Parent of Minor Date

Authorization for Medicare

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Gyn Cancer & Pelvic Surgery, LLC for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

Signature of Patient Date

Gyn Cancer & Pelvic Surgery LLC

Practice limited to Gynecologic Oncology, Reconstructive Pelvic Surgery and Consultative Gynecology

BOARD CERTIFIED IN GYN ONCOLOGY & OB/GYN

Thad R. Denehy, M.D., FACOG, FACS
Robert R. Taylor, M.D., FACOG, FACS

OFFICE FINANCIAL POLICY

All patients must complete our Patient Registration Sheet before seeing the doctor.

You are responsible for supplying our staff with your insurance identification cards. If you do not have the proper forms of identification, you must either reschedule or pay for services in full before seeing the doctor. Subsequently, if we are paid by your insurance or HMO, we will refund you the amount of overpayment.

It is your responsibility to understand which insurance plans your doctor participates with. If he does not participate with your plan, the bill is your responsibility and is due at the time of service. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

As to non-participating insurance companies, "usual and customary rates", our office is committed to providing the highest quality of treatment to our patients, and we charge what is usual and customary for our geographical area and specialty. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. There will be a $10 surcharge for every month a balance is due. There will be an administrative fee of $10 per form for completing all patient forms (disability, SSDI, FMLA, legal documents, etc.). Patients will be charged $25 for a missed appointment.

Thank you for understanding our Office Financial Policy. Please feel free to let our Billing Office know if you have any questions or concerns. I have read the above and agree to and understand its terms.

Signature of Patient _____ Date _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Gyn Cancer & Pelvic Surgery, LLC's Notice of Privacy Practices

Signature of Patient _____ Date _____

Atkins-Kent Building • 101 Old Short Hills Road, Suite 400 • West Orange, NJ 07052
560 Springfield Avenue, Suite 101 • Westfield, NJ 07090
16 Pocono Road, Suite 216 • Denville, NJ 07834
973-243-9300 • Fax 973-325-8254

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NOTICE OF PRIVACY PRACTICES

At GCPS the privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

HIPPA Regulations
The Health Insurance Portability and Accountability Act or HIPPA does three primary things:
1. It helps standardize and simplify the way healthcare organizations exchange electronic health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage; although, it does not guarantee coverage.
3. It creates security rules to ensure the safety and privacy of individual health information and medical records.

HIPPA Ensures the Privacy and Security of Individual Health Information
HIPPA sets minimum security and privacy standards for healthcare organizations to follow. If a state has more stringent privacy and security laws, then those would be followed instead. In addition, HIPAA sets heavy penalties for violations of these standards and the misuse of personal health information.

Defining Individual Health Information
Every time you go to see a doctor, are admitted to the hospital, fill a prescription or send a claim to an insurance company, a record is made of your confidential health information. This type of information is referred to as individually identifiable health information and is the type of information regulated by HIPPA. It can be in any format -- electronic, paper or oral.

Healthcare providers that collect and manage this type of information are therefore covered by these regulations. HIPAA also regulates this type of information in organizations such as: hospitals, health plans, employers, healthcare clearinghouses, claims processors, and others who conduct administrative and financial healthcare transactions.

Added Control Over Health Information
Under HIPPA, you have new rights to understand and control how your health information is used:
1. **Right to Education** – Healthcare providers and health plans are required to provide you with a clear written explanation of how they intend to use and disclose your information.
2. **Right to Access Medical Records** – You have the right to see and get copies of your medical records, request changes and receive a history of non-routine disclosures of your personal health information.
3. **Right to Consent** – Healthcare providers are required to obtain prior consent before sharing personal health information for purposes other than treatment, payment and healthcare operations.
4. **Right to Recourse** – You have the right to file a formal complaint if you believe that violations of the regulations were made.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights by writing to our address: Gyn Cancer & Pelvic Surgery, LLC 101 Old Short Hills Road, Suite 400 West Orange, NJ 07052

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

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CREDIT/DEBIT CARD CHARGE AUTHORIZATION

I hereby authorize GCPS (the "Practice") to charge my Credit Card whatever amounts are listed on each of "Outstanding Balance Due" bills which the Practice sends me for the health care services it provides to me at various times during the entire period that I am a patient of the Practice. This is a continuing authorization which shall remain in force and in effect until I deliver to the Practice a written, signed, and dated revocation of this authorization.

Your privacy is of the utmost importance to us. Accordingly, this information will be scanned into encrypted electronic files; this paper copy will be shredded immediately.

Type of card:_____

Name as it appears on card: _____

Account #:_____

Expiration date: _____

Three digit security code: _____

Zip code: _____

I certify that the information provided above is complete and correct.

_____ _____

Signature of Patient Date

_____

Print Name

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Gyn Cancer & Pelvic Surgery LLC

New Patient Medical Information Sheet

Please fill in information sheet completely and bring with you to your office visit.

Patients Name: _____ Date of Birth: _____

Today's Date: _____ Reason for Visit: _____

Do you have any allergies to medications? O Yes (list below) O No Known Drug Allergies

_____

_____

_____

Do you take medications on a regular basis? O Yes (list below) O No Daily Medications

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Past Medical History: O Yes (see list below) O No Past Medical Problems

O Diabetes	O Hepatitis/Liver Disease	O Osteoporosis
O Heart Disease	O Blood Clots in Veins or Lungs	O Glaucoma
O High Blood Pressure	O Thyroid Over/Under Active	O Emotional Disorders
O Kidney Disease	O Bladder Problems	O Pulmonary Disorders
O Arthritis	O Sexually Transmitted Diseases	O Other: _____

History of Previous Surgeries: O Yes (list below) O No Previous Surgeries

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Please provide your pharmacy's name/address/phone number:

_____

_____

Family Medical History: O Yes (see list below) O No Family Medical History

O Diabetes O Hypertension O Heart Disease O Kidney Disease O Cancer (see below)

Family History of Cancer(s): (Any Ovarian, Uterine, Breast, Colon, Stomach, Kidney, Brain)

Relative:_____ Age:_____ Type:_____

Relative:_____ Age:_____ Type:_____

Relative:_____ Age:_____ Type:_____

Social History:

Smoking: O Yes O No Amount:_____ Alcohol: O Yes O No Amount:_____

Recreational Drugs: O Yes O No Sexual Orientation:_____

Sexual Dysfunction:_____ Sexual Problems:_____

Cervical Cancer Risk Assessment:

Age of First Intercourse:_____ Number of Sexual Partners:_____

Sexually Transmitted Diseases:_____

Menstrual History:

Age of Onset of Menses:_____ Duration:_____ Amount:_____

Days Intervening:_____ Date of Last Menses:_____

Total # of Pregnancies:_____ # Deliveries:_____ # Vaginal:_____ # C/S:_____

Abortions/Miscarriages:_____ Menopause (Year):_____

Date of Last Mammogram:_____ Date of Last Pap Smear:_____

Weight:_____ Height:_____

Review of Systems: (fill in all that apply that have occurred in the last 48 hours or apply to your reason for this visit)

Gynecological:
O heavy periods O hot flashes O abnormal vaginal discharge
O infertility O painful intercourse O frequent yeast infections
O pelvic pain O vaginal dryness O postmenopausal bleeding

Constitutional:
O weight gain/loss O fever O night sweats O insomnia
O fatigue

Eyes:
O glasses/contacts O blurred vision O tunnel or double vision
O unusual sensitivity to light O excessive tearing or dry eyes
O cataracts O floater spots O halos O flashing lights

ENT:
O hearing loss O dizziness O earaches O hoarseness
O infection or discharge O nose bleeding O loss of smell
O sinus problems O excessive dryness/salivation
O ulceration/bleeding in mouth O difficulty swallowing

Cardiovascular:
O palpitations O chest pain O pressure or tightness
O swelling of limbs O difficulty breathing O feeling of suffocation
O heart murmur O varicose veins O cold hands or feet

Respiratory:
O coughs with/without mucus O spitting blood O night sweats
O shortness of breath O wheezing O pain with breathing
O SOB upon exertion How many pillows do you sleep on?_____

Gastrointestinal:
O changes in appetite O heartburn O excessive belching/gas
O nausea O vomiting O vomiting blood O sour stomach
O belly pain O change in bowel habits O constipation
O diarrhea O rectal bleeding O itching O tarry or bloody stools

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Genitourinary:
O excretion of large amounts of urine O frequent urination at night
O pain or burning upon urination O blood in urine
O difficulty urinating O incontinence

Review of Systems (continued):

Musculoskeletal:	O joint pain O stiffness O backache O sciatica O pain in calves when walking O weakness O warm or hot joints
Integumentary/Breast:	O rashes O lumps O itching O dryness O hives O changes in skin O changes in nails O new moles O changes in moles O breast lumps O breast tenderness O nipple discharge or bleeding O breast swelling
Neurological:	O dizziness O drowsiness O confusion O numbness O tingling O tremors O weakness O paralysis O fainting O blackouts O seizures O headaches
Psychiatric:	O nervousness O tension O mood swings O depression O phobias O fear/panic O anxiety O dementia
Endocrine:	O sensitivity to cold/heat O excessive sweating O excessive thirst O excessive hunger O excessive urination O hot flashes O missed periods O dry skin O infertility
Hematological/Lymphatic:	O bruise easily O transfusion reactions O bleeding gums O nose bleeds O swollen or tender lymph nodes
Allergy:	O hay fever O sneezing O hives O itching O multiple colds O slow healing O allergies to foods O allergies to plants O allergies to dyes O allergies to tape

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PATIENT CONFIDENTIALITY AGREEMENT

Patient Name:_____ DOB: _____

SS#: _____

I agree that GCPS may disclose certain portions of my health information to a relative, friend, and/or caregiver because such person is involved with my healthcare or payment relating to my healthcare. Please list below the person(s) with whom GCPS has the permission to discuss such information with, GCPS will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

☐ I WISH TO MAKE NO DESIGNATION AT THIS TIME

NAME:_____ ☐ DISCUSS/LEAVE MESSAGE

RELATIONSHIP:_____ ☐ DO NOT DISCUSS

PHONE:_____

NAME:_____ ☐ DISCUSS/LEAVE MESSAGE

RELATIONSHIP:_____ ☐ DO NOT DISCUSS

PHONE:_____

NAME:_____ ☐ DISCUSS/LEAVE MESSAGE

RELATIONSHIP:_____ ☐ DO NOT DISCUSS

PHONE:_____

Signature of Patient:_____ Date: _____

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PHARMACY/MEDICATION INFORMATION

Patient Name:_____ DOB: _____

Pharmacy Name/Address/Phone Number:_____

_____

_____

List all Drug Allergies:_____

_____

_____

List all Current Daily Medications/Vitamins:_____

_____

_____

_____

Date of Last Menstrual Period:_____

_____

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REQUEST FOR RELEASE OF MEDICAL INFORMATION

I,_____, request that the following medical information be sent to:

Gyn Cancer & Pelvic Surgery, LLC
101 Old Short Hills Road, Suite 400
West Orange, New Jersey 07052
973-243-9300
973-325-8254 (fax)

O Entire Chart
O Laboratory (blood)
O Pathology/Cytology
O Surgery Reports/Admission Records
O Radiology Reports (CT/X-Ray/MRI, etc.)
O Other

Signature of Patient:_____ Date:_____