Cancer Surgery Associates
20 Prospect Ave, Suite 603
Hackensack, NJ 07601

PATIENT INFORMATION

Name: _____

DOB: _____ Age: _____

SS # _____ Sex: _____

Marital Status: S M D W

Address: _____

City: _____

State: _____ Zip Code:_____

Tel: _____

Cell: _____

Work #: _____

E-mail: _____

Language: _____

Ethnicity: □ Hispanic □Not Hispanic

Race: □White □Black/African American

□Asian □Pacific Islander □Other

Referring Doctor: _____

Ph#: _____ Fax: _____

Address: _____

Your **PCP/internist**: _____

Ph#:_____ Fax:_____

Address: _____

Do you have a **Cardiologist**? _____ Y/N

Ph#:_____ Fax:_____

Address:_____

Do you have a **Pulmonologist**? _____ Y/N

Ph#: _____ Fax:_____

Address: _____

Other Specialists: _____ Y/N

Ph#: _____ Fax:_____

Address: _____

EMERGENCY CONTACT:
_____

Relationship to you: _____

Telephone: _____

PHARMACY:_____

Address: _____

City: _____ Zip: _____

Pharmacy Tel:_____

INSURANCE

Primary Insurance: _____

ID#: _____

Group #: _____

Policy Holder's Name: _____

DOB: _____ Relation:_____

Secondary Insurance:_____

ID#: _____

Group #: _____

Guarantor's Name: _____

DOB: _____ Relation : _____

DEDUCTIBLES AND IN-NETWORK CO-PAYMENTS ARE DUE BEFORE SERVICES ARE RENDERED*

I hereby authorize payment directly to **Dr. Donald McCain** for all insurance benefits otherwise payable tot me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Responsible Party Date

MEDICAL HISTORY

Anemia… Type: _____ Y/N

Asthma… Y/N

Cancer… Type: _____ Y/N

Congestive Heart Failure…. Y/N

Diabetes… Y/N

Dialysis… Y/N

When/Where: _____

Diverticulitis… Y/N

Emphysema… Y/N

Gallbladder Disease… Type: _____ Y/N

Gastroesophageal Reflux Disease… Y/N

High Blood Pressure… Y/N

Heart Attack… When: _____ Y/N

Irregular Heart Beat… Y/N

Kidney Failure… Y/N

Liver Disease… Type: _____ Y/N

Phlebitis/ Blood Clots… Y/N

When/Where: _____

Seizures… Y/N

Sleep Apnea… □ C-Pap Machine Y/N

Stroke… When: _____ Y/N

Do you drink **alcohol**… Y/N

If yes, □Monthly □Weekly □Daily

_____ drinks in one day

Do you use **tobacco…** Type:_____ Y/N

How much: _____ How long: _____

□Current □Former Stop Date: _____

History of **substance abuse**… Y/N

□ Alcohol □Drug Type: _____

How much: _____ How long: _____

□Current □Former Stop Date: _____

List any **surgeries** you have had and the **year:**

_____

_____

_____

_____

List any **illnesses** you have been diagnosed with:

_____

_____

List any **symptoms** you have:_____

_____

List all **medications/ vitamins**:_____

_____

_____

_____

_____

List all **allergies**: _____

_____

_____

List any **Family History of Cancer/ Cardiac Issues** (Type and Relation): _____

_____

_____

List any **Medical Implants**: _____

_____

FOR OFFICE USE*

Weight: _____ Height: _____

BP: _____ Pulse Ox: _____

Last Mammography Date: _____

Do you have a Living Will? Y N

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Financial Responsibility Form

INSURANCE COVERAGE:

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours.

DEDUCTIBLES:

- Deductibles are the patient's responsibility. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.
- You will be responsible for a **$26.00 service fee** if your check is returned for non-payment by the bank.

REFERRALS:

- It is your responsibility to obtain referrals if required to do so by your plan.

INSURANCE REQUEST:

- You are responsible for responding to any request from the insurance company for further information. Not doing so will result in a claim denial and you will be responsible for payment.
- You agree to cooperate with our billing company if they request your assistance in appealing your claim with your insurance.

INSURANCE PAYMENTS SENT TO YOU:

- If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of Explanation of Benefits (EOB) received, upon receipt of payment.

COLLECTION ACCOUNTS:

- In case your account is forwarded to our attorney/collection agency you are responsible to pay attorney/collection fees and court costs if applicable.

We emphasize that as a medical care provider our relationship is with you and not your insurance company. It is your responsibility to know your policy and we will assist you.

I have read and understand the financial responsibility form.

_____ _____

Patient Signature **Date**

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HIPPA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosure of Protected Health Information

Uses and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For Example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your information.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensations: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physicians or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Patient Signature **Date**

_____

Print Name

Cancer Surgery Associates
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name _____

Date of Birth _____

Social Security Number _____

Patient Address _____

I authorize the office of _____ to release pertinent medical information with respect to the treatment of the above-referenced patient, including information relating to diagnosis or treatment of mental illness, or drug or alcohol abuse, and/or confidential HIV related information.

Name and address of person(s) or category of person to whom this information will be sent:

Donald A McCain, M.D., Ph.D.

20 Prospect Ave Suite 603

Hackensack, NJ 07601

FAX: 201-342-1030

The nature and extent of information to be disclosed is:

☐ Medical Record from _____ to _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, consults, insurance records, and records sent to you by other health care providers.

☐ Other (list dates of treatment, special reports, etc.):

_____

_____

I understand that, with respect to psychiatric information, refusal to grant consent to release of information will not jeopardize the patient's right to obtain present or future treatment, except where disclosure is necessary for treatment.
This consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon.
According to NJ State Law 8:43G-15.3 there may be a fee for photocopies of medical records
This authorization shall expire in 180 days after the date appearing below or 180 days after the patient's final treatment, whichever is later.

_____ _____

Signature of Patient or Legal Guardian **Date**

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Patient Record of Disclosure

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

HIPPA Law state we are not allowed to discuss a patient's medical status with a third party (family member or friend). We need your written permission to speak with anyone other than yourself regarding your medical condition.

I, the undersigned, give you permission to speak with the following persons regarding my procedures, medical health or any questions regarding my physical well-being:

Name	**Relationship**
Name	**Relationship**
Patient Signature	**Date**

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CANCELLATION POLICY/NO SHOW POLICY FOR DOCTOR APPOINTMENT

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If you must change or miss your appointment, we require a 24-hour notice. Cancellations, last minute or failure to show will result in a **FEE** of $**50.00.**

THIS WILL NOT BE COVERED BY YOUR INSURANCE COMPANY.

Our office will provide confirmation calls. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm our appointment. Failure to do so will result in a charge and cancellation of your appointment.

I understand the Office Cancellation Policy.

_____ _____

Patient Signature Date

_____

Print Name