Initial COS Visit
Packet

- **Patient copies of post-op instructions are on top of the packet.**
- **If more than one page, staple them together and place one patient label on the first page only.**
- **No need to hole punch patient copies of post-op instructions. Just place instructions inside the chart.**

PELOSI MEDICAL CENTER

PATIENT CLINICAL SUMMARY

MEDICAL HISTORY	
Date of Onset	**Medical Condition**

SURGICAL HISTORY			
Date	**Surgical Procedure**	**Date**	**Surgical Procedure**

MEDICATIONS & SUPPLEMENTS					
Medication	**Date Started**	**Date Stopped**	**Medication**	**Date Started**	**Date Stopped**

ALLERGIES/SENSITIVITIES (Drugs, Materials, Food, or Environmental Factors)	
☐ **No known allergies/sensitivities and other reactions to drugs, materials, food, or environmental factors**	
Allergen/Sensitivity	**Type of Reaction**

Date Updated	Signature	Date Updated	Signature

Pelosi Medical Center

PATIENT INFORMATION UPDATE

(Please Print) Date: ____ /___/___

Last Name: First Name: MI:

Preferred: Maiden: Miss/Ms/Mrs/Mr

Birthdate: / / Social Security #: - - Race:

Marital Status: ___Divorced ___Married ___Single ___Widowed ___Separated

Driver's License #:

Primary Language: Religion:

Address:

City: State: Zip code:

Phone Home: ( ) - Primary Work: ( ) - Cell: ( ) -

Employer Name: Employer Address:

Occupation:

Email Address:

Preferred method in which we may contact you: ☐ Email ☐ Voicemail ☐ Text Message

Preferred Pharmacy: Address: Tel #:

Do you have an Advance Directive? ☐ Yes ☐ No If yes, do you have a Proxy Directive? ☐ Yes ☐ No

If yes, name of Proxy (Healthcare Representative): _____

Do you have an Instruction Directive? ☐ Yes ☐ No

VISIT INFORMATION

Why have you come to the office today?

GYNECOLOGIC: ☐ Annual exam ☐ Problem visit If you are here for a problem visit, please explain:

_____

COSMETIC: ☐ Cosmetic Consultation ☐ Cosmetic Procedure

Pelosi Medical Center

Female Health Assessment Questionnaire

NAME: _____

TODAY'S DATE: ___/___/___ **PHONE:** _____ **EMAIL:** _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or difficulty with sexual intercourse	☐	☐	☐	☐	☐
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

Patient ID

Pelosi Medical Center

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Policy Attachment 06.09(a)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA'), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Pelosi Medical Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the Center at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____ Signature: _____ Date: _____

Family members or others you authorize us to discuss your protected health information with:

Last Name: _____ First Name: _____

Tel #: _____ ☐ Spouse ☐ Son/Daughter ☐ Parent ☐ Other, specify _____

Last Name: _____ First Name: _____

Tel #: _____ ☐ Spouse ☐ Son/Daughter ☐ Parent ☐ Other, specify _____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices but was unable to do so as documented below:

Reason:

_____

_____

Date: _____ Initials:_____

PELOSI MEDICAL CENTER

PATIENT HISTORY

TODAY'S DATE: ____/_____/_____

PAST MEDICAL HISTORY

MAJOR ILLNESS	DATE	MAJOR ILLNESS	DATE

PAST SURGERIES (INCLUDING COSMETIC SURGERY)

NAME OF OPERATION	DATE	NAME OF OPERATION	DATE

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, and nonprescription medications)

DRUG NAME & DOSE	WHO PRESCRIBED	DRUG NAME & DOSE	WHO PRESCRIBED

ALLERGIES & SENSITIVITIES (FOOD, MEDICATION, & ENVIRONMENTAL)

ALLERGY/SENSITIVITY	TYPE OF REACTION
NO KNOWN ALLERGIES OR SENSITIVITIES ☐	

SMOKING AND ALCOHOL HISTORY

	NEVER	CURRENT	FORMER	AGE STARTED	AGE STOPPED	AMOUNT USED/DAY
SUBSTANCE USE						
ALCOHOL						
TOBACCO						

INFECTION RISK

	EXPOSED TO	POSSIBLY EXPOSED TO:
HEPATITIS B		
HIV		
TUBERCULOSIS		

	YES	NO
HISTORY OF BLOOD TRANSFUSION:		
HISTORY OF SEXUALLY TRANSMITTED DISEASE:		
NO KNOWN INFECTION RISK ☐		

PATIENT SIGNATURE: _____

FORM COMPLETED BY: ☐ PATIENT ☐ OFFICE MED ASST ☐ OTHER

Pelosi Medical Center

PATIENT RIGHTS & RESPONSIBILITIES

As a patient, you have the right to:

- Receive an understandable explanation from your physician of your complete medical condition including recommended treatment, expected results, risks and reasonable alternatives. If your physician believes that some of this information would be detrimental to your health or beyond your ability to understand, the explanation must be given to your next of kin or guardian.
- Give informed written consent prior to the start of specified, nonemergency medical procedures or treatments only after your physician has explained—in terms you can understand—specific details about the recommended procedure or treatment, the risks, time to recover and reasonable medical alternatives.
- Be informed of the Center's written policies and procedures regarding life-saving methods and the use or withdrawal of life-support.
- Refuse medication and treatment to the extent permitted by law and to be informed of the medical consequences of refusal.
- Be included in experimental research only when you have given informed consent to participate.
- Receive appropriate assessment and treatment for pain.
- Be transferred to another facility only if the current facility is unable to provide the level of appropriate medical care or if the transfer is requested by you or your next of kin or guardian.
- Receive from a physician in advance an explanation of the reasons for transfer including alternatives, verification of acceptance from the receiving facility, and assurance that the move will not worsen your medical condition.
- Be treated with courtesy, consideration and respect for your dignity and individuality.
- Know the names and functions of all physicians and other health care professionals directly caring for you.
- Expeditiously receive the services of a translator or interpreter, if needed, to communicate with the staff.
- Be informed of the names, titles, and duties of other health care professionals and educational institutions that participate in your treatment. You have the right to refuse to allow their participation.
- Be advised in writing of the Center's rules regarding the conduct of patients and visitors.
- Receive a summary of your rights as a patient, including the name(s) and phone number(s) of the staff to whom to direct questions or complaints about possible violations of your rights.
- Have prompt access to your medical records. If your physician feels that this access is detrimental to your health, your next of kin or guardian has a right to see your records.
- Obtain a copy of your medical records for a reasonable fee within 30 days after submitting a written request to the Center.
- Receive a copy of the Center charges, an itemized bill, if requested, and an explanation.
- Appeal any charges and receive an explanation of the appeals process.
- Obtain the Center's help in securing public assistance and private health care benefits to which you may be entitled.
- Receive sufficient time before discharge to arrange for follow-up care.
- Be provided with physical privacy during medical treatment and personal hygiene functions, unless you need assistance.
- Be assured confidentiality about your patient stay. Your medical & financial records shall not be released to anyone outside the Center without your approval, unless you are transferred to another facility that requires the information, or release of the information is required & permitted by law.
- Have access to individual storage space for your private use and to safeguard your property if unable to assume that responsibility.
- Be free from physical and mental abuse.
- Be free from restraints unless authorized by a physician for a limited period of time to protect your safety or the safety of others.
- Receive treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay or source of payment.
- Exercise your constitutional, civil and legal rights.

As a patient, you have the responsibility to:

- Provide, to the best of your knowledge, accurate & complete information about present complaints, past illnesses, hospitalizations, medications, & other matters relating to your health. You have the responsibility to report unexpected changes in your condition to the responsible practitioner. As a patient you are responsible for reporting whether you understand a contemplated course of medical action and what is expected of you.
- Report dissatisfaction with the quality of care or service provided.
- Follow the treatment plan recommended by the practitioner primarily responsible for your care. This may include: following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care, implement the responsible practitioner's orders, and enforce the applicable facility rules and regulations.
- Keep appointments and, when you are unable to do so for any reason, notify the responsible practitioner.
- Be accountable for your actions if you refuse treatment or do not follow the practitioner's instructions.
- Follow rules and regulations affecting patient care and conduct.
- Be considerate of the rights of other patients and personnel. Either you or your decision maker has the responsibility for being respectful of the property of other persons and of the Center. Verbally abusive language and verbally disruptive conduct are not acceptable, and if it continues after a request to stop, you or your visitor(s) will be asked to leave the grounds or be escorted from the premises by Law Enforcement.

Questions and Complaints/Grievances

- If you have concerns about the care you received at this center, you may contact the facility Director, Marco Pelosi II, MD at 201-858-1800.
- You have the right to report any safety concerns to the **NJ State Department of Health** at 800-792-9770 or PO Box 367, Trenton, NJ 08625.
- You have the right to report any safety concerns to the **Accreditation Association for Ambulatory Health Care** at: 5250 Old Orchard Road, Suite 200, Skokie, IL 60077. Tel: 847.853.6060. Email: info@aaahc.org
- For information concerning **Medicare coverage**, call 800-MEDICARE (800-633-4227) or contact: Centers for Medicare and Medicaid Services, 7500 Security Blvd, Baltimore, MD 21244.
- For information regarding **Medicaid coverage**, the State's Health Benefits Coordinator for **Medicaid** and/or **NJ** FamilyCare can be reached toll free at 1-800-701-0710. Hearing impaired members can **call** the TDD / TTY number at 1-800-701-0720.

Patient Signature _____ Date _____

Print Name _____

Pelosi Medical Center

COSMETIC SURGERY FINANCIAL AGREEMENT

DATE: ____/____/____ PATIENT'S WEIGHT: _____LBS

PROCEDURE	FEE*
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____
Facility Fee	$ _____
Anesthesia Fee	$ _____
Total	$ _____
Less Deposit	$ _____
Balance Due	$ _____

Methods of Payment

- Cash, personal checks, cashier's check, traveler's check, and money orders. There will be a $20.00 service charge on returned checks.
- Credit cards: Visa, MasterCard, American Express and Debit Cards.
- Financing is available through CareCredit.com.

Cost of Surgery

The date of consult constitutes the day of the quote. The quoted surgical fee remains valid provided that: (1) the surgery is scheduled and the deposit is paid within six months of the date the quote was made, (2) the surgery is done within six months of the quote, and (3) the patient's weight does not increase by more than 5% after the time of the quote. The balance of the total fee must be paid **ONE MONTH** prior to your scheduled surgery date.

Scheduling Deposit

To reserve a day for your surgery, a $500.00 deposit is required. This is credited toward your actual surgery cost.

Patient Initials: _____

Pelosi Medical Center

COSMETIC SURGERY FINANCIAL AGREEMENT

Cancellation and Refunds

Please understand that the Pelosi Medical Center must uphold these policies as we have an obligation to our patients who may have requested the same day and to our surgical team and anesthesiologist who are scheduled to work. Also, there are numerous medical supplies that are ordered specifically for your surgery.

If you cancel your surgery **within 14 (fourteen) days** of your scheduled procedure, there is a $500.00 cancellation fee.

If you cancel your surgery **within 3 (three) days** of your scheduled procedure or fail to attend on your scheduled surgery date, there is a $1,000 cancellation fee.

The balance of your surgery pre-payment will be refunded in full by business check within 30 days. This time is required to ensure all pre-payment transactions have cleared and are validated by the appropriate financial institutions.

There will be no refund for services already provided.

Touch Up Procedures

Patient understands that liposuction and abdominoplasty are not weight reduction procedures. Patient understands that to maintain their newly contoured body shape, a commitment is required to change eating habits in order to avoid weight gain and loss of the newly contoured body shape.

A touch up procedure is additional work of the same type and on the same area(s) done at the original procedure for the reason that a reasonable aesthetic result was not achieved at the time of the original procedure. There is a facility fee of $500 for all touchup procedures. However, there will be no additional surgical charge for the touchup procedure under the following conditions:

1. The touchup procedure is performed within six months of the original procedure
2. The patient's weight remained the same since the date of the original procedure
3. The procedure is not a request for additional fat injections in any area treated with autologous fat transfer at the original procedure
4. The touchup procedure is for the same body area as the original procedure

If any of the above conditions are not met, there will be a surgical fee for the new/redo procedure. If the services of an anesthesiologist are required for the touchup procedure, these costs will not be waived by this policy and the patient will be responsible for paying the anesthesiologist fee.

Treatment and Complications

The practice of medicine and surgery is not an exact science. Although good results are anticipated, there can be *no guarantee or warranty, expressed or implied, by anyone as to the actual results you may get.* Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. These may result in additional charges *for which you are responsible*.

** In the event of default, I hereby agree to pay all costs of collection, including but not limited to attorney fees, court costs, all interest allowed by law, collection agency fees, etc.

I have read and understand the terms of this Cosmetic Surgery Financial Agreement.

_____ _____/_____/_____

Patient Signature Date