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

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Attachment 06.09(a)

Entiendo que conforme a la Ley de Portabilidad y Responsabilidad del Seguro Médico promulgada en el año 1996 ("HIPAA" por sus siglas en inglés) tengo ciertos derechos de privacidad en relación con mi información médica protegida. Entiendo que esta información puede y podrá usarse para:

- Llevar a cabo, planificar y dirigir mi tratamiento y controles posteriores entre los múltiples proveedores de salud involucrados en mi tratamiento, directa o indirectamente.
- Obtener el pago de terceros.
- Llevar a cabo las operaciones normales de asistencia médica, tales como evaluaciones de calidad y certificaciones médicas.

Confirmo que he recibido su *Información sobre las Prácticas de Privacidad* conteniendo una descripción más completa sobre cómo usar y revelar mi información médica. Entiendo que el Pelosi Medical Center tiene derecho a modificar su *Información sobre las Prácticas de Privacidad* y que puedo acudir en cualquier momento al Centro ubicado en la dirección que se señala en el membrete y obtener un ejemplar actualizado de la *Información sobre las Prácticas de Privacidad.*

Entiendo que puedo solicitar por escrito que ustedes limiten la forma cómo usar o revelar mi información privada para realizar un tratamiento, pago u operaciones de asistencia médica. Entiendo, asimismo, que ustedes no están obligados a aceptar mis restricciones; sin embargo, en el caso de hacerlo, deberán sujetarse a ellas.

Nombre del Paciente: _____ _____
(Apellido) (Nombre)

Relación con el Paciente: _____ Firma: _____ Fecha: _____

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

Apellido: _____ Nombre: _____

Tel #: _____ ☐ Esposo ☐ Hijo/Hija ☐ Padre ☐ Otro, especificar _____

Apellido: _____ Nombre: _____

Tel #: _____ ☐ Esposo ☐ Hijo/Hija ☐ Padre ☐ Otro, especificar _____

Para uso exclusive del consultorio

No me fue posible obtener la firma del paciente como confirmación de recepción de la presente Notificación sobre las Prácticas de Privacidad por lo siguiente:

Razón:

_____

_____

Fecha: _____ Iniciales:_____

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

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