# SPECIALTY SURGICAL ASSOCIATES

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FRANK J. BORAO, M.D., F.A.C.S., F.A.S.M.B.S
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10 Industrial Way East, Eatontown, NJ 07724 - Tel: 732-389-1331 – Fax: 732-542-8587

## PATIENT INFORMATION (PART I)

*--- PLEASE PRINT ALL INFORMATION ---*

Last Name: ______________ First Name: ______________ MI___ ☐Male☐Female

Address: ______________ City: ______________ State: ____ Zip: ________

Date of Birth: ____/____/____ Age: ______ SS#: ______-______-______ Marital Status: ______

Home Phone #: ______________ Work Phone # or other phone # **(Required):** ______________

Employer (Name & Address) ______________

Name of Spouse / Emergency Contact: ______________

Referring Physician (Name, Address & Phone #): ______________

**Primary Care Physician**: Name, Address & Phone # **(Required)** / **Cardiologist:**

______________

Pharmacy & Phone #: ______________ **Personal Email Address:** ______________

### INSURANCE INFORMATION: PLEASE GIVE US YOUR CARD TO PHOTOCOPY

**CO-PAYMENTS ARE DUE AT THE TIME OF VISIT**

Primary Carrier: ______________ ID#: ______________

Subscriber's Name: ______________ Date of Birth: ______________

Secondary Carrier: ______________ ID#: ______________

Subscriber's Name: ______________ Date of Birth: ______________

I HEREBY AUTHORIZE C.J. SPECIALTY SURGICAL ASSOCIATES TO FURNISH INFORMATION CONCERNING MY ILLNESS AND TREATMENT TO THE INSURANCE CARRIERS. I ALSO HEREBY ASSIGN C.J. SPECIALTY SURGICAL ASSOCIATES PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

☒ ______________________________ ______________

SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF MINOR) DATE

### * ONLY IF AUTO RELATED: COMPLETE INFORMATION BELOW

Date of Accident: ______________ Auto Related: [ ] Job Related: [ ]

Claim #: ______________ Adjuster: ______________ Phone #: ______________

Insurance Company - Name & Address: ______________

FOR WORKER'S COMPENSATION AND NO FAULT CASES, IF PAYMENT IS NOT RECEIVED WITHIN SIX MONTHS I AM RESPONSIBLE FOR FULL PAYMENT TO THE PHYSICIAN.

______________________________

SIGNATURE OF PATIENT (RESPONSIBLE PARTY, IF MINOR)

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## PATIENT MEDICAL HISTORY (PART II)

*--- PLEASE PRINT ALL INFORMATION ---*

Last Name: ______________________ First Name: ______________________ Date: __________

**REASON FOR VISIT:** (Check Below) **Date of First Symptom:** ______________________

[ ] Hernia
[ ] Ulcer
[ ] Pilonidal Cyst
[ ] Gallbladder
[ ] Lymph Nodes
[ ] Cyst
[ ] Gastric Problems
[ ] Abdominal Pain
[ ] Rectal Bleeding
[ ] Colonoscopy
[ ] Hemorrhoids
[ ] Anal/Rectal Pain
[ ] Other (Specify) ______________________

**PATIENT HISTORY:**

**Hypertension** [ ] Yes [ ] No **Diabetes** [ ] Yes [ ] No **Heart Disease** [ ] Yes [ ] No **Asthma** [ ] Yes [ ] No
**Stroke** [ ] Yes [ ] No **HIV**[ ] Yes [ ] No
**Hepatitis** [ ] Yes [ ] No **High Cholesterol** [ ] Yes [ ] No
**Cancer** [ ] Yes [ ] No (specify type) ______________________
Other (Specify) ______________________
**DID YOU HAVE A COLONOSCOPY?** [ ] Yes [ ] No **Date of your Last Colonoscopy** ______________

WEIGHT ___________ HOW LONG HAVE YOU BEEN AT THIS WEIGHT ___________ HEIGHT__________

**DO YOU USE TOBACCO NOW?** [ ] Yes [ ] No
**IN THE PAST?** [ ] Yes [ ] No
**DAILY AMOUNT USED** ______________
**HOW MANY YEARS** ______________

**DID YOU EVER CHEW TOBACCO?** [ ] Yes [ ] No

**ALCOHOL USE:** [ ] Yes [ ] No Frequency: [ ] Daily [ ] Occasional

**ARE YOU ALLERGIC TO LATEX?** [ ] Yes [ ] No **ARE YOU ALLERGIC TO PENICILLIN?** [ ] Yes [ ] No

**ALLERGIES TO MEDICATIONS**: ______________________

**LIST OF CURRENT MEDICATIONS (Dosage and Frequency):**

**PREVIOUS SURGERIES (Dates, Hospitals and name of Surgeon):**

*Do you have an Advanced Directive? (Living Will)* *[ ] Yes [ ] No*

**FAMILY HISTORY:**

[ ] **Cancer** (Specify type and family member) ______________________
[ ] **Arthritis** [ ] **Stroke** [ ] **Heart Disease** [ ] **Kidney Disease** [ ] **Diabetes**
[ ] **Other** (Specify)______________________

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# PATIENT MEDICAL HISTORY (Part III)

*--- PLEASE PRINT ALL INFORMATION ---*

Last Name: ______________________ First Name: ______________________ Date__________

## REVIEW OF SYSTEMS: *(Indicate below all that apply to you on a regular basis)*

| | | | | | |
|---|---|---|---|---|---|
| **General:** | [ ] Night Sweats | [ ] Fever | [ ] Poor Appetite | [ ] Weight Loss | [ ] Fatigue [ ] Malaise |
| **Eyes:** | [ ] Redness | [ ] Itching | [ ] Blurriness | [ ] Double Vision | [ ] Blindness |
| **ENT:** | [ ] Ringing in ears | [ ] Sinusitis | [ ] Hearing Loss | [ ] Hoarseness | [ ] Difficulty Swallowing |
| **Heart:** | [ ] Palpitations | [ ] Angina | [ ] Chest Pain | [ ] Swollen Ankles | |
| **Lungs:** | [ ] Frequent Cough | [ ] Wheezing | [ ] Coughing Blood | [ ] Pain w/Breathing | [ ] Difficulty Breathing |
| **GI:** | [ ] Abdominal Pain | [ ] Constipation | [ ] Nausea/Vomiting | [ ] Blood in Stool | |
| | [ ] Heartburn | [ ] Diarrhea | [ ] Rectal Bleeding | | |
| **GU:** | [ ] Pain w/Urination | [ ] Frequent Urination | [ ] Blood in Urine | [ ] Difficulty w/Urination | |
| **Ortho:** | [ ] Arthritis | [ ] Chronic Back Pain | | [ ] Swollen Joints | |
| **Skin:** | [ ] Ulcerations | [ ] Hair Loss | [ ] Infections | [ ] Psoriasis | [ ] Rash |
| **Neuro:** | [ ] Slurred Speech | [ ] Weakness | [ ] Migraines | [ ] Fainting | [ ] Seizures |
| **Psych:** | [ ] Mood Disorder | [ ] Depression | [ ] Insomnia | [ ] Anxiety | [ ] Agitation |
| **Endo:** | [ ] Weight Gain | [ ] Excessive Sweating | | [ ] Excessive Thirst | [ ] Intolerance Heat/Cold |
| **Heme:** | [ ] Bruising | [ ] Bleeding | [ ] Phlebitis | [ ] Swollen Lymph Nodes | |
| **Immune:** | [ ] Skin Reactions | [ ] Allergies/Seasonal | | [ ] Hives | [ ] Frequent Urination |

**Have you had a pneumonia vaccine in the last 5 years?** __________

**Have you had the flu vaccine this season?** __________

# Central Jersey Specialty Surgical Associates, LLC
## Notice of Privacy

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. We have a legal duty to safeguard your protected health information (PHI).

We are legally required to protect the privacy of your health information. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your information. We are legally required to follow the privacy practices that are described in this notice.

1. **How we may use and disclose your protected health information.** We use and disclose health information for many reasons. For some of these disclosures, we need your specific authorization. Below are the different categories of use and disclosures.
    a. **Uses and disclosures that do not require your authorization**
        i. For treatment. We may disclose your information to hospital, physician, nurses, and other health care personnel in order to provide, coordinate, or manage your health care or other related services. We may provide other health care providers with information to assist them in treating you.
        ii. To obtain payment for treatment. We may use and disclose your information in order to bill and collect payment for the treatment and services provided to you. We may also provide information to another provider involved in your care for the other provider's payment activities.
        iii. For health care operations. We may disclose your information, as necessary, to operate this facility and provide quality care. We may use your information in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your information to our attorneys, consultants, and other in order to make sure we are complying with the laws that affect us.
        iv. When a disclosure is required by federal, state, or local law; judicial or administrative proceedings; or law enforcement. We may disclose information when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or when subpoenaed or ordered in a judicial or administrative proceeding.
        v. For public health activities. We may disclose information to prevent, control, or report disease, injury, or disability as permitted by law; or to notify a person who has been exposed to a communicable disease or may be at risk for contracting or spreading a disease as authorized by law.
        vi. For health oversight activities. We may disclose information to assist the government or other health oversight agency with activities including audits, civil, administrative, or criminal investigations, proceedings, or actions.
        vii. For purposes of organ donation. We may disclose information to organ donor organizations to assist them in organ donations and transplants.
        viii. For research purposes. In certain circumstances we may provide information in order to conduct medical research.
        ix. To avoid harm. In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide information to law enforcement personnel or persons able to prevent or lessen such harm.
        x. For specific government functions. We may disclose information of military personnel and veterans in certain situations. We may also disclose information for national security and intelligence activities.
        xi. For worker's compensation. We may provide information in order to comply with WC's laws.

xii. Appointment reminders. We may disclose your information for the following reasons: to contact you to remind you of an appointment, to describe or recommend treatment alternatives, or to furnish information about health related benefits and services that may be of interest to you. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

b. **Uses and disclosures of your PHI that require written authorization.** In general, we need your specific written authorization on our HIPPAA Authorization Form to use or disclose your PHI for any purpose other than those listed above in Section 1A. For example, we would need your written authorization to disclose psychotherapy notes, or need you to indicate on the HIPPAA Authorization Form that we may send you marketing materials. We will seek your specific written authorization for at least the following information unless the use or disclosure would otherwise be permitted or required by law as described above:

i. Disclosures to family, friends, or others. We may disclose your PHI to family members and relatives, close friends, caregivers, or other individuals that you may identify.

1. So long as we:
    a. Obtain your agreement;
    b. Provide you with the opportunity to object to the disclosure and you do not object; and
    c. We reasonably infer that you would not object to the disclosure.
2. If you are not present or, due to your incapacity in an emergency, you are unable to agree or object to a use or disclosure, we may exercise our professional judgment in order to determine whether such use or disclosure would be in your best interests. Where we would disclose information to a family member, other relatives, or a close friend, we would disclose only that information we believe is directly relevant to his or her involvement with your care or payment related to your care. We will also disclose your PHI in order to notify or assist with notifying such persons of your location, general condition, or death. You may at any time request that we do NOT disclose your PHI to any of these individuals.

ii. HIV/AIDS information. **In most cases, we will NOT release any of your HIV/AIDS related information unless your authorization expressly states that we may do so.** There are certain purposes, however, for which we may be permitted to release your HIV/AIDS to your insurance company or HMO for purposes of receiving payment for services we have provided you with. Other instances include, but are not limited to:

1. For diagnosis and treatment;
2. For medical education;
3. For disease prevention and control, when permitted by the New Jersey Department of Health;
4. To comply with certain court orders; and
5. When otherwise required by law, the New Jersey Department of Health, or another entity.

iii. Sexually transmitted infection information. In certain cases, we must obtain your specific authorization prior to disclosing any information that would identify you as having or being suspected of having a sexually transmitted infection. We may use and disclose information related to sexually transmitted infections without obtaining your authorization only where we are permitted by law, including to the New Jersey Department of Health and Senior Services, to your physician or a health authority, or to a prosecuting officer or court if you are being prosecuted under New Jersey law. Where necessary, your physician or a health authority may further disclose such information to protect your health and welfare, or the health and welfare of your family and the public.

iv. Tuberculosis information. We must obtain your specific written authorization prior to disclosing any information that would identify you as having or being suspected of having tuberculosis (TB).

We may use and disclose TB information where authorized by law, such as for research purposes, to the New Jersey Department of Health, or otherwise authorized by a court order.

v. Psychotherapy notes. We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law.

vi. Drug and alcohol information. We must obtain your specific written authorization prior to disclosing information related to drug and alcohol treatment or rehabilitation under certain circumstances such as where you received drug or alcohol treatment at a federally funded treatment facility or program.

vii. Genetic information. We must obtain your specific written authorization prior to obtaining or retaining your genetic information, or using or disclosing it for treatment, payment, or health care operations purposes. We may use or disclose your genetic information without your written authorization only where it would be permitted by law, such as for paternity tests for court proceedings, newborn screening requirements, identifying a body, or otherwise authorized by a court order.

viii. Information related to emancipated treatment of a Minor. If you are a minor who has sought emancipated treatment from us, such as treatment to your pregnancy or treatment of your child, or a sexually transmitted infection (STI), we must obtain your specific written authorization prior to disclosing any of this information to another person, including your parent or guardian, unless otherwise permitted or required by law.

ix. Marketing activities. **We must obtain your specific written authorization order to use any of your PHI to mail or e-mail you marketing materials.** However, we may provide you with marketing materials face-to-face without obtaining authorization, in addition to communicating with you about services or products that relate to your treatment, case management, or care coordination, alternative treatments, therapies, providers, or care settings. If you do provide us with you written authorization to send you marketing materials, you have the right to revoke your authorization and may do so at any time for future marketing communications. If you wish to revoke your authorization, please contact us by phone or mail using the contact information provided in Section 4.

x. Activities where we receive money for exchanging PHI. For certain activities in which we would receive money (renumeration) directly or indirectly form a third party in exchange for your PHI, we must obtain your specific written authorization prior to doing so. However, we would not require your authorization for activities such as for treatment, public health, or research purposes. You have a right to revoke your authorization at any time. IF you wish to revoke your authorization, please contact our office by phone or mail using the contact information provided in Section 4.

xi. All other uses and disclosures require your prior written authorization. Other than as stated above, we will not disclose your information without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action upon the authorization.

2. **Individual rights.** You have the following rights with respect to your personal health information:
   a. The right to request limits on uses and disclosures of your PHI. You have the right to request in writing that we limit how we use and disclose your information. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.
   b. The right to choose how we send PHI to you. You have the right to ask that we send information to you at an alternate address. We must agree to your request so long as we can easily provide it in the manner you requested.
   c. The right to see and get copies of your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. We will respond to you after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in

writing, our reasons for the denial and explain your rights to have the denial reviewed. If you request copies of your PHI, we will charge you $1.00 for each page.

d. The right to get a list of the disclosures we have made. You have the right to get a list of instances in which we have disclosed your information. The list will not include uses of disclosures made for purposes or treatment, payment, or health care operations, those made to pursuant to your written authorization, or those made directly to your family. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 1, 2003. We will respond within 60 days of reviewing your written request. We will provide a 12-month period list at no charge, but if you make more than one request in the same year, we will charge you $10.00 for each additional request.

e. Right to request access report. You may request an access report of all accesses to your PHI maintained in an electronic designated record set within the period of three years from the date of your request for the access report. The first access report you request within a period of twelve months is free. Any subsequent requested accounting may result in a reasonable charge for the access report. We will generally respond to your request in writing within thirty days from the receipt of the request.

f. The right to correct or update your PHI. If you believe that there is a mistake in your information or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your written request. We may deny you request if the PHI is (1) correct and complete, (2) not created by us, (3) not allowed to be disclosed, or (4) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. You have the right have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your information.

g. The right to get this notice by e-mail. You have the right to get this notice by e-mail.

h. Right to notice of breach. We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your PHI through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured PHI and inform you of what steps you may need to take to protect yourself.

3. **Complaints/additional information.** You may contact our office at any time if you wish any additional information or have questions concerning this notice of your PHI. If you feel that your privacy rights may have been violated, you may also contact our office OR file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. We will NOT retaliate against you if you file a complaint with us or the Office of Civil Rights. If you wish to file a written complaint with the Office of Civil Rights, please contact our office and we will provide you with the contact information.

4. **Our contact information.** You may call us with any concerns or for additional information regarding our privacy practices by calling or writing our office at:

**Central Jersey Specialty Surgical Associates, LLC**
**10 Industrial Way East**
**Suite 104**
**Eatontown, NJ 07724**

*This notice went into effect on April 1, 2003*
*Last updated October 2013*

# SPECIALTY SURGICAL ASSOCIATES

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## RECEIPT OF NOTICE OF PRIVACY PRACTICES
## WRITTEN AKNOLEDGMENT FORM

I have received a copy of CJ Specialty Surgical Associates, LLC's Notice of Privacy Practices

_________________________________ _________________________

Name of Patient Date

_________________________________

Signature of Patient

_________________________________ _________________________

Signature of Guardian if patient under 18 y/o Relationship to Patient

DISCLOSURES TO FAMILY, FRIENDS OR OTHERS:
Please indicate if we may provide your PHI to a family member, friend, or other person that is involved with your care.

Yes, I _______________________ authorize the disclosure of my medical records to:

_________________________________________________________________

Indicate name and relationship

____ NO I do not authorize the disclosure of my medical records.

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

________________ ________________

*Date* *Initials*

*Reason:* _______________________________________________________

_________________________________________________________________

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Diplomate of the American Board of Surgery
Diplomate of the American Board of Colon & Rectal Surgery

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Diplomate of the American Board of Surgery
Diplomate of the American Board of Colon & Rectal Surgery

**Frank J. Borao,** M.D., F.A.C.S., F.A.S.M.B.S.
General and Advanced Laparoscopic Surgery
Diplomate of the American Board of Surgery

**Steven J. Binenbaum,** M.D. F.A.C.S., F.A.S.M.B.S.
Minimally Invasive
General and Bariatric Surgery

**Gurdeep S. Matharoo**, M.D., F.A.C.S.
Board Certified – American Board of Surgery
Advanced Laparoscopic, Robotic & Bariatric Surgery

# MEDICAL RECORDS RELEASE FORM

**DATE:** ______________________________

**PATIENT:** __________________________________________________ **DOB:** ____________

**I,** ______________________________________________________________
(PRINT NAME OF PATIENT)

**AUTHORIZE:** _________________________________________________________
(PRINT NAME OF DOCTOR)

_________________________________________________________
(ADDRESS)

_________________________________________________________

________________________ ________________________
(TELEPHONE #) (FAX #)

**TO RELEASE ALL MEDICAL RECORDS TO:**

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

**SIGNED:** ________________________________________ **DATE:** ____________________

**WITNESS:** ________________________________________ **DATE:** ____________________