COSMEDIXonCALL

REGISTRATION FORM

Name: **DOB:** **Age:** **Date:**

Address: **City:** **State:** **Zip:**

Home Tel: **Work Phone:** **Cell:**

Email: **Driver's Lic#:**

Marital Status: Married **Employment Status**: Employed

Occupation: **Employer Name**: **Telephone #:**

If under 18: Guardian/Parent's Name **Telephone #:**

Address of Parent/Guardian:

Spouse's Name: **Telephone #:**

Spouse's Address (if different):

Emergency Contact: **Telephone #:**

Pharmacy Name: **Telephone #:**

Primary Physician: **Tel #:** **Fax #:**

Has anyone in your family been treated at our practice? ☐ **Yes** ☐ **No**

Name and Relationship to patient:

Referred by:

Family: Friend: Google: Internet Site:

Magazine: Newspaper: Other:

<u>Primary Insurance and Policy Holder</u>

Name of Insurance: **Tel #:**

Billing Address to send claims (On the back of the ID card):

Policy/ID #: **Group #** **Effective Date:**

Subscriber's Name: **DOB:**

Relationship to Patient: Self/Spouse/Child or Other:

COSMEDIXonCALL

Medical History Questionnaire

Name: **DOB:** **Date:**

Reason for visit:

Have you consulted with another specialist about this matter: ☐ **Yes** ☐ **No**
Name of Doctor:

Primary Doctor:

Telephone Number:

Address:

General State of Health: ○ **Good** ○ **Fair** ○ **Bad**
If you responded fair or bad, please explain why:

Height: **Weight:**
Have you lost or gained weight in the past year? Lost: ○ **Gained:** ○ **How Much:**
Date of last: **Check up:** **EKG:** **Chest X-ray:**

Past Medical History (List All Conditions):

Do you have any of the following (Please Check):

☐ Diabetes	☐ Hypertension	☐ Prostate Problems	☐ Clotting
☐ Asthma	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Coagulopathy
☐ Hepatitis	☐ High Cholesterol	☐ Pulmonary Disease	☐ Bleeding Disorder
☐ Reflux	☐ Venous Thrombosis	☐ Stroke	☐ Depression
☐ Ulcers	☐ Heart Attack	☐ Thyroid problems	☐ History of Cancer
☐ Glaucoma	☐ Kidney Disease	☐ Autoimmune Diseases	☐ Anxiety
☐ Cancer	☐ Heart Arrhythmia	☐ Gastrointestinal Diseaser	☐ Psychiatric Illness

Pertinent Operative History:

Have you reacted badly to anesthesia or being put to sleep for surgery:	Yes ○ No ○
Has anyone in your family reacted badly to anesthesia or being put to sleep:	Yes ○ No ○
Have you reacted badly to Local Anesthesia (i.e. Novocaine, Lidocaine):	Yes ○ No ○
Have you ever suffered from Scarlet or Rheumatic Fever:	Yes ○ No ○
Do you bruise or bleed easily:	Yes ○ No ○
Do you for large scars or Keloid from surgery or when you cut yourself:	Yes ○ No ○
Do you have frequent infections or boils:	Yes ○ No ○
Do you have skin conditions, rashes, hives, and eczema:	Yes ○ No ○
Does your religion forbid blood transfusions:	Yes ○ No ○

Past Surgical History (List All Operations with Type/Year):

Have you had any of the following surgeries or procedures? (Please Check):

☐ Cosmetic Surgery	☐ appendix removal	☐ breast surgery
☐ Gallbladder removal	☐ hernia surgery	☐ hemorrhoids surgery
☐ C-section	☐ orthopedic surgery	☐ pacemaker placement
☐ Vascular Surgery	☐ tonsil surgery	☐ defibrillator placement
☐ Cancer Surgery	☐ oral surgery	☐ skin cancer removal
☐ Colon Surgery	☐ heart surgery	☐ brain surgery
☐ skin excisions	☐ spine surgery	☐ Gynecologic Surgery (Ovaries, Uterus)
☐ botox injections	☐ fillers (Juvederm, Restylane, etc)	

Medications (Type/Dosage):

Are you taking any of the following (Please check):

☐ Aspirin	☐ Motrin	☐ Coumadin	☐ Herbal Supplements
☐ Ticlid	☐ Plavix	☐ Celebrex	☐ Birth control
☐ Vitamins	☐ Accutane (Last Dose)		☐ Retin A (If yes last treatment)
☐ Steroids, Cortisone or ACTH (How long?)			☐ Hormone Supplement/Replacement

Daily Consumption of the following:

Coffee: Tea: Alcohol**:** Tobacco:

Allergies to Medicines (Describe the Reaction):

Allergies to Suture Materials: ☐ Yes ☐ No

Latex allergy? ☐ Yes ☐ No

OB/Gyn History Pregnancies:
Children:
Last Menstrual Period:
Last Mammogram:

Family History:

	Age:	**State of Health:**
Mother:		
Father:		
Brothers:		
Sisters:		
Children:		

Has any family member had the following (Check and Indicate Relationship):

☐ Breast Cancer:
☐ Ovarian Cancer:
☐ Other types of Cancer:
☐ Diabetes:
☐ Arthritis:
☐ High Blood Pressure:
☐ Stroke:
☐ Heart Disease:
☐ Lung Disease:
☐ Kidney Disease:
☐ Psychiatric Illness (Depression, Manic Depression):
☐ Bleeding Disorders:
☐ Deep Venous Thrombosis:
☐ Excessive Clotting:
☐ Epilepsy:
☐ Asthma:
☐ Tuberculosis:

Social History:

Employment/Job Description:
Marriage Status:
Smoking History (Packs/Day &
Years): Other Household Smokers:
Mind Altering/Illicit Drug History:
Alcohol Consumption (Amount/Day)
Children (number and age)

REVIEW OF SYMPTOMS

CONSTITUTIONAL SYMPTOMS

Good general health lately:	○ No	○ Yes
Recent weight change:	○ No	○ Yes
Fever:	○ No	○ Yes
Fatigue:	○ No	○ Yes
Headaches:	○ No	○ Yes

EYES

Eye disease or injury:	○ No	○ Yes
Wear glasses/contact lenses:	○ No	○ Yes
Blurred or double vision:	○ No	○ Yes
Glaucoma:	○ No	○ Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing:	○ No	○ Yes
Earaches or drainage	○ No	○ Yes
Chronic sinus problem/ rhinitis	○ No	○ Yes
Nose bleeds	○ No	○ Yes
Mouth sores	○ No	○ Yes
Bleeding gums	○ No	○ Yes
Bad breath or bad taste	○ No	○ Yes
Sore throat or voice change	○ No	○ Yes
Swollen glands in neck	○ No	○ Yes

CARDIOVASCULAR

Heart trouble	○ No	○ Yes
Chest pain or angina pectoris	○ No	○ Yes
Palpitation	○ No	○ Yes
Shortness of breath	○ No	○ Yes
with walking/lying flat	○ No	○ Yes
Swelling of feet, ankles, or hands	○ No	○ Yes

RESPIRATORY

Chronic or frequent coughs	○ No	○ Yes
Spitting up blood	○ No	○ Yes
Shortness of breath	○ No	○ Yes
Asthma or wheezing	○ No	○ Yes

GASTROINTESTINAL

Loss of appetite	○ No	○ Yes
Change in bowel	○ No	○ Yes
Nausea or vomiting	○ No	○ Yes
Frequent diarrhea	○ No	○ Yes
Painful bowel movements	○ No	○ Yes
Constipation:	○ No	○ Yes
Rectal bleeding or blood in stool	○ No	○ Yes
Abdominal pain	○ No	○ Yes

GENITOURINARY

Frequent urination	○ No	○ Yes
Burning or painful urination	○ No	○ Yes
Blood in urine	○ No	○ Yes
Change in force of stream	○ No	○ Yes
Incontinence or dribbling	○ No	○ Yes
Kidney stones	○ No	○ Yes
Sexual difficulty	○ No	○ Yes
Male — testicle pain	○ No	○ Yes
Female — periods: pain/irregular	○ No	○ Yes
Female — vaginal discharge	○ No	○ Yes

MUSCULOSKELETAL

Joint pain	○ No	○ Yes
Joint stiffness or swelling	○ No	○ Yes
Weakness of muscles or joints	○ No	○ Yes
Muscle pain or cramps	○ No	○ Yes
Back pain	○ No	○ Yes
Cold extremities	○ No	○ Yes
Difficulty in walking	○ No	○ Yes

INTEGUMENTARY (skin, breast)

Rash or itching	○ No	○ Yes
Change in skin color	○ No	○ Yes
Change in hair or nails	○ No	○ Yes
Varicose veins	○ No	○ Yes
Breast pain	○ No	○ Yes
Breast lump	○ No	○ Yes
Breast discharge	○ No	○ Yes

NEUROLOGICAL

Frequent or recurring headaches	○ No	○ Yes
Light headed or dizzy	○ No	○ Yes
Convulsions or seizures	○ No	○ Yes
Numbness or tingling sensations	○ No	○ Yes
Tremors	○ No	○ Yes
Paralysis	○ No	○ Yes
Stroke	○ No	○ Yes
Head Injury	○ No	○ Yes

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PSYCHIATRIC

Memory loss or confusion	○ No	○ Yes
Nervousness	○ No	○ Yes
Depression	○ No	○ Yes
Insomnia	○ No	○ Yes

ENDOCRINE

Glandular or hormone problem	○ No	○ Yes
Thyroid disease	○ No	○ Yes
Diabetes(insulin or non insulin	○ No	○ Yes
Excessive thirst or urination	○ No	○ Yes
Heat or cold intolerance	○ No	○ Yes
Skin becoming dryer	○ No	○ Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal cuts; bruising	○ No	○ Yes
Anemia	○ No	○ Yes
Phlebitis	○ No	○ Yes
Past transfusion	○ No	○ Yes
Enlarged glands	○ No	○ Yes

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ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	○ No	○ Yes
Morphine, Demerol, or other narcotics	○ No	○ Yes
Novocaine, Lidocaine or other anesthetics	○ No	○ Yes
Aspirin or other pain remedies	○ No	○ Yes
Iodine, methiolate or other antiseptic .	○ No	○ Yes
Food or Drug allergies	○ No	○ Yes
Consistent cough for more than 2 weeks	○ No	○ Yes

ALAN BIENSTOCK, MD

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Notice of Privacy Practices Consent Form

This consent form attests to the fact that I have received and read the packet on the Notice of Privacy Practices from the above physician.

_____
Printed Name of Patient/Guardian

_____
Signature of Patient/Guardian

_____
Date

ALAN BIENSTOCK, MD

NOTICE OF PRIVACY PRACTICES

EFFECTIVE: SEPTEMBER 23, 2013

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 is provided to you as a requirement of the Health Insurance Portability & Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE - You will be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information in accordance with law.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION - "Protected health information" is individually identifiable health information and includes demographic information (for example, age, address, etc.), and relates to your past, present or future physical or mental health or condition and related health care services. Our Practice is required by law to do the following: (1) keep your protected health information private; (2) present to you this Notice of our legal duties and privacy practices related to the use and disclosure of your protected health information; (3) follow the terms of the Notice currently in effect; (4) post and make available to you any revised Notice; and (5) notify affected individuals following a breach of unsecured protected health information. We reserve the right to revise this Notice and to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. The Notice's effective date is at the top of the first page and at the bottom of the last page.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION - Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

Required Uses and Disclosures - By law, we must disclose your health information to you unless it has been determined by a health care professional that it would be harmful to you. Even in such cases, we may disclose a summary of your health information to certain of your authorized representatives specified by you or by law. We must also disclose health information to the Secretary of the U.S. Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws on the protection of your health information.

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 may disclose your protected health information from time-to-time to another physician or health care provider (for example, a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care. In emergencies, we will use and disclose your protected health information to provide the treatment you require

Payment - Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities we may need to undertake before your health care insurer approves or pays for the health care services recommended for you, such as determining eligibility or coverage for benefits. For example, obtaining approval for a surgical procedure might require that your relevant protected health information be disclosed to obtain approval to perform the procedure at a particular facility. We will continue to request your authorization to share your protected health information with your health insurer or third-party payer.

Health Care Operations - We may use or disclose, as needed, your protected health information to support our daily activities related to providing health care. These activities include billing, collection, quality assessment, licensing, and staff performance reviews. For example, we may disclose your protected health information to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may call you by name in the waiting room when your physician is ready to see you. We will share your protected health information with other persons or entities who perform various activities (for example, a transcription service) for our Practices. These business associates of our Practice are also required by law to protect your health information. We may use or disclose your protected health

information as necessary to contact you in order to raise funds for our Practice. Any such communication will tell you how you may opt out of receiving future fundraising communications from us.

Required by Law - We may use or disclose your protected health information if law or regulations requires the use or disclosure.

Public Health - We may disclose your protected health information to a public health authority who is permitted by law to collect or receive the information. For example, the disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; or report reactions to medications or problems with medical products. We may provide proof of immunization without authorization, to your school if (i) the school is required by State or other law to have proof of immunization prior to admission and (ii) we obtain and document your permission or, for a minor, the permission of the parent, guardian or other person acting *in loco parentis* for the individual.

Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, or other regulatory programs.

Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events; track products, enable product recalls; make repairs or replacements; or conduct post-marketing review.

Legal Proceedings - We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement - We may disclose protected health information for law enforcement purposes, including information requests for identification and location; and circumstances pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donations - We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaver organ, eye or tissue donations.

Research - We may disclose protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Threat to Health or Safety - Under applicable Federal and State laws, we may disclose your protected health information to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Workers' Compensation - We may disclose your protected health information to comply with workers' compensation laws and similar government programs.

Inmates - We may use or disclose your protected health information, under certain circumstances, if you are an inmate of a correctional facility.

Parental Access - State laws concerning minors permit or require certain disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION - In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Following are examples in which your agreement or objection is required.

Individuals Involved in Your Health Care - Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. If you should become deceased, we may disclose your protected health information to a family member or other individual who was previously involved in your care, or in payment for your care, if the disclosure is relevant to that person's prior involvement, unless doing so is inconsistent with your prior expressed preference. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION - You may exercise the following rights by submitting a written request to our Privacy Officer. Our Privacy Officer can guide you in pursuing these options. Please be aware that our Practice may deny your request; however, in most cases you may seek a review of the denial.

Right to Inspect and Copy - You may inspect and/or obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that our Practice uses for making decisions about you. This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. You will be charged a fee for a copy of your record and we will advise you of the exact fee at the time you make your request. We may offer to provide a summary of your information and, if you agree to receive a summary, we will advise you of the fee at the time of your request.

Right to Request Restrictions - You may ask us not to use or disclose any part of your protected health information for treatment, payment or health care operations. Your request must be made in writing to our Privacy Officer. In your request, you must tell us: (1) what information you want restricted; (2) whether you want to restrict our use or disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. If we believe that the restriction is not in the best interests of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your protected health information in violation of that restriction, unless it is needed to provide emergency treatment. You may ask us not to disclose certain information to your health plan. We must agree with that request only if the disclosure is not for the purpose of carrying out treatment (only for carrying out payment or health care operations) and is not otherwise prohibited by law and pertains solely to a health care item or service for which we have been paid out of pocket in full by you or by another person on your behalf other than your health plan. You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Alternative Confidential Communications - You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Request Amendment - If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosure - You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment or health care operations as described in this Notice and excludes disclosures made directly to you, to others pursuant to an authorization from you, to family members or friends involved in your care, or for notification purposes. The accounting will only include disclosures made no more than 6 years prior to the date of your request. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

Rights Related to an Electronic Health Record – If we maintain an electronic health record containing your protected health information, you have the right to obtain a copy of that information in an electronic format and you may choose to have us transmit such copy directly to a person or entity you designate, provided that your choice is clear, conspicuous, and specific. You may request that we provide you with an accounting of the disclosures we have made of your protected health information (including disclosures related to treatment, payment and health care operations) contained in an

electronic health record for no more than 3 years prior to the date of your request (and depending on when we acquired an electronic health record).

Right to Obtain a Copy of this Notice - You may obtain a paper copy of this Notice from us, or, if you agree, by email.

Special Protections - This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV-related information, family planning information, mental health information, psychotherapy notes, and substance abuse information. These laws have not been superseded and have been taken into consideration in developing our policies and this Notice. Psychotherapy notes, release of protected health information for marketing purposes or sale of protected health information, are all specifically subject to more strict privacy standards and most uses and disclosures require express authorization from you.

Complaints - If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION - Our Privacy Officer is Alan Bienstock, MD and can be contacted at this office or by calling our telephone number (917) 257-7560. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices.