Patient Demographics

Please complete this form in its entirety.

Patient Name:____

Address: ____

City:____ State:____________ Zip:_____________

Home Phone # (________)______________________ Cell # (________)___________________________

Date of Birth ______ /_____ /______ Age: ______ [ ] Male [ ] Female [ ] Other ______________

Social Security #: _______-_______-_________ Email:____

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced/Separated

Primary Language: _______________________ Full Time Student [ ] No [ ] Yes - at ________________

Employer: ___________________________________ Occupation:___________________________

Who referred you to our facility?

[ ] Friend / Relative/ Previous Patient: ____

[ ] Physician / Hospital ____

[ ] www.BreslowMD.com [ ] Social Media: ______________________________

Medical Doctor's Name/ Primary Care Physician: ____

Address: ____ Phone #(_______)_________________

Pharmacy Name: ______________________________ Pharmacy Phone #(_______)_______________

Pharmacy Address: ____

- INSURANCE INFORMATION -

Primary Insurance Company Name: ____

Phone Number #(____)___________________ ID # ____

Policyholder Name:___________________________ DOB_____/_____/_____ Relationship ______________

Guarantor's Employer: ____________________________________Work #(_____)_____________________

Secondary Insurance Company Name: ____

Phone Number #(____)___________________ ID # ____

Policyholder Name:___________________________ DOB_____/_____/_____ Relationship ______________

Guarantor's Employer: ____________________________________Work #(_____)_____________________

By signing, I confirm that the information that I have provided is accurate to the best of my knowledge.

Patient Signature____ Date _____/_____/______

PATIENT DISCLOSURE CONSENT

HIPAA privacy rules give individuals the right to request a restriction of uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that communications be made via alternative means such as sending information to the individuals' place of employment instead of their home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER ***(check & complete all that apply)***

- ☐ Home telephone # ____
  - ☐ OK to leave a detailed message.
  - ☐ Leave a message with a callback number ONLY.
- ☐ Work telephone # ____
  - ☐ OK to leave a detailed message.
  - ☐ Leave a message with a callback number ONLY.
- ☐ Cell Phone #____
  - ☐ OK to leave a detailed message.
  - ☐ Leave a message with a callback number ONLY.
- ☐ **Emergency Contact Person:** ________________________________

  Relationship ____

  Phone # ____
  - ☐ **OK to leave a message with detailed information.**
  - ☐ **Leave a message with a callback number ONLY.**

- ☐ Alternate telephone # _______________________________________

PRIVACY RULES REQUIRE US TO TAKE REASONABLE STEPS TO LIMIT THE USE OR DISCLOSURE OF YOUR INFORMATION TO THE MINIMUM NECESSARY. TO ACCOMPLISH THE INTENDED PURPOSE, USES AND DISCLOSURES ARE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY SITUATION.

____

Signature   Print Name   Date

Patient Name:

____

Last First Middle

I request that payment of authorized insurance benefits be made on my behalf to
Gary D. Breslow, M.D. / Patrick J. Greaney, Jr. M.D.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE INSURANCE POLICY(S) mentioned herein and attached hereto. I authorize any holder of my medical information and records to release to the health care financing administration and its agents, or any insurance company and any information needed to determine these benefits payable for the related services.

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, I HEREBY INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS:

The Breslow Center
1 West Ridgewood Avenue
Suite 110
Paramus, NJ 07452

If applicable, I hereby authorize The Breslow Center to commence arbitration and/or litigation proceedings against the appropriate insurance carrier and/or initiate a complaint to the Insurance Commissioner for any reason on my behalf in order for said provider to obtain payment for services furnished to me.

I understand and agree that this assignment does not discharge my responsibility in the event that my insurance company does not make payment and that I am financially responsible for the fees for services rendered.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Patient Signature:____ Date__________

Guardian Signature:____ Date __________
(if patient is a minor)

Print Name: ____________________________Relationship to Patient ____________

Witness Signature:____ Date__________

Summary of Notice of Privacy Practices

This summary is provided to assist you in understanding the Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your right as a patient and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information
We will use and disclose information in order to treat or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for services or to allow insurance companies to process insurance claims for services rendered to you by us or health care providers. Finally, we will disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of staff.

Uses and Disclosures based on Your Authorization
Except as states in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without you written authorization.

Uses and Authorizations Not Requiring Your Authorization
In the following circumstances, we may disclose your health information without written authorization:

- To family members or close friends who are involved in your health care
- To certain limited research purposes for purposes of public health safety
- To government agencies for purposes of their audits, investigations, and other oversight activities
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights
As our patients, you have the following rights:

- To have access to/and or a copy of your health information
- To receive an accounting of certain disclosures we have made regarding your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To request notice of our privacy practices

If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read (or have had the opportunity to read if I so choose) and understand the notice.

______________________________ ______________________________

Patient Name (Please Print) *Parent OR Authorized Representative (If Applicable)*

______________________________ ______________________________

Signature *Date*

Gary D. Breslow, M.D. / Patrick J. Greaney, Jr. MD

PATIENT PHOTOGRAPHIC AUTHORIZATION

The Breslow Center does not use your photographs unless we have your permission.

I consent to the taking of photographs by Gary D. Breslow, M.D. / Patrick J. Greaney, Jr. M.D. AND/ OR the staff of me and/or parts of my body in connection with the surgical procedure(s) which I am considering having performed by Gary D. Breslow, M.D. / Patrick J. Greaney, Jr. M.D.

Digital Morphing: I consent to permit Gary D. Breslow, M.D. / Patrick J. Greaney, Jr. M.D. AND/OR the other staff members of The Breslow Center for Plastic Surgery, P.A. to perform computerized changes of these images (described as "image morphing") in order to help me better understand various possible cosmetic results following surgery. It has been explained to me and I fully understand that demonstration of these morphed images in no way constitutes a guarantee of my appearance following surgery, and is being used solely as an instrument of demonstration and discussion of the surgery for which I am seeking consultation.

Internal Office Use: I hereby give The Breslow Center for Plastic Surgery P.A. and those acting pursuant to its authority permission to use my photograph, video, testimonial or interview for internal office use only. It will be used for an indefinite period of time and all personal identifiers will be removed.

____ ______________________________

Patient Signature OR Authorized Representative *(If Applicable)* Date

Gary D. Breslow, M.D. / Patrick J. Greaney, Jr. MD

TREATMENT CONSENT AND RESPONSIBILITY AGREEMENT

Please read each section carefully. You may request a copy of this form for your own records.

Patient Name: ______________________________ **Date:** ____________________

I, the undersigned, do hereby request and consent to an evaluation and treatment by Dr. Gary D. Breslow /Dr. Patrick Greaney, Jr. and/or The Breslow Center for Plastic Surgery. I wish to rely on Dr. Gary Breslow/Dr. Patrick Greaney, Jr to exercise judgment for my best interest to me or that of my dependent, the above-named patient, during the course of treatment. I will inform those involved in treating me or my dependent of any sensitive areas or adverse conditions that I or my dependent may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, may be charged directly to me and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable.

I acknowledge that Dr. Gary D. Breslow/ Dr. Patrick Greaney, Jr and The Breslow Center for Plastic Surgery do not participate directly with any insurance company or managed care plans (except Medicare) and that I am responsible for any outstanding fees for services provided to me or to my dependent, the above-named patient, by The Breslow Center for Plastic Surgery that are not reimbursed through insurance or other third party payers. I understand that a potentially refundable deposit to cover fees for uncovered services may be required at the time of service or follow-up. I acknowledge that a 1.5% per month interest charge may be added to any balance unpaid after 90 days of aging. I further acknowledge that I will be held responsible for any and all collection expenses incurred by Dr. Gary D. Breslow /Dr. Patrick Greaney, Jr. and/or The Breslow Center for Plastic Surgery including a 30% attorney fee on any balance referred to an attorney for collection as a result from my delay in payment for services rendered by Dr. Gary D. Breslow /Dr. Patrick Greaney, Jr. and/or The Breslow Center for Plastic Surgery.

I understand that I will be responsible for all facility and anesthesia fees incurred for subsequent revision and/or emergency procedures performed on me or my dependent, the above-named patient, as well as necessary supplies including but not limited to implants, unless otherwise specified by Dr. Gary D. Breslow /Dr. Patrick Greaney, Jr. and/or The Breslow Center for Plastic Surgery. Any surgeon's fee that may be incurred for subsequent revision and/or emergency procedures will be addressed on a case by case basis.

I authorize The Breslow Center for Plastic Surgery to submit all precertification requests and claims directly to the insurers on my behalf. I hereby authorize the release of my medical records and other information necessary to process insurance claims. I understand and agree that any and all monies received from insurance companies and/or other third-party payers as reimbursement for services rendered to me or to my dependent, the above-named patient, by Dr. Gary D. Breslow /Dr. Patrick Greaney, Jr. and/or The Breslow Center for Plastic Surgery shall be forfeited in full to Dr. Breslow/ Dr. Greaney and The Breslow Center for Plastic Surgery. Any other arrangements that may involve insurance billing, reimbursement, payment plan, or payment deferral, must be made in writing with the office manager and/or Dr. Breslow. Verbal agreements are not acceptable.

______________________________ ______________________________

Patient Signature OR Authorized Representative (If Applicable) *Relationship to Patient*