NEW PATIENT REGISTRATION FORM (ENGLISH/ SPANISH)

MONTCLAIR SURGICAL ASSOC. P.A.

Karl W. Strom, M.D., F.A.C.S., Silvia Fresco, M.D., F.A.C.S.
Kevin Bain, D.O., F.A.C.S. Iryna Popiv, D.O.

DATE/ FECHA: _____

Last Name/Apellido	First Name/Nombre	Home Ph#/Telefono de casa	Cell Ph#/Telefono Celular
Home Address/Direccion de Casa	Apt #	City/Ciudad	State/Estado / Zip/Codigo Postal
Social Security#/Seguro Social	Date of Birth/Fecha de Nacimento	Sex/Sexo ☐M ☐F	Age/Tu Edad / Marital Status/Estado Matrimonial ☐M ☐ S ☐D ☐W ☐ Other/Otro
Driver's License#/Licencia de Conducir	State/Estado	E-mail Address/Correo Electronico	
Name ofEmployer/Nombre de Empleador	Occupation/Ocupacion	Work Phone #/Telefono del Trabajo	
Primary Care Physician's Name/Nombre del Medico Primario		PCP Phone#/Telefono del Medico Primario	
Name of your Pharmacy/Nombre del su Farmacia		Pharmacy Phone#/Telefono del Farmacia	
Emergency Contact Name/Nombre del Contacto de Emergencia	Relationship/Relacion	Phone#/ Numero de Telefono	

PRIMARY INSURANCE
Seguro Primario

Please furnish referral at this time if required for today's visit.
(Por favor, envíe la referencia en este momento si es necesario para la visita de hoy.)

Insurance Company's Name/ Nombre del Seguro	Policy ID#/Numero de la Poliza	Provider Services Ph#/ Telefono del Seguro
Name of Subscriber/Nombre del Suscriptor	Date of Birth/Fecha de Nacimiento del Suscriptor	SS# ofSub./Seguro Social del Suscriptor

Relationship to Patient/ Relacion Al Paciente → ☐ Self/Yo ☐ Spouse/cónyuge ☐ Parent/Padre ☐ Child/niño ☐ Other/Otro

SECONDARY INSURANCE
Seguro Secundario

Please furnish referral at this time if required for today's visit.
(Por favor, envíe la referencia en este momento si es necesario para la visita de hoy.)

Insurance Company's Name/ Nombre del Seguro	Policy ID#/Numero de la Poliza	Provider Services Ph#/ Telefono del Seguro
Name of Subscriber/Nombre del Suscriptor	Date of Birth/Fecha de Nacimiento del Suscriptor	SS# ofSub./Seguro Social del Suscriptor

Relationship to Patient/ Relacion Al Paciente → ☐ Self/Yo ☐ Spouse/cónyuge ☐ Parent/Padre ☐ Child/niño ☐ Other/Otro

Medicare Patients Only: I request that payment ofauthorized Medicare benefits be made either to me or on my behalf to Montclair Surgical Associates, P.A. (MSA) for any services rendered to me by the physicians of MSA. I authorize any holder ofmedical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

Solo pacientes de Medicare: solicito que el pago de los beneficios autorizados de Medicare se haga a mí o en mi nombre a Montclair Surgical Associates, P.A. (MSA) por cualquier servicio que me hayan prestado los médicos de MSA. Autorizo a cualquier titular de información médica sobre mí a divulgar a la Administración de Financiamiento de Atención Médica (HCF A) y sus agentes cualquier información necesaria para determinar estos beneficios o los beneficios pagaderos por servicios relacionados.

Signature/Firma: _____ **Date/Fecha:** _____

Non-Medicare Patients: I request that payment of authorized benefits be made either to me or on my behalf to Montclair Surgical Associates, P.A. (MSA) for any services rendered to me by the physicians of MSA. I authorize any holder of medical information about me to release to my insurer and its agents any information needed to determine these benefits of the benefits payable for related services.

Pacientes que no son de Medicare: solicito que el pago de los beneficios autorizados se haga a mí o en mi nombre a Montclair Surgical Associates, P.A. (MSA) por cualquier servicio que me hayan prestado los médicos de MSA. Autorizo a cualquier titular de información médica sobre mí a divulgar a mi aseguradora y sus agentes cualquier información necesaria para determinar estos beneficios pagaderos por servicios relacionados.

Signature/Firma: _____ **Date/Fecha:** _____

Surgical Assistant Policy

Only the operating surgeon can decide if an assistant surgeon is required for the proper conduct of an operation. Some insurance plans do not cover the services of an assistant surgeon, even when requested by the operating surgeon with the patient's best interest and safety in mind. Please be advised that in such cases you will be billed directly for the assistant's services. The usual and customary fee for the assistant is 25% of the surgeon's fee. We are happy to discuss this policy with you if there are any questions. Your signature affirms that you have read this policy.

Solo el cirujano que opera puede decidir si se requiere un cirujano asistente para la realización adecuada de una operación. Algunos planes de seguro no cubren los servicios de un cirujano asistente, incluso cuando lo solicita el cirujano que opera teniendo en cuenta los mejores intereses y la seguridad del paciente. Tenga en cuenta que, en tales casos, se le facturará directamente por los servicios del asistente. La tarifa usual y habitual para el asistente es el 25% de la tarifa del cirujano. Estaremos encantados de discutir esta política con usted si tiene alguna pregunta. Su firma afirma que ha leído esta política.

Signature/Firma: _____ **Date/Fecha:** _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY ACT NOTICE AND DESIGNATION OF DISCLOSURE

PATIENT NAME _____ DATE OF BIRTH _____

I wish to be contacted in the following manner (Fill out all that apply):

Telephone, Written, and Fax Communication

Home/Cell Telephone Number:( )_____

Written Communication

__ OK to mail to my home address that I listed on Registration

Fax Communication: ( ) _____

Designation of Certain Relatives, Close Friends and other Caregivers:

I agree that the practice may disclose certain health information to a family member, close friend, or other caregiver since such person is involved with my health care or payment relating to my healthcare. In that case, Montclair Surgical Associates, P.A. will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of practice making limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing.

Print Name: _____Relationship: _____
Print Name: _____Relationship: _____
Print Name: _____ Relationship: _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as a part of my health care, Montclair Surgical Associates, P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as: * A basis for planning my care and treatment.* A means of communication among the many health professionals who contribute to my care.* A source of information for applying my diagnosis and surgical information to my bill. * A means by which a third-party payer can verify that services billed were actually provided, and I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent.

I understand that the Montclair Surgical Associates, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Montclair Surgical Associates, P.A. reserves the right to change their notice and practices prior to the implementation, in accordance with Section 164.520 of the Code of Regulations. I wish to have the following restrictions to the use or disclosure of my health information.

I understand that s part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **ACCEPT/ DECLINE** (CIRCLE ONE) the terms of this consent.
I have been presented with and understand Montclair Surgical Associates, P.A. Notice ofPrivacy Policy.

Patient's Signature:_____ **Date:**_____

If not signed by the patient, please indicate your relationship to the patient (parent, spouse)_____

FOR OFFICE USE ONLY

[ ] Consent received by

[ ] Consent refused by patient, and treatment refused as permitted

Revised 10/2014

Notice of Assignment of Benefits to a Provider

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as physician or hospital. I _____ **(Name)** hereby authorize and request that payment of benefits by my **primary insurance company**: _____ and or my **secondary insurance company (if any)**: _____ be made directly payable to Stafford Surgical Specialists, LLC for services furnished to me or my dependent.

Insurance Authorization and Assignment of Benefits

Please be advised that the undersigned hereby designate and authorize the release of any information relating to all claims for benefits submitted on behalf of myself and or dependent. I agree to participate and assist with any appeal process necessary to collect payment for services rendered. I further agree that I will be bound by this signature and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and or dependents. I understand I am financially responsible for all amounts incurred.

I certify that the information I have reported with regard to my insurance coverage is correct and I hereby authorize the use of this signature on all insurance submissions. A photocopy of this Assignment/Authorization shall be as effective and valid as the original. I acknowledge receipt of a completed and signed copy of this assignment of benefits and release form.

(Patient or Authorized Signature): _____

Print Name: _____

Date: _____

Montclair Surgical Associates, P.A.

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Kevin Bain, D.O., F.A.C.S.

PATIENT PCP CONTACT FORM

Patient Name:_____ Date:_____

PLEASE PROVIDE YOUR DOCTOR'S NAME, ADDRESS AND PHONE NUMBER. IT IS VERY IMPORTANT THAT WE RECEIVE THIS INFORMATION SO THAT A REPORT CAN BE SENT TO HIM/HER.

Physician's Name:_____

Address: _____

Phone Number:_____

Primary Physician since:_____