SAMRA PLASTIC & RECONSTRUCTIVE SURGERY, LLC

PATIENT INFORMAITON

NAME:_____ HOME PHONE:_____
ADDRESS:_____ CELL PHONE:_____
CITY:_____ EMAIL:_____
STATE:_____ ZIP CODE:_____ SOCIAL SECURITY#:_____
MARTIAL STATUS:_____ DATE OF BIRTH:_____
EMPLOYER:_____ AGE:_____ GENDER: M F
EMPLOYER ADDRESS:_____
WORK PHONE:_____ OCCUPATION:_____
FAMILY PHYSICIAN:_____ PHARMACY:_____
REFERRED BY: (CIRCLE ONE**) WEBSITE FACEBOOK GOOGLE EMAIL MESSAGE REALSELF COMMUNITY MAGAZINE HEALTHVIEWS**
DOCTOR:_____ FRIEND:_____

RESPONSIBLE PARTY (if patient is a minor) OR SPOUSE

NAME:_____ HOME PHONE:_____
ADDRESS:_____ EMAIL:_____
CITY:_____ STATE:_____ ZIP CODE:_____
SOCIAL SECURITY #:_____ WORK PHONE:_____
RELATIONSHIP TO PATIENT:_____ DOB:_____

PRIMARY INSURANCE INFORMATION **SECONDARY INSURANCE INFORMATION**

INSURANCE CO. NAME_____ INSURANCE CO. NAME_____
ID#:_____ ID#:_____
GROUP#:_____ GROUP#:_____
ADDRESS:_____ ADDRESS:_____
_____ _____
PHONE:_____ FAX:_____ PHONE:_____ FAX:_____

WORKERS COMP AUTOMOBILE ATTORNEY

CARRIER NAME:_____ CLM#:_____
ADDRESS:_____ CITY:_____ STATE:_____ZIP:_____
PHONE #:_____ FAX:_____
ADJUSTOR NAME:_____ ATTORNEY NAME:_____

I authorize the release of any medical information necessary to process my claim. I hereby authorize payment directly to Dr. Said A. Samra of group insurance benefit otherwise payable to me. I understand I'm financially responsible to the doctor for charges not covered by this assignment. I understand balances for which I am responsible are subject to interest charges if payments are delinquent (1.5% per month).

Cost of Collection: If this account becomes delinquent, I may be responsible for additional billing costs; and if this account is assigned to a collection agency or attorney for collection, I agree to the addition of a collection fee of $50.00 or 35% of the balance owed, whichever is greater. I acknowledge a fee of $40.00 or the actual bank charge, whichever is greater, for any returned check.

Authorization for Disclosure of Information: I authorize Dr. Samra/ Samra Plastic & Reconstructive Surgery to disclose complete information concerning his medical findings and treatment to the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Samra's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Appointment Cancellation Policy: We ask that you give the office a minimum of 24 hour notice if you are unable to keep your office appointment. You must speak directly to staff. There will be a $75 charge for missed or no show appointments.

Elective Surgery Cancellation Policy: There will be a fee of 10% of the charges for any elective surgical procedure cancelled by the patient less than ONE WEEK from the scheduled date; 20% fee for cancellation less than TWO BUSINESS DAYS; 50% fee if cancelled THE DAY OF SURGERY.

A photocopy of the form shall be considered as valid as original.

PATIENT/ SUBSCRIBER SIGNATURE:_____ DATE:_____

SAMRA PLASTIC & RECONSTRUCTIVE SURGERY, LLC

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Samra Plastic & Reconstructive Surgery, LLC, may use and disclose protected health information (PHI about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Samra Plastic & Reconstructive Surgery, LLC'S Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Samra Plastic & Reconstructive Surgery, LLC, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Samra Plastic and Reconstructive Surgery Privacy Officer 733 North Beers Street Suite U1 Holmdel NJ 07733.

With my consent, Samra Plastic & Reconstructive Surgery, LLC may speak with fellow staff members, fax, email, text, call my home, cellular or other designated location and leave a message on voice mail or in mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others whether it may be secure or non-secure means. With my consent, Samra Plastic and Reconstructive Surgery, LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request Samra Plastic & Reconstructive Surgery, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Samra Plastic & Reconstructive Surgery's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Samra Plastic & Reconstructive Surgery may decline to provide treatment.

PATIENT PROTECTED HEALTH INFORMATION DISCLOSURE AUTHORIZATION

PLEASE PRINT:

1. NAME:_____ RELATIONSHIP:_____
2. NAME:_____ RELATIONSHIP:_____
3. NAME:_____ RELATIONSHIP:_____

Listed above are the names of relatives and/or friends with whom the physicians and staff of Samra Plastic & Reconstructive Surgery, LLC have my permission to disclosure and discuss my protected health information. Information includes my past, present or future physical or mental health condition and related healthcare services. I understand that this authorization will remain in effect until I make a written request to rescind this permission.

DATE:_____ PATIENTS NAME:_____

SIGNATURE OF PATIENT/LEGAL GUARDIAN:_____

Health Information Exchange (HIE)

We, along with other health care providers in NJ, participate in Jersey Health Connect, a health information exchange (HIE) which allows patient information to be shared electronically through a secured network that is accessible to the providers treating you. We may disclose your medical information to Jersey Health Connect HIE, unless you opt-out of participating in the HIE.

Personal Health Record (PHR)

Certain portions of your medical record are available electronically to you in a PHR which is accessible at MyMeridianHealth.com. Enrollment is required. We may disclose your medical information to the Jersey Health Connect HIE for purposes of adding your medical information to your Personal Health Record (PHR).

SAMRA PLASTIC & RECONSTRUCTIVE SURGERY, LLC

DISCLOSURE OF FINANCIAL INTEREST

Public law of the State of New Jersey and rules of the Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service. Accordingly, take notice that practitioners in this office do have a financial interest in the following health care service(s) to which patients is referred:

The Ambulatory Surgery Center at Old Bridge
400 Perrine Road, Suite 408, Old Bridge NJ 08857

Jeunesse Medical Spa
733 North Beers St, Suite U7, Holmdel NJ 07733
300 Perrine Rd, Suite 334, Old Bridge NJ 08857

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

FINANCIAL OBLIGATION

Samra Plastic & Reconstructive Surgery will submit your claim to your insurance carrier for services rendered. If you are not in-network, your carrier will make payment directly to you within thirty days. This money is not yours to keep but rather is payment for the doctor's services. Do not cash the insurance check. Please endorse the back of the check and write "Payable to Samra Plastic & Reconstructive Surgery" below your signature. As soon as you receive the insurance check, you must forward it to:

SAMRA PLASTIC & RECONSTRUCTIVE SURGERY 733 NORTH BEERS STREET, SUITE U1
HOLMDEL, NJ 07733

All payments will be accompanied by an explanation of benefits (EOB) which explains how your insurance carrier arrived at the amount of money it issued. Failure to provide this copy to our office may impact the balance we consider to be your obligation. An administrative fee of $100 will be incurred if the insurance check and EOB are not forwarded to our office within seven days.

Please cooperate with our billing staff. Our billing staff is here to help you. At times, they may request you to contact your insurance carrier to reprocess the claim for prompt payment and/or reconsideration of the final payment.

I have read the above and clearly understand.

Please sign below to acknowledge this form.

_____ _____

PRINT NAME **SIGNATURE**

_____ _____

DATE **WITNESS SIGNATURE**

PHOTO CONSENT

In connection with the medical advice and/or surgical services which I am receiving from my physician, I consent that photographs and/or video may be taken of me, or parts of my body. The photographs and/or video shall be used for medical records and if, in the judgement of my physician(s), medical research, education or if science will be benefited by their use. Such photographs, videos and information relating to my case may be published and republished either separately or in connection with each other, in professional journals or medical books or used for any other purposes which my physician may deem proper in the interest of medical education, knowledge or research. Additionally, I consent for these photographs and/or video be used by my physician(s) on their website, presentations or other venues, such as Facebook, Instagram, Twitter and/or Pinterest. It is specifically understood that in any such publications or use, I shall not be identified by name.

_____ _____

PRINT NAME **SIGNATURE**

_____ _____

DATE **WITNESS SIGNATURE**

SAMRA PLASTIC & RECONSTRUCTIVE SURGERY, LLC

REVOCABLE ASSIGNMENT OF BENEFITS & AUTHORIZATION

I, _____ (**"Patient**"), assign to my medical provider SAMRA PLASTIC & RECONSTRUCTIVE SURGERY, LLC (the "**Provider**"), any and all of my rights and benefits under my insurance contract and/or my employee welfare benefit plan(s) as well as all of my rights and benefits under the Employee Retirement Income Security Act of 1974 ("**ERISA**") and any other applicable state or federal law(s), regulation(s), statute(s), or rule(s), which are in any way related to the medical services provided to me by **Provider** at any time.

I assign to **Provider** any and all of my rights and benefits under my plan or policy as well as state and/or federal law(s), regulation(s), statute(s), or rule(s), to seek plan or policy documents, file appeals, seek statutory and other penalties, seek equitable relief, commence legal action, and directly receive payment of benefits insofar as they in any way relate to the treatment and/or services provided to me by **Provider** at any time. I assign to **Provider** any recovery, settlement, penalty, and/or other relief obtained.

I authorize **Provider** to file insurance claims on my behalf for services rendered to me at any time by **Provider**. I direct that all reimbursable payments for treatment and/or services rendered to me by **Provider** go directly to the **Provider** or any individual or entity they deem appropriate,

I authorize **Provider** to file arbitration and/or litigation in my name and on my behalf against my PIP carrier, Healthcare Carrier, Employee Welfare Benefit Plan, Workers' Compensation Plan, or any similar entity, which is in any way related to the treatment and/or services provided to me by **Provider** at any time.

I authorize **Provider** to retain an attorney of **Provider's** choice on my behalf for collection of **Provider's** bills and/or to file insurance claims on my behalf for services rendered to me. I authorize and consent to **Provider** acting on my behalf in this regard and in regard to my general health insurance coverage, and I specifically authorize **Provider** to pursue any administrative appeals conducted pursuant to any contract, plan, law or statute, including, but not limited to, **ERISA**.

Provider may affirmatively disclaim any part of this assignment and authorization at any time and for any and/or no reason(s) through writing. There is no reciprocal right on the part of the **Patient** once this document is executed. **Patient** does not retain any power, right, or ability, to revoke or withdraw any authorization or assignment. Should **Provider** disclaim any part of this assignment or authorization it shall result in the right(s) and/or benefit(s) explicitly disclaimed returning to **Patient**.

_____ _____

PATIENT NAME PATIENT SIGNATURE

_____ _____

DATE WITNESS