STEPHEN A. CHAGARES, M.D., F.A.C.S.
GENERAL, LAPAROSCOPIC AND BREAST SURGERY
1 EXECUTIVE DRIVE, SUITE 4
TINTON FALLS, NEW JERSEY 07701
(732) 450-9700
FAX: (732) 450-1511
EMAIL: OFFICE@TPSNETWORK.COM

INSURANCE INFORMATION

DATE: _____

Name of Patient: _____

Name of Primary Insurance Co.:_____

Insurance Co. Address & Phone#:_____

Policy #:_____Group #:_____

Subscriber's Name: _____

Subscriber's DOB_____

Subscriber's SS#: _____

Name of Secondary Insurance Co.:_____

Insurance Co. Address & Phone #:_____

Policy #:_____Group #:_____

Subscriber's Name: _____

Subscriber's DOB: _____

Subscriber's SS#:_____

Revised 7/18/17

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DATE:_____

PATIENT INFORMATION

Patient's Name:_____
(Last) (First)

Address:_____ City: State: Zip

Home Phone: (____)_____ Cell Phone :(____)_____

Work Phone: (____)_____ Email:_____

Do you accept our office's use of your email? Please initial: Yes_____or No _____

Age:_____Sex:_____ Date of Birth:_____

Social Security #:_____Married:___Single:____Widowed:___Divorced:___Partner_____

Race: African-American Asian Caucasian Hispanic Other:_____ **Decline to Provide**: ☐

Ethnicity: Hispanic or Latino Not Hispanic or Latino **Decline to Provide**: ☐

Language:_____ **Decline to Provide**: ☐

Occupation:_____Employer:_____

Business Address:_____

Spouse or Parent's Name:_____SS#:_____

Spouse or Parent's Employer:_____

Person Financially Responsible: Patient_____; Parent_____; Other_____Name_____

Address of Person Financially Responsible:_____

Emergency Contact Name & Relationship: _____

Emergency Contact Address:_____Phone: (_____)_____

Family Physician:_____ Phone: (_____)_____

Other Physician(s) you have seen in the last year:_____

Name of person or physician who referred you to this office:_____

Reason for visit:_____

Have you consulted other physicians about the reason for your visit today? Yes____or No____

If yes, please list their names:_____

Pharmacy Name:_____
City:_____
Phone#:_____

ALLERGIES TO MEDICINE Yes____; No____ Please list:_____

Allergies to other substances:_____

_____

Allergies to Latex? Yes_____; No_____

Medications, Drugs:

What is your approximate daily consumption of the following:
Caffeine(coffee, tea, etc.)_____; Alcohol_____;Other intoxicating or mood/mind altering drugs or drugs to help concentration (specify)_____
Have you ever smoked?_____ Do you currently smoke?_____ If yes, how often?_____
Does anyone in your household smoke? No____ Yes_____ How often?_____

Please list ALL medications, their dosages and the prescribing Physician (including BIRTH CONTROL PILLS, DIURETICS (water pills), BLOOD PRESSURE or HEART MEDICATIONS, TRANQUILIZERS, HORMONE, BLOOD THINNERS, NOSE DROPS and SPRAYS, INHALER MEDICINES, ASPIRIN, and HERBAL SUPPLEMENTS. Please include any over-the-counter medications, nutritional supplements or diet pills:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Pertinent Preoperative Information

Have you had a persistent cough which has lasted for more than two weeks?	No___; Yes__	Have you ever had scarlet fever or rheumatic fever?	No___; Yes__
Have you ever reacted badly to being put to sleep for surgery?	No___; Yes__	Do you bleed or bruise unusually easily (from cuts, surgery, tooth extractions?	No___; Yes__
Has any member of your family reacted badly to being put to sleep for surgery?	No___; Yes__	Do you occasionally/typically heal with prominent scars or keloids?	No___; Yes__
Are you allergic to adhesive tape?	No___; Yes__	Do you have any skin disease, hives, eczema or rash?	No___; Yes__
Are you on aspirin therapy?	No___; Yes__	Do you have frequent infections or boils?	No___; Yes__
Are you allergic to Bananas, Kiwi Chestnuts?	No___; Yes__	Have you taken steroid medications, cortisone, or ACTH?	No___; Yes__
Do you have high blood pressure?	No___; Yes__	Do you have shortness of breath with walking?	No___; Yes__
Are you presently on Birth Control Pills?	No___; Yes__	Do you have, or have you had any back trouble?	No___; Yes__
Are you presently on Estrogen Replacement Therapy?	No___; Yes__	Do you have a particular aversion to blood transfusions if medically necessary?	No___; Yes__
Are you on any blood thinners?	No___; Yes__	Do you have, or have you had any significant emotional problems?	No___; Yes__
Do you have any history of or headaches?	No_____; Yes_____	Have you ever had, or been advised seek psychiatric care?	No___; Yes__
		Do you use NSAIDS (Tylenol, Motrin, Aleve, etc.) regularly?	No___; Yes__

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MEDICAL HISTORY

General State of Health: Good_____; Fair_____; Poor_____

Height_____Weight_____

Serious illness, please list:_____

Is there any risk of pregnancy at this time? Yes_____No_____

Personal Medical History:

Mitral Valve Prolapse:	Yes	No	
High Blood Pressure:	Yes	No	
Heart Disease:	Yes	No	
Stroke:	Yes	No	
Diabetes:	Yes	No	
Asthma:	Yes	No	
Cancer:	Yes	No	If yes, what type?_____
Sleep Apnea:	Yes	No	
Low Thyroid:	Yes	No	
Autoimmune Disease:	Yes	No	

Any other significant medical history:

Have you ever had any illness or disorder of the following? (Circle if Yes)

(1) Brain (including strokes, epilepsy)
(2) Arms or Legs
(3) Nervous System (including paralysis, numbness)
(4) Intestines/Bowels
(5) Reproductive System
(6) Ears
(7) Face (Paralysis)
(8) Stomach
(9) Bones of Joints
(10) Urinary System
(11) Breasts
(12) Nose, Sinuses, Throat
(13) Heart
(14) Blood/Blood Vessels
(15) Liver
(16) Eyes (including glaucoma, dryness)
(17) Endocrine System or Diabetes
(18) Lungs
(19) Loss of strength in any part of your body
(20) Loss of feeling, numbness or tingling in any parts of your body

If circled, please explain:_____
_____
_____

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Previous Surgery (Please list):

Operation Year Hospital Surgeon Anesthesia(Local or General) Outcome

_____
_____
_____
_____
_____
_____

Have you had significant complications or after effects from any of these operations? No_____or Yes_____

If "Yes", please explain:

_____
_____

Family Medical History: *Family Relationship to you:*

Mitral Valve Prolapse:	Yes	No	_____
Hypertension:	Yes	No	_____
Heart Disease:	Yes	No	_____
Stroke:	Yes	No	_____
Diabetes:	Yes	No	_____
Asthma:	Yes	No	_____
Cancer:	Yes	No	_____

What type? _____

Sleep Apnea:	Yes	No	_____
Tuberculosis	Yes	No	_____
Lung Disease	Yes	No	_____
Kidney Disease	Yes	No	_____
Epilepsy	Yes	No	_____
Blood/Bleeding Disorders	Yes	No	_____
Chronic Headaches	Yes	No	_____

Any other significant family medical history:

_____
_____

STEPHEN A. CHAGARES, M.D., F.A.C.S.
GENERAL, LAPAROSCOPIC AND BREAST SURGERY

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dr. Stephen Chagares has my consent to use and disclose my Protected Health Information ("PHI") to carry out treatment, to obtain payment from third parties and to perform healthcare operations as outlined below._____**(Initial)**

I have been given a copy of the HIPAA Notice of Privacy Practices ("HIPAA Notice") which contains a complete description of PHI._____**(Initial)**

I have the right to review, and to the extent I desire to do so, I have reviewed the HIPAA Notice prior to signing this Consent form._____**(Initial)**

I authorize Dr. Stephen Chagares to use and disclose my PHI in the following manner:

1. Transmit my PHI through the following means in order to carry out treatment, obtain payment from third parties and perform healthcare operations:
    a. Cell Phone Number: _____
    b. Home Phone Number: _____
    c. Email Address: _____
    d. Mailing Address: _____
    e. Fax Number: _____

2. Disclose my PHI to the following family members in order to carry out treatment, obtain payment from third parties and perform healthcare operations:
    a. Name: _____ Contact Information: _____
    b. Name: _____ Contact Information: _____
    c. Name: _____ Contact Information: _____

    OR I do *not* authorize disclosure of my PHI to anyone other than myself._____(Initial)

3. Transmit my PHI to other health care providers as well as my health insurance carrier in order to carry out treatment, obtain payment and perform healthcare operations_____**(Initial)**

By signing this form, I consent to Dr. Stephen Chagares use and disclosure of my PHI as outlined above:

I,_____, acknowledge that I have read and understand the above.

Patient Signature (or authorized representative)	**Date**

I may revoke my consent in writing except to the extent that Dr. Stephen Chagares has already made disclosures in reliance upon my prior consent. If I do not sign this Consent, Dr. Stephen Chagares may decline to provide treatment.

If you have any questions about the HIPAA Notice, please contact our office at (732) 450-9700 and ask to speak with the Office Manager.

STEPHEN A. CHAGARES, M.D., F.A.C.S.
GENERAL, LAPAROSCOPIC AND BREAST SURGERY

HIPAA NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this would be:

- the coordination of your health care with all of your health care physicians.
- contacting you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization reviews. Examples of this would be, the use and disclosure of your health information:

- on a bill for your visit sent to your insurance company.
- about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

Public Health Risk means disclosure of your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability to the public.

Required by law means we may use and disclose your health information about you:

- when required by State and Federal law.
- to authorized federal officials for intelligence, counterintelligence, and other National Security activities as authorized by law.
- when required by the Secretary of Health and the Department of Health and Human Services for the purposes of investigating or determining compliance with the privacy law.
- to a health oversight agencies for activities, authorized by law, for the government and certain private health oversight agencies to monitor the healthcare system, government programs and compliance with civil rights.

- to law enforcement officials, if required by law, or where permitted by law, or in response to a valid subpoena.
- to a court or administrative agency when a judge or agency orders us to do so and in legal proceedings, such as in a response to a discovery request, subpoena, court order, etc.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to our Privacy Officer:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of PHI.
- The right to obtain and we have the obligation to receive written acknowledgement that you have read a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

This notice is effective as of January 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Service, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Privacy Officer
The Plastic Surgery Center
535 Sycamore Avenue
Shrewsbury, NJ 07702
(732)741-0970

For more information about HIPAA or to file a complaint:

The U.S. Department of Health &
Human Services of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257 Toll Free: 1-877-696-6775

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

I have been presented with a copy of Dr. Stephen Chagares' Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____
PATIENT'S NAME (Print)

_____
PATIENT OR LEGAL GUARDIAN SIGNATURE

_____
RELATIONSHIP TO PATIENT: (if other than self)

_____
DATE SIGNED

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only
If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

STEPHEN A. CHAGARES, M.D., F.A.C.S.
GENERAL, LAPAROSCOPIC AND BREAST SURGERY

A PATIENT'S BILL OF RIGHTS ACT

YOU have the right to be treated respectfully.

YOU have the right to be informed about your diagnosis, to know what your treatment options are, and to know what the potential outcomes of each treatment may be.

YOU have the right to know the names of those treating you.

YOU have the right to refuse treatment, as permitted by law. You can refuse treatment and still receive alternative care.

YOU have the right to privacy. No medical practitioner should ever release information about your condition or treatment to anyone, unless you give express consent to release such information.

YOU have a right to review your medical records, and if necessary have the information explained to you.

YOU have the right to know what your anticipated cost of treatment may cost you.

YOU are responsible for providing all information about your current condition, prior procedures, illnesses and medications. This info is necessary to determine the best treatment for you.

YOU are responsible for being considerate of the needs of others in the office.

YOU are responsible for providing all insurance information when requested, and following the requirements for your individual insurance plan for seeking treatment with the doctor.

Signed:_____ Date: _____

Print Patient's Name: _____

(To be placed in patient's permanent file.)

Revised 7/18/17

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ASSIGNMENT OF BENEFITS

1. Assignment of Right to Reimbursement and Payment. Pursuant to N.J.S.A 26:2S-6.1(c) and the common law, I hereby assign any and all of my rights to receive payments to any and all benefits under my insurance policy to my medical provider, Dr. Stephen Chagares, relating to and/or arising out of any and all medical treatment provided by Dr. Stephen Chagares to me, including, but not limited to, major medical, personal injury protection (PIP), and workers' compensation benefits otherwise payable to me, regardless of whether Dr. Stephen Chagares is a participating or non-participating provider of my health insurance carrier.

2. Irrevocable Assignment of All Benefits and Legal Rights. I hereby irrevocably assign to Dr. Stephen Chagares any and all of my legal rights, benefits, and claims relating to and/or arising out of my health insurance policy/policies and the medical treatment provided by Dr. Stephen Chagares to me; the assignment to Dr. Stephen Chagares includes, but is not limited to, any and all of my legal rights to major medical, personal injury protection (PIP), and workers compensation benefits, and includes, but is not limited to, my assignment of any and all legal rights to file and prosecute my legal rights and benefits to any and all appeals, claims, and litigation against my health insurance policy/policies relating to and/or arising out of the aforesaid. I hereby name Dr. Stephen Chagares as my Designated Authorized Representative and further authorize any plan administrator or fiduciary, insurer, and my attorney to release to Dr. Stephen Chagares any and all plan documents, insurance policy and/or settlement information upon written request from the Dr. Stephen Chagares in order to assert any and all of my legal rights relating to and/or arising out of my health insurance policy and the medical treatment provided by Dr. Stephen Chagares to me in order to prosecute any and all claims for such medical benefits, reimbursement, and any and all applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

3. Waiver and Release of HIPPA. I hereby authorize my insurance carrier, the plan sponsor, and/or any employer and/or plan administrator to release all of my medical information under HIPPA to Dr. Stephen Chagares, relating to and/or arising out of any and all determinations of any claims for medical services provided by Dr. Stephen Chagares to me.

This assignment shall be binding on and inure to the benefit of Dr. Stephen Chagares, its successors, assigns and its legal representatives.

A photocopy of this assignment is to be considered as valid as the original. I expressly acknowledge and agree that I have read and fully understand this Assignment of Benefits and expressly acknowledge and agree that by executing this Assignment of Benefits below I agreed to its terms herein.

_____ _____

Signature of Insured/Guardian Date

_____

Print Name of Insured/Guardian

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Breast Questionnaire

Please check and circle any of the following in which apply to you:

_____ Dominant mass or lump	Right	Left
_____ Change in size	Right	Left
_____ Thickening of skin	Right	Left
_____ Nipple change	Right	Left
_____ Nipple discharge, bloody	Right	Left
_____ Nipple discharge, non-bloody	Right	Left

Other Concerns: _____

Age of first menstrual period: _____

Date of last menstrual period: _____

Age at menopause: _____

Have you ever been on hormone replacement therapy? If so, when? _____

Number of pregnancies: _____ Deliveries: _____

Miscarriages: _____ Terminations: _____

Did you breast feed? Yes: _____ No: _____ / If so, for how long? _____

Have you ever taken birth control pills? If so, when? _____

Have you had breast related issues? _____

Have you had any type of radiation? _____

Have you ever had breast cancer? _____

Has anyone in your family had breast cancer? _____

Relationship to you: _____ Age of Onset: _____

Bra Size: _____

_____ _____

Signature of patient, guardian or representative **Date**