Joseph P. Fodero, M.D.

Plastic Surgery
239 West Northfield Road
Livingston, NJ 07039
(973) 992-3818
Fax: (973) 992-2466
www.drfodero.com

Member of the American Society Of Plastic Surgeons

American Board of Plastic Surgery

Date: _____ Patient Name: _____ Cell Phone: _____
FIRST MI LAST

SSN: _____-_____-_____ ☐ Male ☐ Female Birthdate: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parent's employer: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: _____

E-mail address: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

Responsible Party

Name of person responsible for this account: _____ Relationship to patient: _____

Address: _____ Home Phone: _____

Driver's License #: _____ Birthdate: _____ Financial Institution: _____

Employer: _____ Work Phone: _____

Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information

Name of Insured: _____ Relationship to patient: _____

Birthdate: _____ SSN: _____-_____-_____ Date employed: _____

Name of employer: _____ Work Phone: _____

Address of employer: _____ City: _____ State: _____ Zip: _____

Insurance company: _____ Group # _____ Union or Local # _____

Ins. Co. address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of Insured: _____ Relationship to patient: _____

Birthdate: _____ SSN: _____-_____-_____ Date employed: _____

Name of employer: _____ Work Phone: _____

Address of employer: _____ City: _____ State: _____ Zip: _____

Insurance company: _____ Group # _____ Union or Local # _____

Ins. Co. address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

I hereby authorize Dr. Joseph P. Fodero to examine, diagnose, and treat me. A copy of this authorization shall be as valid as the original.

Dr. Fodero only participates with Medicare.

Signature: _____ Date: _____

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INSURANCE ASSIGNMENT AND RELEASE

I certify that, I and and/or my dependant(s) have insurance coverage with _____ and assign directly to **JOSEPH P. FODERO, M.D.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed of one year for the date signed below.

_____ _____
Signature of patient, Guardian, or Personal Representative Date

_____ _____
Please print name of patient, Guardian, or Personal Representative Date

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Patient Authorization to Use or Disclose Protected Health Information

I, _____ , understand that as part of my healthcare, Joseph P. Fodero, MD originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for the 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 means of communication to my insurance company regarding the proper payment of my claim and/or appealing their decision,
- A source of information for applying my diagnosis and surgical information to my bill, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have read and/or been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent,
- The right to object to the use of my health information for directory purpose, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Joseph P. Fodero, MD is not required to agree to the restrictions requested. I understand that I may revoke this contract 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 Joseph P. Fodero, MD reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Joseph P. Fodero, MD change their notice, they will send a copy of any revised notice to the address I've provided.

I wish the following restrictions to the use or disclosure of my health information.

_____
_____
_____

I understand that as part of this organization's treatment, payment, or health care 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 the terms of the consent.

Patient's Signature: _____ Date: _____

For Office Use Only
( ) Consent received by _____ on _____.

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( ) Consent refused by patient, and treatment refused as permitted.
( ) Consent added to the patient's medical record on _____.

FINANCIAL POLICY STATEMENT

To help our patients fully understand our billing process, we ask that you read and sign our financial policy statement.

You are responsible for bringing the necessary referral(s) to the office on the day of your appointment. If you do not have the required referral form(s) on the day of the appointment, you are responsible for payment at the time of service and must sign waiver.

As a courtesy Dr. Joseph P. Fodero, MD will submit a claim to your insurance carrier. Depending upon your individual policy, your coverage, your deductible and/or co-payment requirements, you may be billed for the balance.

When Dr. Joseph P. Fodero, MD participates fully in your insurance plan, you are still responsible for paying any co-insurance, deductible and/or co-payment(s) as indicated by your carrier, as well as any non-covered service(s) under their contract. Once payment has been made or denied by the insurance company you will be billed and be responsible to pay the balance.

Due to the fact that our office does not participate with any insurance carriers, checks may be forwarded directly to the insured. These checks should be forwarded to Dr. Joseph P. Fodero, MD with a copy of the explanation of benefits within ten days, whether or not the responsible party has received a bill from our office, as sometimes insurance carriers do not notify non-participating providers when payments are sent to the patients.

If you are seen in the office as a worker's compensation case, we require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____
(if patient is a minor)