Ocean County Foot & Ankle
Surgical Associates, P.C.

Vincent J. Migliori,*
D.P.M., F.A.C.F.A.S.
Russell D. Petranto,*
D.P.M., F.A.C.F.A.S.
Matthew Regulski,
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A.B.M.S.P., F.A.S.P.M.
Darelle A. Pfeiffer,*
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A Note to our Patients about Insurance

While we make every effort to assist you with your insurance questions and submissions, you must understand that it is YOUR responsibility to verify your insurance coverage and to understand the extent of that coverage.

Insurance companies are obligated to YOU, THE INSURED, and not to our office. It is often difficult or impossible for us to get information regarding your insurance. Together, we can make sure you receive the best care possible under your insurance company guidelines.

Thank you.

Billing Manager

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P.C.

Name: _____ SS#: _____

Date of Birth: _____ Age: _____ Home Phone #: _____

Cell #: _____ E-Mail _____

Address: _____

City: _____ State: _____ Zip: _____

PLEASE CIRCLE: Female / Male Married / Single / Other

Race: White / American Indian / Asian / African American / Other: _____

Ethnicity: Hispanic or Latino - Not Hispanic or Latino

Primary Language: _____

Employed By: _____ Occupation:_____

Business Phone: _____Address:_____

City: _____ State:_____ Zip:_____

PHARMACY: _____/Phone: _____/Address:_____

Primary Care Physician:_____ Phone: _____

Please list any specialists currently treating you:

Specialist: _____Phone #: _____ Specialty: _____

Specialist: _____Phone #: _____ Specialty: _____

In Case of an Emergency, whom may we contact? _____

Relationship: _____Phone Number: _____

Whom May We Thank for Referring You? _____

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE. TO ASSIST IN THE COORDINATION OF MY CARE, I HEREBY GIVE WRITTEN CONSENT TO THE DOCTORS OF OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, PC TO VIEW MY PRESCRIPTION HISTORY PROVIDED THROUGH ELECTRONIC HEALTH RECORD EXCHANGE.

_____ _____

SIGNATURE DATE

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P.C.

TELEHEALTH AND CONFIDENTIAL COMMUNICATIONS

Patient Name: _____

Date of Birth: _____

Telehealth is the exchange of medical information via electronic communications. Providers provide services using interactive audio and video telecommunication, providing real-time communications. This allows patients to receive medical care by a provider without being present in the office setting. Alternatives to Telemedicine are in office appointments. Privacy and security are important to Ocean County Foot & Ankle Surgical Associates, P.C. and only electronic systems approved by Federal and State regulations will be used. However, it is important to understand that some systems are not encrypted and security protocols could fail, resulting in a breach of privacy of personal health information. Privacy of medical records also applies to telemedicine, and Ocean County Foot & Ankle Surgical Associates, P.C. will safeguard all information in accordance with HIPAA.

Telemedicine consultations and follow up appointments may be used to discuss and monitor examination, treatment and follow up of procedures. The use of video equivalent technology to deliver healthcare is new technology and may not be equivalent to direct in office Provider contact. Telemedicine may also be used to diagnose some conditions. Photo and video recordings may be taken during the Telemedicine encounter.

We offer helpful administrative information by regular text messaging, email and video communication, such as appointment reminders. There is some level of risk that information in a regular text message or email could be read by someone besides yourself. Please let us know if you would like us to communication with you by text message or email. In some instances, video communication may be used at the doctor's discretion.

I understand my right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right of future care or treatment.

Communicate with me by <u>Email</u> for important health and practice updates: ☐ **Yes** ☐ **No**

My email address is: _____ I will let you know right away if my email address changes.

Communicate with me by <u>Text Message</u>: ☐ **Yes** ☐ **No**

My cell phone number is: (___)_____ I will let you know right away if my cell phone number changes.

Communicate with me via <u>Video Communication</u>: ☐ **Yes** ☐ **No**

* Email, Text and Video Communication may not be encrypted.

I request that all communications to me (by telephone, mail or otherwise) by Ocean County Foot & Ankle Surgical Associates, P.C., and/or its staff be handled in the following manner:

☐ I authorize my healthcare provider to disclose to third parties, who may intercept these messages, notification of a pending or missed appointment.

☐ I give my permission for Ocean County Foot & Ankle Surgical Associates, P.C. to leave a message on my voicemail.

We may discuss your medical history with (Name & Relationship to You):

_____

We may discuss your bill with (Name & Relationship to You):

_____

Patient Signature: _____

Date: _____

****

For Practice Use Only Practice:

Accepts: _____ Denies: _____

Entered (Initial): _____Date: _____

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P.C.

Assignment of Benefits, Release Form & Financial Policy

Patient Name: _____

Primary Insurance: _____

Policy Number:_____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber Employer: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber Employer: _____

Do you have prescription drug coverage? YES NO

Is today's visit related to an auto accident or workmen's comp. claim? YES NO
***** If the above question applies to you,**
please fill out the reverse side of this form ***

I hereby instruct and direct the mentioned insurance companies to pay by check, made out and mailed to:
Ocean County Foot & Ankle Surgical Associates, P.C.
54 Bey Lea Road
Toms River, NJ 08753
for the professional or medial expense benefit allowable, otherwise payable to me.
This is a direct assignment of my rights and benefits under this policy.

- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered
- I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case.
- I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _____ Date: _____

Relationship (if not self): _____

****

For Office Use Only:

□ Insurance Card & ID Scanned _____ by _____
Date Initials

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P. C.

AUTO ACCIDENT / WORKERS COMPENSATION

Patient Name: _____

AUTO/COMP Insurance Carrier: _____

Claims Address: _____

_____

Claim Number: _____

Date Of Accident/Loss: _____

Adjusters Name & Telephone Number: _____

_____

Adjusters Fax Number: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

Signature: _____

Relationship (If not self):_____

Date Signed: _____

Ocean County Foot & Ankle Surgical Associates, P.C.
Patient Questionnaire

Name: _____ Date: _____

Chief Complaint: _____

Statistics: Height: _____ Weight: _____ Shoe Size: _____

Past Medical History: Please check all that apply.

- ❑ Diabetes (Problems with blood sugar) Type I or Type II
- ❑ Thyroid Disorders Hyperthyroid or Hypothyroid
- ❑ Congestive heart failure
- ❑ Angina (chest pain) Onset _____
- ❑ Previous heart attack Onset _____
- ❑ Heart murmur Onset _____
- ❑ Valve Problem Please Specify _____
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Stroke/TIA Onset _____
- ❑ Cancer: When diagnosed? What type? _____
- ❑ Seizures: What type? When was last one? _____
- ❑ Bleeding disorders: Please specify:_____
- ❑ Sleep apnea
- ❑ Asthma
- ❑ Emphysema
- ❑ COPD
- ❑ Sarcoidosis
- ❑ Tuberculosis:When diagnosed_____/Treatment Date_____
- ❑ HIV / AIDS
- ❑ Autism: Please specify _____
- ❑ Gastrointestinal Disorders: Please specify ___ _____
- ❑ Kidney Disorders: Please specify _____ _____
- ❑ Hepatitis: What type _____
- ❑ Cirrhosis
- ❑ Liver Disease
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Bone Density Date: _____
- ❑ Lupus
- ❑ Migraines
- ❑ Back or neck problems
- ❑ Glaucoma
- ❑ Cataracts: Right Eye, Left Eye, Both Eyes
- ❑ Rheumatic fever
- ❑ Depression
- ❑ Prostate problems: Please specify _____
- ❑ Difficulty with anesthesia: What happens?_____ _____
- ❑ Gout
- ❑ No Past Medical History

❑ Please list any other medical conditions not listed above: _____ _____

Allergies:	**Yes**	**No**	**Reaction**
Do you have allergies to medications:	[ ]	[ ]	
Please Specify: _____			
Latex	[ ]	[ ]	_____
Shellfish	[ ]	[ ]	_____
X-ray contrast /Iodine	[ ]	[ ]	_____

Have you ever had radiation treatment? If yes, when? _____

Do you have a living will or advanced directive? (for patients 18 yrs & above) _ _____

If yes, can you provide our office a copy?

Do you or your caregiver have any of the following barriers that may affect your medical care? Please describe.

Cultural/Religious Barrier _____ Language Barrier_____

Visual Barrier_____ Auditory Barrier_____

History Reviewed by Doctor: _____
See Attached List.

Medications:

Please list all medications that you currently take both prescription and over the counter:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Do you currently take any of the following? If yes please explain.

Blood Thinners _____
Vitamin E _____
Aspirin _____
Ginkgo Biloba _____
Motrin/Ibuprofen/Advil or any other anti-inflammatory agent _____
Weight Loss Supplements or Herbal Preparations _____

Past Surgical History:

Please list any surgery that you have had and the date they were performed:

_____
_____
_____

Family History:

Does anyone in your family suffer from any of the following medical conditions? If yes, please state the person and describe the medical problem.

Bleeding problems/Clotting Disorders _____
Cancer _____
Diabetes _____
Heart Disease _____
Hypertension _____
Thyroid Problems _____
Any other medical condition not listed _____
_____

Social History:

Do you drink alcohol? _____ If yes, what type? Beer, Wine, Liquor

How much do you drink? _____ How often do you drink? _____
Do you smoke? _____ Have you ever smoked: _____
If yes, how many years? _____ If yes, how much do you smoke per day? _____
If you no longer smoke, when did you quit? _____

Do you drink Coffee? _____ If yes, how much per day? _____

Do you drink Soda with caffeine? _____ If yes, how much per day? _____

Do you drink Tea? _____ If yes, how much per day? _____

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ATTN: State of New Jersey Medicaid Participants
Effective 12-1-2011

The Department of Human Services, as part of the 2012 budget initiatives, has moved some of the Medicaid client population to Medicaid managed care health plans. There are four health plans available: Amerigroup of New Jersey, Healthfirst Health Plan of New Jersey, United Healthcare Community Plan and Horizon NJ Health.

We here at Ocean County Foot & Ankle Surgical Associates are ONLY participating with Horizon NJ Health. Please note that a referral is required for Horizon NJ Health and you will not been seen without it and/or responsible for your bill.

If you have Amerigroup of New Jersey, Healthfirst Health Plan of New Jersey or United Healthcare Community Plan, we are non-participating and you will be responsible for any charges incurred with our office.

By signing below, you understand the aforementioned.

Patient Signature: _____

Patient Printed Name: _____

Patient Date of Birth: _____

Date: _____

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MEDICATION TREATMENT CONTRACT

The treatment of chronic pain may involve the use of many different modalities such as nerve blocks, exercise, surgery, psychology techniques and pain medications. Some of the medications prescribed by your doctor may include substances such as Ibuprofen (Motrin and Advil), Ultram or Amitriptyline (Elavil) an anti-depressant drug that may decrease pain. Your doctor may also decide to do a trial with an opioid analgesic, such as Percocet, Oxycodone or a derivative, to assess its efficacy in treating your pain.

Some patients have an excellent response to Percocet and Percocet-like drugs (opioids). These patients experience a notable decrease in their pain without interfering side effects, such as sedation and nausea. This favorable response allows these patients to increase their function. Unfortunately, not all patients have a favorable response to these medications and may experience significant side effects that prevent further use of this type of pain medication. Additionally, these drugs do not decrease all pain syndromes. Your doctor has no way of knowing what side affects you may experience or how much pain relief you may experience. Furthermore, these medicines may cause unintended psychological effects such as a false sense of well-being and improved ability to cope with problems. Sometimes patients who experience these psychological effects may use these medicines in a way other than prescribed.

There exists significant misunderstandings regarding the use of certain analgesics. The following definitions are important for you to understand.

1. Physical Dependence: A pharmacological property of certain drugs, such as caffeine and opioids that cause biochemical changes in the body, such that abruptly stopping these drugs will result in withdrawal response.

2. Addiction: A psychological and behavioral syndrome in which there is a drug craving and drug-seeking behavior for purposes other than those intended by your physician. For example, addictive behavior would include increasing your usual dosage or opioid (without prior discussion with your doctor) for psychological benefit to self-medicate during a stressful situation.

3. Tolerance: A pharmacologic property of certain drugs defined by the need for increasing dosages to maintain effect.

There is a risk of addiction and overdose associated with opioid drugs, EVEN when taken as prescribed. Alternative treatments are available. Opioids are highly addictive, with the risk of developing dependency, risk of taking more than prescribed and/or mixing sedatives, benzodiazepines or alcohol, which can result in fatal respiratory depression. The risk of addiction in patients who do not have a prior addiction history can happen. The risk of addictive behavior is much higher in patients who have a prior history of addiction. Your doctor may decide that certain medicines are no longer appropriate, while others you should continue but only with very careful treatment guidelines.

INFORMED CONSENT

I understand that the use of certain opioid analgesics can be safe and effective treatment for my acute pain. I also understand that there exists a risk of developing an addiction disorder, even if taken as directed.

I **will not** increase my dosage unless I discuss this with my physician first, and he or she advises me to do so.

I **will not** give, lend, share, sell or transfer my medication to anyone else. Likewise, I will not receive, borrow or purchase additional opioid analgesics from anyone who is not a healthcare provider.

I **will** fill my prescriptions with only one pharmacy. If, for some reason, I need to change pharmacies or use more than one, I will notify my physician and both pharmacies about the change.

I **will** obtain opioid analgesics from only one physician. If I receive these medications from another physician, I will not request or obtain these medications from Ocean County Foot & Ankle Surgical Associates.

If I obtain these medications from Ocean County Foot & Ankle Surgical Associates, then I **will not** get additional opioid analgesics from any other healthcare provider unless I notify him/her about this agreement. Even if I get treatment in an emergency department, I will inform the provider about this agreement. If I get additional medications, I will notify the physician's office on the next business day.

If any of my medication is lost or stolen, I will report this to the local police department and obtain a stolen/missing item report.

I **will not** alter my prescription in any way.

I have no history of substance (drug or alcohol) abuse. If I previously or concurrently use drugs or alcohol, I have brought it to my physician's attention.

I **will** agree to random urine/serum (blood) drug testing if and when requested.

IF I VIOLATE THIS AGREEMENT, MY DRUG THERAPY WILL BE TERMINATED.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____

PHARMACY NAME AND ADDRESS: _____

PHYSICIAN OBTAINING CONSENT: _____

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NOTICE OF PRIVACY ACTS

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 PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. This notice takes place **April 14, 2003,** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay that may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-rated benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based on Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that is in your best interest based on our professional judgment. We may use or disclose protected heath information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a corner, protected health examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information or an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture and individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $1.00 for each page, $0.00 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposed other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in such and agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail) you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services.

Name of Contact Person: Russell D. Petranto, DPM, FACFAS

Telephone: (732) 505-4500 **Fax:** (732) 505-6457
Address: 54 Bey Lea Road
Suite 1
Toms River, NJ 08753

Authorized Signers: Cynthia Shymanski

SUMMARY OF NOTICE OF PRIVACY PRACTICES

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

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

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

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

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

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and 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 patient, you have the following rights:

- To have access to and/or copy of your health information;
- To receive an accounting of certain disclosures we have made of 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 receive notice of our privacy practices.

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

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY ACTS

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature