# Patient Clinical Summary

**Patient Name:** __________________________

**Birthdate:** ___/___/___  **MR #** ____________

## Medical History

<table>
<thead>
<tr>
<th>Date of Onset</th>
<th>Medical Condition</th>
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## Surgical History

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<thead>
<tr>
<th>Date</th>
<th>Surgical Procedure</th>
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## Medications & Supplements

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<thead>
<tr>
<th>Medication</th>
<th>Date Started</th>
<th>Date Stopped</th>
<th>Medication</th>
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## Allergies (Medication, Food, or Environmental)

<table>
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<tr>
<th>Allergen</th>
<th>Type of Reaction</th>
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**Date Updated** | **Signature**
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Form 084  09.02.15
Patient Name: ____________________________
Birthdate: ____/_____/____   MR #: ___________

(Please Print)  Date: ____/_____/____

Last Name:                      First Name:                      MI:                      

Preferred:                      Maiden:                      Miss/Ms/Mrs/Mr:                      

Birthdate: / /                      Social Security #: - -                      Race:                      

Marital Status: Divorced Married Single Widowed Separated

Driver’s License #:                      

Primary Language:                      Religion:                      

Address:                      

City:                      State:                      Zip code:                      

Phone: Home: ( ) - Primary Work: ( ) - Cell: ( ) -                      

Employer Name:                      Employer Address:                      

Occupation:                      

Email Address:                      

Preferred Pharmacy:                      Address:                      Tel #:                      

Do you have an Advance Directive?  □ Yes  □ No  If yes, do you have a Proxy Directive?  □ Yes  □ No

If yes, name of Proxy (Healthcare Representative): ________________________________

Do you have an Instruction Directive?  □ Yes  □ No

VISIT INFORMATION

Why have you come to the office today?

GYNECOLOGIC:  □ Annual exam  □ Problem visit  If you are here for a problem visit, please explain:

COSMETIC:  □ Cosmetic Consultation  □ Cosmetic Procedure

How did you hear about us?  □ Search Engine  □ Facebook  □ Jersey Journal  □ Other ________________________________
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (‘HIPAA’), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Pelosi Medical Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the Center at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**For Office Use Only**

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices but was unable to do so as documented below:

Reason:

____________________________________________________________________________________________

____________________________________________________________________________________________

Date: ___________________________  Initials: ____________
If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or clinical staff.

### PAST MEDICAL HISTORY

<table>
<thead>
<tr>
<th>MAJOR ILLNESS</th>
<th>DATE</th>
<th>MAJOR ILLNESS</th>
<th>DATE</th>
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### PAST SURGERIES (INCLUDING COSMETIC SURGERY)

<table>
<thead>
<tr>
<th>NAME OF OPERATION</th>
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<th>NAME OF OPERATION</th>
<th>DATE</th>
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### CURRENT MEDICATIONS

(INCLUDING HORMONES, VITAMINS, HERBS, AND NONPRESCRIPTION MEDICATIONS)

<table>
<thead>
<tr>
<th>DRUG NAME &amp; DOSE</th>
<th>WHO PRESCRIBED</th>
<th>DRUG NAME &amp; DOSE</th>
<th>WHO PRESCRIBED</th>
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### ALLERGIES & SENSITIVITIES (FOOD, MEDICATION, & ENVIRONMENTAL)

<table>
<thead>
<tr>
<th>ALLERGY/SENSITIVITY</th>
<th>TYPE OF REACTION</th>
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NO KNOWN ALLERGIES OR SENSITIVITIES ☐

### SMOKING AND ALCOHOL HISTORY

<table>
<thead>
<tr>
<th>SUBSTANCE USE</th>
<th>NEVER</th>
<th>CURRENT</th>
<th>FORMER</th>
<th>AGE STARTED</th>
<th>AGE STOPPED</th>
<th>AMOUNT USED/DAY</th>
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<tbody>
<tr>
<td>ALCOHOL</td>
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<td>TOBACCO</td>
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### INFECTION RISK

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<tr>
<th>EXPOSED TO</th>
<th>POSSIBLY EXPOSED TO:</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>HEPATITIS B</td>
<td>HISTORY OF BLOOD TRANSFUSION:</td>
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<tr>
<td>HIV</td>
<td>HISTORY OF SEXUALLY TRANSMITTED DISEASE:</td>
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<tr>
<td>TUBERCULOSIS</td>
<td>NO KNOWN INFECTION RISK ☐</td>
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### PATIENT SIGNATURE:

__________________________

FORM COMPLETED BY: ☐ PATIENT ☐ OFFICE MED ASST ☐ OTHER

Page 1 of 1
PATIENT’S BILL OF RIGHTS AND RESPONSIBILITIES

In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of Pelosi Medical Center.

The patient has the right to:

- Be treated with courtesy & respect, with appreciation of his/her individual dignity and with protection of his/her need for privacy.
- Be informed of his/her right to change their provider if other qualified providers are available.
- Be accurately notified of the accreditation status of the facility, reflecting AAAHC as the accrediting entity.
- Know that any marketing or advertising regarding the competence and capabilities of the organization is not in any way misleading to the patient.
- Know who is providing medical services and availability of other qualified providers if change is requested.
- Know what patient support services are available, including whether an interpreter is available if he/she does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given, by the health care provider, information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Receive impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental/research and to give his or her consent or refusal to participate in such experimental research.
- Participate in decisions involving their health care, unless contraindicated by concerns for their health.
- Participate in an appropriate assessment and management of pain.
- Refuse treatment, except as otherwise provided by law.
- Be given, upon request, full information & necessary counseling on the availability of known financial resources for his/her care.
- Know, upon request & in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- Be advised prior to care in the event any facility providers do not have Malpractice insurance.
- Express grievances regarding any violation of his or her rights, as stated in applicable state and/or Federal law, through the grievance procedure of the health care provider or health care facility, which served him or her, and to the appropriate state-licensing agency.

A patient is responsible for providing the healthcare team with:

- To the best of his/her knowledge, accurate & complete information about present complaints, past illnesses, hospitalizations, medications, dietary supplements, over-the-counter medications, allergies as well as reactions, & other matters relating to his/her health.
- A complete list of current medications including over-the-counter products & dietary supplements, & any allergies or sensitivities.
- Report of unexpected changes in his or her condition to the health care provider.
- Confirmation to the health care provider whether he/she comprehends a contemplated course of action & what is expected of him/her.
- Full participation with the treatment plan recommended by the health care provider.
- A responsible adult to transport him/her home from the facility and remain with him/her for twenty-four hours (24), if required by his/her provider.
- Punctuality at appointments and when he or she is unable to do so for any reason, notifying the health care facility.
- Accountability for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- Fulfillment of his or her financial obligations for health care provided by the facility as promptly as possible.
- Cooperation in following facility rules and regulations affecting patient care and conduct.
- Information regarding his/her living will, medical power of attorney, or other directive that could affect his/her care.
- Consideration and respect of the facility staff and property.
- Any concerns or questions regarding what to expect relative to pain, pain management and other options available.

Filing Complaints

If you have concerns about the care you received at this center, call the facility Medical Director at 201-858-1800.

If you have a complaint against this center, or practitioner contact the Board of Medical Examiners by completing a complaint form that can be retrieved at http://www.state.nj.us/lps/ca/bme/bmeform.htm.

If you are a Medicare recipient and have a complaint against a health care professional or facility you may contact the Office of the Medicare Beneficiary Ombudsman by calling 1-800-MEDICARE or www.medicare.gov

Patient Signature ______________________ Date ______________________
Print Name ___________________________ MR # __________________________
Pelosi Medical Center

COSMETIC SURGERY FINANCIAL AGREEMENT

Patient Name: _______________________________

Birthdate: ___ / ___ / ___  MR #: ____________________

DATE: ___ / ___ / ___  PATIENT’S WEIGHT: _______LBS

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<th>PROCEDURE</th>
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<td>Anesthesia Fee</td>
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<td>Less Deposit</td>
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<tr>
<td>Balance Due</td>
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Methods of Payment

• Cash, personal checks, cashier’s check, traveler’s check, and money orders. There will be a $20.00 service charge on returned checks.
• Credit cards: Visa, MasterCard, American Express and Debit Cards.
• Financing is available through CareCredit.com.

Cost of Surgery

The date of consult constitutes the day of the quote. The quoted surgical fee remains valid provided that: (1) the surgery is scheduled and the deposit is paid within six months of the date the quote was made, (2) the surgery is done within six months of the quote, and (3) the patient’s weight does not increase by more than 5% after the time of the quote. The balance of the total fee must be paid at least TWO (2) weeks before surgery.

Scheduling Deposit

To reserve a day for your surgery, a $500.00 deposit is required. This is credited toward your actual surgery cost.

Patient Initials: _______
Cancellation and Refunds

Please understand that the Pelosi Medical Center must uphold these policies as we have an obligation to our patients who may have requested the same day and to our surgical team and anesthesiologist who are scheduled to work. Also, there are numerous medical supplies that are ordered specifically for your surgery.

If you cancel your surgery within 14 (fourteen) days of your scheduled procedure, there is a $500.00 cancellation fee. If you paid by credit card, an additional 2.5% of the amount charged to your credit card will be deducted from your refund in addition to the $500 cancellation fee.

If you cancel your surgery within 3 (three) days of your scheduled procedure or fail to attend on your scheduled surgery date, there is a $1,000 cancellation fee. If you paid by credit card, an additional 2.5% of the amount charged to your credit card will be deducted from your refund in addition to the $1000 cancellation fee.

The balance of your surgery pre-payment will be refunded in full by business check within 30 days. This time is required to ensure all pre-payment transactions have cleared and are validated by the appropriate financial institutions.

There will be no refund for services already provided.

Touch Up Procedures

Patient understands that liposuction and abdominoplasty are not weight reduction procedures. Patient understands that to maintain their newly contoured body shape, a commitment is required to change eating habits in order to avoid weight gain and loss of the newly contoured body shape.

A touch up procedure is additional work of the same type and on the same area(s) done at the original procedure for the reason that a reasonable aesthetic result was not achieved at the time of the original procedure. There will be no additional surgical charge for the touchup procedure under the following conditions:

1. The touchup procedure is performed within sixteen weeks of the original procedure
2. The patient’s weight remained the same since the date of the original procedure
3. The procedure is not a request for additional fat injections in any area treated with autologous fat transfer at the original procedure
4. The touchup procedure is for the same body area as the original procedure

If any of the above conditions are not met, there will be a surgical fee for the new/redo procedure. If the services of an anesthesiologist are required for the touchup procedure, these costs will not be waived by this policy and the patient will be responsible for paying the anesthesiologist fee.

Treatment and Complications

The practice of medicine and surgery is not an exact science. Although good results are anticipated, there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results you may get. Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. These may result in additional charges for which you are responsible.

** In the event of default, I hereby agree to pay all costs of collection, including but not limited to attorney fees, court costs, all interest allowed by law, collection agency fees, etc.

I have read and understand the terms of this Cosmetic Surgery Financial Agreement.

______________________________  __________/_____/______  
Patient Signature  Date
PELOSI MEDICAL CENTER

VTE RISK FACTOR ASSESSMENT

Patient Name: __________________________

Birthdate: __/__/____ MR #: __________

Date: __/__/___ Age: _________ Wt (lbs): __________ BMI: __________

Sex: _________ Ht (in): __________

CHOOSE ALL THAT APPLY

Add 1 Point for Each Risk Factor

___ Age 41-60 years
___ Minor surgery (< 45 min) planned
___ Past major surgery within last month
___ Visible varicose veins
___ History of inflammatory bowel disease
___ Swollen legs (current)
___ Overweight or obese (BMI > 30)
___ Serious infection (< 1 month)
___ Lung disease (e.g., emphysema, COPD)
___ Heart attack
___ Congestive heart failure
___ Other risk factors ___________________

Add 2 Points for Each Risk Factor

___ Age 61-74 years
___ Planned major surgery (> 45 minutes)
___ Previous malignancy (excl skin cancer, but not melanoma)
___ Central venous access within last month
___ Non-removable plaster cast that kept pt from moving leg within last month
___ Confined to a bed for 72 hrs or more

Add 3 Points for Each Risk Factor

___ Age 75 years or over
___ History of blood clots – either DVT or PE
___ Family history of blood clots (thrombosis)
___ Personal or family history of positive blood test indicating increased risk of blood clotting

Add 5 Points Each Risk Factor that applies now or within the past month

___ Elective hip or knee joint replacement surgery
___ Broken hip, pelvis, or leg
___ Serious trauma e.g., multiple broken bones due to a fall or car accident
___ Spinal cord injury resulting in paralysis
___ Experienced a stroke

TOTAL RISK FACTOR SCORE __________

Score | Risk Level | Prophylaxis for Surgical Patients
---|---|---
0-2 | Low | • Early ambulation
3-8 | Increasing | • Apply antiembolism stockings and intermittent pneumatic compression device
| | • Flex patient’s knees to approximately 5° by placing a pillow underneath them
| | • Stage multiple procedures
| | • Provide patient with DTV Patient Information Sheet
| | • Instruct patients who are taking oral contraceptives or hormone replacement therapy to discontinue taking these medications 1 week prior to surgery.
> 8 | 18.3% | • Not a candidate for office-based surgery

Form 085 10.04.15