North American
HEROES MEDICAL

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____ City: _____

State: _____ Zip: _____ Gender: M / F E-mail: _____

Patient SS#: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____

Pharmacy: _____ Pharmacy Phone: ( ) _____ Town: _____

Patient Status: (Circle) Single Married Other Employed: (Circle) Y / N Student: (Circle) Full-time Part-time

Patient's Employer or School: _____ Employer or School Phone: ( ) _____ Ext: _____

Patient representative name(print), relationship to patient, and phone number:

_____

Current Primary Care Provider: _____ Provider Phone: _____

Insured's(policyholder) Name: _____ Insured's DOB: _____

Patient relationship to insured: Self Spouse Child Other

Insured's Address: _____ City: _____

State: _____ Zip: _____ Gender: M / F Home Phone: ( ) _____

Cell Phone: ( ) _____ Insurance Plan or Program Name: _____

Insurance ID Number: _____ Primary Insurance (Group or FECA Number): _____

Insured's Employer or School Name: _____

Secondary or Other Insurance Policyholder Name: _____

Secondary Policy Holder's DOB: _____ Gender: M / F

Secondary Insurance Plan Name or Program Name: _____

Emergency Contact: _____ Relationship to patient: _____

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

Who referred you to us? _____

Assignment of Benefits

Name of Insured: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed before for any services, supplies, or equipment provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable or related services or equipment to the organization, the Center of Medicare and Medicaid Services (CMS), my insurance carrier or other medical entity. A copy of this authorization will be sent to my CMS, my insurance company or other entity if requested. The original Authorization will be kept on file by my organization.

I understand that I am financially responsible to the organization for any charges that are not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained for all payment products received.

Organization: North American Heroes Medical

Name of patient or representative (print): _____ Relationship to patient: _____

Signature of patient: _____ Date: _____

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CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: _____ Gender: M / F DOB: _____ Date: _____

Last Exam: _____ Reason for today's visit: _____

Symptoms (Check ✓ if you currently have or had in the past year)

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headache
- ☐ Loss of sleep
- ☐ Weight loss
- ☐ Anxiety
- ☐ Numbness
- ☐ Sweating
- ☐ Seizures
- ☐ Others: _____

Gastrointestinal
- ☐ Poor appetite
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas pain
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Other: _____

Eye Ear Nose Throat
- ☐ Bleeding gums
- ☐ Blurry vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision problems
- ☐ Other: _____

Joint/Muscle/Bone
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Cardiovascular
- ☐ Chest pain
- ☐ Hypertension
- ☐ Low pressure
- ☐ Irregular pulse
- ☐ Palpitations
- ☐ Ankle Swelling
- ☐ Varicose veins
- ☐ Other: _____

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Mole changes
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores wont heal
- ☐ Others: _____

Genitourinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ No bladder control
- ☐ Painful urination
- ☐ Other: _____

Men Only
- ☐ Breast lump
- ☐ Erectile dysfunction
- ☐ Testicular pain
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Swollen scrotum
- ☐ Other: _____

Women Only
- ☐ Abnormal pap smear
- ☐ Bleeding
- ☐ Breast lump
- ☐ Menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Miscarriage
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Date of last menstrual: _____
- ☐ Mammogram: _____
- ☐ Last pap smear: _____
- ☐ Currently pregnant? Yes / No
- ☐ No. Of Children: _____

Allergies:

_____

_____

_____

Surgeries:

_____

_____

_____

Hospitalizations:

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Auto Immune Disorders:

_____

Check ✓ if you currently have or had any of the following:

- ☐ Alcoholism
- ☐ Anorexia
- ☐ Bulimia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Golter
- ☐ Gonorrhea
- ☐ Pacemaker
- ☐ Chemical dependency
- ☐ Appendicitis
- ☐ Cancer
- ☐ Kidney disease
- ☐ Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Arthritis
- ☐ Cataract Surgery
- ☐ Scarlet Fever
- ☐ Bleeding disorders
- ☐ Chickenpox
- ☐ Psychiatric issues
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Herpes zoster
- ☐ Venereal disease
- ☐ Anemia
- ☐ HIV-positive
- ☐ Migraine
- ☐ Gout
- ☐ Hernia
- ☐ Thyroid fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Stroke
- ☐ Ulcers
- ☐ Multiple Sclerosis
- ☐ Other: _____

Is your asthma moderate to severe? Yes / No or N/A

Do you have a history of respiratory disease? Yes / No

Have you ever had an anaphylactic reaction requiring medical attention? Yes / No

In the past year, have you had an allergy scratch test or immunotherapy medication made for you? Yes / No

Have you ever taken any allergy medication including allergy shots? Y / N If yes, please list: _____

Have you ever taken any steroids? (oral, inhaled, or topical) Y / N If yes, please list: _____

Patient Signature: _____ Date: _____

Physician signature: _____ Date: _____

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HEROES MEDICAL

PRIVACY NOTICE

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.

Effective April 14th, 2003

The privacy of your medical information is important to us. You may be aware that U.S. government regulations established privacy rule (HIPAA) governing protected health information. This notice tells you about how it may be used, and about certain rights that you have. The Office Manager oversees privacy matters at your facility. You can contact him/her at 732-503-4373 if you desire to have any questions or concerns.

USE AND DISCLOSURE OF PROTECTED INFORMATION

Federal law provides that we may use your medical information (Protected Health Info) for treatment of you without further notice to you. For example, we may send your referring physician a copy of your initial evaluation or a periodic progress report to let them know how your care is progressing. Federal law provides that we may use your PHI for healthcare operations without further notice to you, or written authorization by you. For example, our accountants may see your name, dates, or treatments and procedure codes during audits for our records. We may use or disclose your medical information, without further notice to you, or specific authorization by you. Required by law, for public health purposes, in judicial or administrative proceedings, to report child abuse, by health oversite agency for oversite activities. Authorized by law, such as the Department of Health, Office of Professional Discipline Medical Conduct. Permitted by law to a funeral director, law for organ donation purposes, to avert a serious threat to health or safety, by military authorities if you are a member of the armed forces for the United States, and for research purposes. New jersey law provides additional protection for information regarding HIV/AIDS. We will continue with New Jersey State law with respect to such information. We may contact you by email, text message, or phone at your residence, or on your cellular phone to remind you of appointments or to provide information about treatment alternatives. Unless you instruct otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence. You can make reasonable requests, in writing, for us to use alternative methods of communication with you in a confidential manner. Other uses or disclosure of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

RIGHTS THAT YOU HAVE

You have the right to request restrictions on some of the uses or disclosures described in the previous document. Except as stated below, we are not required to agree to such restrictions. You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged.)

You have the right to your medical information. Such requests must be in writing and must state the reason for the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request accounting of any disclosures we make of your medical information, except for disclosures we make to you, to carry out treatment, payment, or health care operations, or as requested by your written authorization, or as permitted of required under 45 CFR 164.502 or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosure made before April 14th, 2003.

OBLIGATIONS WE HAVE

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and our privacy policies. We are required to abide by the terms of this notice as long as it is currently in effect. We reserve the right to revise this notice and make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our facility, and copies will be available here. If you want to file a complaint about violations of your privacy right, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints will be directed to the Office Manager. No retaliatory.

Signature: _____ Date: _____

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HIPAA Form

North American Heroes Medical would like you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any healthcare operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow North American Heroes Medical to use their Patient Health Information for the purpose of treatment, payment healthcare operations, and coordination of care.

2. The patient has the right to obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosure has been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's consent needs only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in the office. We have taken all precautions that are known by the office to assure you that your records are not readily available to those who do not need them.

6. Patients have full rights to file a formal complaint with our privacy official about any possible violations of this policy and its procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment, and/or health care operations, the doctor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and agree to these policies and procedures.

_____ _____ _____

Name Signature Date

North American
HEROES MEDICAL

CONSENT FOR OUTPATIENT TREATMENT AUTHORIZATION

1. I hereby authorize the hospital, the physicians, dentists, and other healthcare professionals to provide such medical care and to administer such treatment, including immunizations, as deemed necessary or advisable to me or the named patient each time I or the named patient presents to an ambulatory care service. To the extent possible, I have been informed of risks and complications that may occur and that may be available.
2. I acknowledge that no guarantees or assurances have been made to me concerning the results intended for my treatment.

MEDICARE PATIENTS

3. I authorize any holder of medical or other information about me to release the Social Security Administration, its intermediates or carriers of any information needed for his or related Medicare class. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

GUARANTEE OF ACCOUNT

4. For and in consideration of service rendered to (name of patient) _____ by this facility, I hereby agree to pay the full bill for all the charges which are not covered by BlueCross, Workers Compensation, or any balance due which is not covered by insurance or excluded by a co-insurance clause.

RELEASE OF INFORMATION

5. I permit the hospital to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for the collection of benefits or payment of hospital charges.

ASSIGNMENT OF BENEFITS

6. I assign to the hospital all benefits from any corporation, agencies, and person for these services. I authorize payments of these benefits directly to the hospital.

DISCLOSURE OF FINANCIAL INTEREST

7. State requirements and the Center for Medicare & Medicaid Services require that we disclose to patients a physician's financial interest in an ambulatory surgical center or other health center to which the physician refers his or her patients. The following physicians have a 100% economic interest in Heroes Medical Clinic, located in New Jersey.

    Dr. Abhijeet Rastogi, MD
    Dr. Kieran Slevin, MD

8. I confirm that I have read and fully understand the above.

Patient/Relative or Guardian: _____ _____
Print Name Signature

Relationship (if signed by other than patient): _____

Interpreter (if required): _____

Witness: _____ _____ _____
Print Name Signature Date

GUARANTOR:

_____ _____ _____
Print Name Signature Date

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PAYMENT NOTIFICATION ACKNOWLEDGEMENT

Please be advised that we are an OUT OF NETWORK facility and you will receive payment from your insurance carrier for the services that we have provided for you. This payment will be in YOUR NAME and the provider listed will be _____. The payments you received must be endorsed and submitted to us for payment for services rendered.

I, _____, understand and acknowledge that I may be personally reimbursed for medical services rendered to me by North American Heroes Medical from my insurance carrier and that I am liable for the remittance of all payments. I understand that all Checks and Explanation of Benefits should be endorsed and submitted to North American Heroes Medical within 30 days of receipt of payment. Should I cash the checks, I legally assume full responsibility for any and all outstanding balances. If payment is not submitted within 30 days, you will be referred to our collection agency.

Patient: _____ Date: _____

Signature: _____

Witness: _____

North American Heroes Medical
202 Rt. 37 W
Suite 5
Toms River, NJ 08755

Any questions or concerns, please contact the Office Manager at 732-503-4373, Ext. 1511.

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I hereby authorize North American Heroes Medical to use pictures of me (or my child/ward) taken in a photograph, digital image, videotape, motion picture, and/or testimonial (written words). The undersigned hereby releases North American Heroes Medical, its agents or employees, as well as any and all users and exhibitors or said pictures, from any and all claims, demands, accountings, and causes for which the aforesaid videotape, testimonial, motion picture, digital image, or photograph likeness may be used pursuant to this consent and general release. It is also my understanding that I will receive no compensation for my likeness or testimonial.

Date: _____

Name (Print): _____

Signature: _____

Name of person(s) in photo: _____

Address: _____

_____

Phone Number: _____

Email: _____

Witness Name (Print): _____

Witness Signature: _____

North American
HEROES MEDICAL

Date: _____	**For Staff Use Only**
Attention: _____	Fax: _____
RE: _____	Date of Birth: _____

RELEASE OF MEDICAL RECORDS

Authorization for Use or Disclosure of Protected Health Information

1. **Authorization**

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to North American Heroes Medical.

2. **Effective Period (Choose One)**

This authorization for release of information covers the period of healthcare from:

A. □ _____ to _____.

OR

B. □ all past, present, and future periods.

3. **Extent of Authorization (Choose One)**

A. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse, other pertinent information unless excluded (see below)).

OR

B. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Genetic Testing Results
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

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6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative and his or her relationship to patient

Patient Initials: _____ Patient's Date of Birth:_____
Today's Date: _____