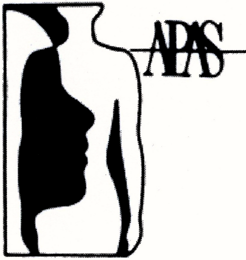

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Name____ Date ___________________

Date of Birth ____________________ Age ___________ Social Security No ____________________

Demographics ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

Reason for your Visit ____

Who referred you to this office ☐Doctor ☐Patient ☐Web Site ☐Other

Please elaborate (name and phone) ____

If your visit pertains to an injury, what was the date ____________________________

Preferred Language ☐English ☐Spanish ☐Other ____________________

Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Latino

Race ☐American Indian/Alaskan ☐Asian ☐African American ☐Native Hawaiian/Pacific ☐Other ☐White

---

PERSONAL INFO

Email _____________________________ Cell #_______________ Home #____________

Street ______________________________ City ________________ State _____Zip_______

WORK INFO

Occupation _________________ Employer__________________ Phone # __________________

Street _______________________________ City _________________ State _____ Zip_______

INSURANCE INFO

Insurance Co. (primary) ____________________________ (secondary) ______________________

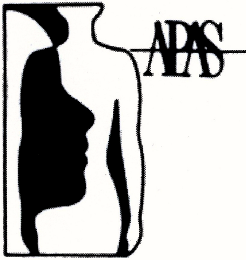
Guarantor (Name of Primary Insured) ____

DOB _________ SS# _________________ Relationship to the patient ___________________

Who is your primary medical doctor (name and phone no.) ______________________________________

Jerrold Zeitels MD Richard Tepper MD

955 S. Springfield Ave Suite 105 Springfield, NJ 07081 908.654.6540



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Name____ Age_______ Today's Date _______________

Height _______ Weight __________ Please approximate your blood pressure (i.e. 120/80) ____________________

Any RECENT fever, chills or unintended weight loss? ☐Yes ☐No

Problems with your Heart (previous heart attack)? ☐Yes ☐No

Problems with your Breathing (asthma, shortness of breath)? ☐Yes ☐No

Do you have Obstructive Sleep Apnea? ☐Yes ☐No Do you use a CPAP machine? ☐Yes ☐No

Have you ever had a Blood Clot (DVT) in your legs? ☐Yes ☐No

Have you ever had excessive bleeding from surgery? ☐Yes ☐No

Have you ever had a complication from surgery? ☐Yes ☐No

*Please explain*____

Have you ever had a complication from anesthesia (not including nausea / vomiting)? ☐Yes ☐No

Have you ever received a blood transfusion? ☐Yes ☐No

Did you have any metal implant? (where ___________________________) ☐Yes ☐No

Do you smoke? ☐Never ☐Quit ☐Few cigs/day ☐½ pack ☐1 pack ☐> 1 pack/day

Do you drink Alcohol / Beer / Wine? ☐No ☐Yes (*if yes, please select* ☐social ☐few/week ☐heavy)

Current Medications ☐No ☐Yes (if yes, list name and dosage)_________________________________

____

Allergies to Medicine (or latex)? ☐No ☐Yes (what happens?) _____________________

____

Do you take Blood Thinners? ☐No ☐Baby Aspirin ☐Full Aspirin ☐Coumadin ☐Eliquis

☐Pradaxa ☐Savaysa ☐Xarelto ☐Lovenox ☐Plavix

Do you take supplements? ☐No ☐Dong Quai ☐Ginger ☐Ginkgo Biloba ☐Vitamin E ☐Garlic

☐Ginseng ☐Omega-3 fatty acid ☐Feverfew ☐Other (names / dosages) ___________________________

____

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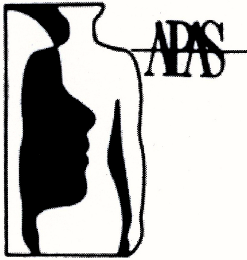

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Current Medical Conditions (check all that apply)

☐*NONE*
☐Anxiety
☐Asthma
☐A-fib (atrial fibrillation)
☐Bleeding Problems
☐Cancer (explain below)
☐CHF (heart failure)
☐Cholesterol (high)
☐COPD (emphysema)
☐COVID-19
☐Diabetes
☐Glaucoma
☐Heart Attack ("MI")
☐Heart (coronary) Disease
☐Hepatitis or HIV
☐High Blood Pressure
☐Kidney Failure - Dialysis
☐Migraines
☐Mitral Valve Prolapse
☐MRSA (Staph infection)
☐Rheumatoid Arthritis
☐Seizures
☐Stroke (or TIA)
☐Thyroid (low)

Other Medical

____

____

Previous Surgery ☐No ☐Yes (please explain)

____

____

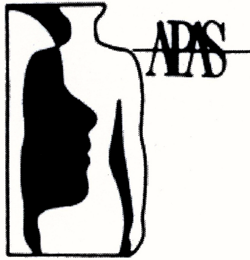
Family History ☐No ☐Yes (please explain)

☐Cancer ☐Heart Disease ☐Bleeding Problems ☐Other ________________________________

____

Have you *recently* experienced any of the following (you may underline or circle)?

☐Constitutional: Recent fevers or unexplained weight loss
☐Head-Neck: Recent vision changes, dry eyes or irritation, nasal problems, or neck pain
☐Heart: Recent chest pain, palpitations, a need to take nitroglycerin under your tongue, or angina
☐Lungs: Recent shortness of breath, cough, or difficulty breathing
☐Hematology: Easy bruising, difficulty clotting, very heavy periods, or frequent and/or excessive nose bleeds
☐GI: Recent stomach pains / nausea / vomiting / GI problems
☐Skin: Unexplained rashes, difficulty healing, wounds that won't heal, or skin cancer concern
☐Neuro: Recent headaches, dizziness, or poor balance
☐Hand: Change in fingertip feeling, weakness, dropping things unexpectedly
☐Musculoskeletal: Neuropathy, pain in calves when walking



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WELCOME TO THE PRACTICE

FROM OUR PHYSICIANS: Thank you for entrusting your care to us. We are board-certified plastic surgeons who are licensed to practice medicine in the State of New Jersey. We are committed to providing safe, private and personalized care. "Provider(s)", when used, refers to Dr. Jerrold Zeitels and / or Dr. Richard Tepper.

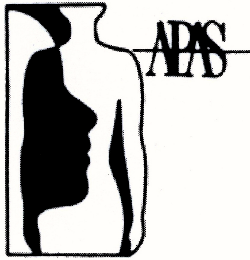
PRIVACY PRACTICES / MY RIGHTS ACKNOWLEDGEMENT: You have received the Notice of Privacy Practices / My Rights and have been provided an opportunity to review it. Our practice collects information and stores this information in a certified EHR system. Annual reporting requirements by state or federal agencies may require release of this information. When your permission is required, you will be asked to sign the necessary forms. Generally speaking, we are permitted to release your information when it pertains to your treatment, payment, and healthcare operations. We do not sell your personal information. We may use your email and cell (mobile) number to notify you about an appointment general practice information, new procedures and cosmetic services. We may request that you provide an on-line rating. You may choose to unsubscribe within the email. You may specify a preferred method of communication. Your email will not be used to transmit personal information or HIPAA-protected information unless you provide consent. You may email us at your discretion. Our office emails are NOT encrypted so use your best judgement. Anything you send to us, and any reply to such, will not be encrypted. Do not rely on an email to transmit any medical information of an urgent or emergent nature. If you have a medical emergency, dial 911 or go to the nearest emergency room.

WHAT IS EXPECTED OF YOU (the patient): It is our goal to provide you with the highest quality of care. In order to do so, it is imperative that we have your fullest cooperation. Even with the best medical training and experience, not every surgical or cosmetic procedure has a perfect outcome. Complications sometimes arise. It is important that any and all recommendations made by us are followed completely in order to increase the likelihood of a positive and healthy outcome. This includes taking prescribed medication, stopping certain medications when advised and being honest about what medications or substances or recreational products you might use. If a test or outside evaluation is recommended, doing so in timely fashion is expected. Failure to adhere to our recommendations may negatively affect your outcome.

PLAY A PART IN YOUR CARE: Feel free to ask questions of anyone in this organization. Please speak the office manager about any concerns you may have (Diane Ballistreri). If you feel that concerns have not been addressed to your satisfaction, you may contact AAAASF at 888-545-5222 or by email at ***info@aaaasf.org***. You may also contact the office of the Medicare beneficiary Ombudsman James McCracken at 877.582.6995 or 609.943.4026, or at http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

INFECTION CONTROL: Staff members are educated about proper infection control techniques upon hire and annually thereafter. We follow CDC guidelines and recommendations. We adhere to AAASF and State Ambulatory Surgery Center regulations in our facility. We screen patients for COVID symptoms and history. However, we cannot guarantee that you will not contract a viral or other infection while on the premises.

PHOTOS, VIDEO OR DIGITAL IMAGES: Your signature confirms that you understand that photos, videos or digital images (collectively referred to as "images") may be obtained during treatment and that any or all may be used to document care. By signing, you consent to such "images" being taken and understand that our practice retains all ownership rights to these "images". You may view them or obtain copies if requested. These "images" will be secured in a manner consistent with our privacy policy and maintenance of medical records. "Images" may reveal private or personal details and may further reveal your identity, and your signature acknowledges your approval of this.



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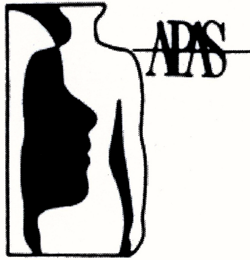
AUTHORIZATION TO RELEASE INFORMATION: You ("the patient") hereby authorize "my provider" or any "affiliate" to release any and all information regarding treatment, including digital photos or "images", even if they reveal your identity or other private area on your body, to your insurance carrier(s), Workers' Compensation Carrier, Case manager, PIP representative or other health professional, as necessary to obtain insurance pre-approval or payment, and to process your insurance claim(s) generated in the course of examination and /or treatment. "Affiliate" refers to any outside company we hire to assist with our business operations. A photocopy of this agreement is considered as valid as the original. This order will remain in effect until revoked by you in writing.

FEDERAL AND STATE LAWS REGARDING SURPRISE / BALANCE BILLING: The newly enacted Federal Law (No Surprises Act) and the existing New Jersey Law (Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act) offer protections against surprise medical bills and balance billing. The following information is a just a summary. A complete copy is posted by our front desk, is available on our practice websites (www.DrRichardTepper.com and www.NJPlasticSurgeryGroup.com) and a copy was provided to you at check-in, as required by law. Transparency is important to us. We believe that no one wants to receive a "surprise bill". Prior to any procedure you have, we will advise you in writing of the fee and once we have your agreement, we will proceed. In cases where your insurance benefits are being used, we will also advise you of your approximate cost sharing amounts, including deductibles, copays and coinsurance, to the best of our abilities, understanding that there are limitations of what an insurance company agent will reveal to us. We are not permitted to just waive these cost sharing amounts as that would constitute an enticement. As required, we will also always provide you with advanced notice of those plans with which we do, and do not, participate. This information can also be found on our website, and our registration packet contains information as well. Participation status can change, so you should always confirm how we participate with your specific plan, either by contacting your insurance company or by asking our patient coordinators. Insurance companies and government agencies are encouraging people to use in-network services in order to save money. However, many individuals believe that accessing their out-of-network benefit coverage, a benefit for which they pay, is beneficial, perhaps due to more skilled or personalized care. If you require assistance understanding this information, please don't hesitate to ask the office staff for assistance.

If you believe you've been wrongly billed, you may contact:
https://www.cms.gov/nosurprises/consumers
To submit a federal complaint, you may contact:
https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing
To submit a complaint in the state of New Jersey, you may contact:
https://www.state.nj.us/dobi/consumer

FINANCIAL POLICY - COSMETIC SURGERY: Payment for cosmetic surgery must be made at least one week prior to the procedure. We do not submit insurance claims for cosmetic surgery. The price you pay for cosmetic surgery will state the surgeon's fee, anesthesia fee (if any) and facility fee on the specified procedural date. When applicable, we will collect fees for the hospital / surgery center and anesthesia group solely for your convenience and send those fees to the respective people. Collecting fees in no way implies that we take any responsibility for any action taken by either anesthesia or the hospital / surgery center. If you choose, you may pay them directly. Hospital / Surgery center and anesthesia fees are based on an estimate of the time required for your procedure. You may receive a refund for unused time, but it is your responsibility to pursue such a refund. You may be billed for additional time if required. You are responsible for payment if extra time is needed. We are not responsible for that. We may elect, at our own discretion, to assist you with such, but you acknowledge that we bear no responsibility for those refund / additional charges and make no guarantees, implied or otherwise.



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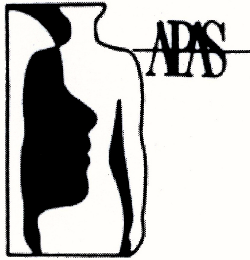
FINANCIAL POLICY - POST OPERATIVE CARE: We include routine postoperative care at no cost, typically 10 days for minor procedures and usually 90 days for larger ones. Any and all additional treatments including, but not limited to, medications, garments, scar treatments, laser therapy, and/or revisions, that you may need and / or desire are not included in your cost for surgery unless otherwise clearly stated in writing. At our sole discretion and with no implied warranty or guarantee, we may choose to extend your care or provide additional services at no cost or a reduced cost. You should check with your insurance company prior to having cosmetic surgery as some companies have provisions regarding coverage for complications related to cosmetic surgery. If you experience an adverse event, such as an infection, poor wound healing, hematoma or bleeding, blood clot or other situation requiring treatment, whether as an outpatient or in the hospital, such treatments may result in additional charges to you and are not included in the price you pay for cosmetic surgery. We bear no responsibility for charges rendered by the hospital or anesthesia providers.

FINANCIAL POLICY - SURGICAL REVISIONS: From time to time, a patient may require, or desire, a surgical revision. Surgery is not an exact science and despite best intentions, not every outcome achieves a thin scar, or the perfect amount of skin tightening, or the perfect breast size or shape, or the perfect nose, etc. That description was not inclusive. Sometimes sutures break, wound healing issues arise, infections occur. Surgical revisions are designed to help some of these issues. Surgical revisions are not included in the price you pay for surgery, whether cosmetic or reconstructive, unless specifically stated in writing ahead of time. Cosmetic revisions are frequently offered at no charge, especially if we can perform such in our office, but this decision lies with each doctor individually and there is no implied warranty or guarantee about any outcome or appearance. Even if a revision is offered at no charge, there may still be facility and/or anesthesia fees, whether performed in our own surgical facility or an outside hospital / surgery center. Even if your insurance company initially approved the initial procedure, a revision may not be covered if deemed cosmetic. If a revision is performed and afterwards is denied by your insurance company as being cosmetic, a scenario that sometimes occurs, you agree to be responsible for payment of those services rat a rate equivalent three times the prevailing Medicare rate for codes included on the Medicare fee schedule, and otherwise at our usual self-pay rate. If not approved in advance, you may have the option of proceeding with a cosmetic revision, and the cost will be discussed with you prior to the procedure. In such cases, any additional care you receive, whether required or simply desired, may incur additional charges. From time to time, an executive decision can be made to refund or eliminate patient balances as the cost of business and not a reflection on quality or outcome.

FINANCIAL POLICY - PERSONAL INJURY LAWSUITS: If you initiate a personal injury lawsuit against another person or business because of the injury you sustained, and for which you received treatment by us, the following stipulations and you will: notify us immediately when your lawsuit is filed and provide us with the name and contact information of your attorney. If you prevail in your legal proceeding, by settlement or jury verdict, and receive a money, you consent to have your attorney pay any
outstanding amounts owed to this office prior to releasing funds to you. This paragraph will be enforced in situations where a "subrogation action" occurs, defined as the legal mechanism by which your original insurance company (private health insurer, Medicare, Medicaid, No Fault, other) is deemed not the responsible party and is reimbursed for all costs. When that occurs, it means that we are not bound by any pre-determined fee schedule, as is common with insurers, and the full, unadjusted fee will apply, based on the original charges submitted. In the event that you were offered a "discounted" rate because you were uninsured at the time, even if there is no subrogation action, if you prevail in a personal injury lawsuit, you agree to pay us at the rate of 80% of Fair Health, as can be commonly found on the internet. The balance owed on your account will then be calculated by subtracting what has already been paid from the total non-discounted amount.



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If your insurance company denies a claim because it is considered medically unnecessary, you will be responsible for full payment. If pre-certification is required prior to surgery, we will obtain authorization on your behalf. If you provide inaccurate insurance information and such renders the authorization invalid, resulting in non-payment, you will be the responsibility for the entire balance. Balances remaining after 45 days will be subject to sixteen percent interest (annually). If payment of our fees is not made in what we consider to be a timely manner your account may be sent to collection and may be subjected to additional charges and fees associated with such collection.

CANCELLATIONS: Last minute cancellations are disruptive to the practice and result in unused time. We want patients to take the surgery time and date seriously, to avoid these last-minute cancellations. We reserve the right to impose the following penalties for last minute cancellations: 25% of the full fee if within 72 hours of the procedure, 50% of the full fee if within 48 hours of the procedure, and forfeiture of the entire fee for cancellation within 24 hours of surgery

PRIVACY - NAMES OF PEOPLE WITH WHOM WE CAN SHARE YOUR INFORMAITON

Name ____ Relationship ______________________

Name ____ Relationship ______________________

Name ____ Relationship ______________________

I acknowledge that I have read this ENTIRE registration packet, that I fully understand and accept all the provisions herein, and that I personally signed this page.

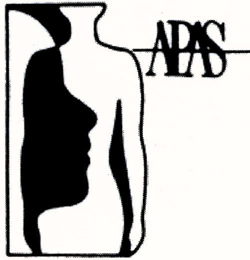
_____________________________________ ___________________________ _____________

Patient Signature (or authorized person) Print Name Date

(Jan 2022)

Jerrold Zeitels MD Richard Tepper MD

955 S. Springfield Ave Suite 105 Springfield, NJ 07081 908.654.6540



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ASSIGNMENT OF BENEFITS & LIMITED POWER OF ATTORNEY

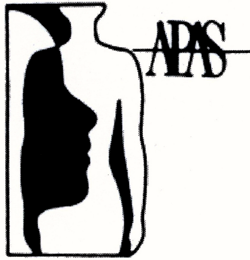
I, the undersigned, irrevocably assign to Dr. Jerrold Zeitels, and / or Dr. Richard Tepper (known as *"my provider")*, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me including, but not limited to, all of my rights and benefits under the **Employee Retirement Income Security Act** ("ERISA") and/or other applicable federal and state laws, applicable to the medical services at issue. This is regardless of the "my provider's" managed care network participation status. I irrevocably authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan/ other responsible party, for any and all rights and benefits under ERISA or applicable federal and / or state statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan documents and other equitable relief. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, "my provider". I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to ERISA. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize "my provider" to release all information necessary to pre-certify a service and / or process my claims under HIPAA, including office records, outside testing or consultation, or digital images obtained during the course of treatment. This information may contain private and/or personally identifiable information.

In the event the insurance carrier responsible for making payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney-in-fact. I further grant limited power of attorney to you as "my provider" to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., if such assists with collection of payment for services. **I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

In the event that I receive direct payment (i.e. "a check") from my insurance company in any amount for services already rendered by "my provider", I agree to forward immediately to "my provider" such checks, made payable to "my provider" (enter the actual physician name). I agree to include the Explanation of Benefits (EOB) in my possession and will further keep a photocopy of the check and EOB for my records. I understand that such an insurance check, even if made payable to me, isn't mine and represents the property of "my provider". I understand that failure to release such check may result in penalties. If you, "my provider", initiate a collection proceeding against me for money I received and failed to turn over to you, I agree to pay any and all of "my provider's" attorneys' fees and court fees in connection with that proceeding.

I acknowledge that I been given ample opportunity to read this and ask questions and am in full agreement with it.
A photocopy of this assignment is to be considered as valid as the original.

______________________________	______________________________	______________
Patient Signature (or authorized person)	**Print Name**	**Date**



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(Jan 2022

COVID-19 INFORMED CONSENT AGREEMENT

I, the undersigned patient, consent to an in-person consultation and/or to have my Doctor and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.

I confirm that neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control (https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf). I have also answered the questions on the next page; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting others and myself at risk.

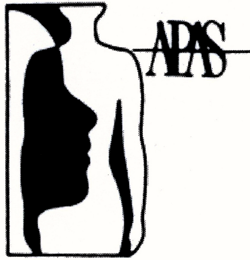
All COVID topics have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure, and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person consultation and/or procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

_______________________________ _______________________

Patient/Authorized Representative Signature Date

____

PRINT Patient/Authorized Representative Name



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(May 2020)

Patient Questionnaire during Covid-19

1. Were you ever diagnosed with, or tested for, Covid-19 YES NO

2. Have you been in contact with anyone who has been sick or tested positive for Covid-19 in the past 14 days YES NO

3. Have you received your Covid Vaccine YES NO

   Vaccine Brand: Pfizer Moderna Johnson & Johnson

   Number of doses: 1 2 3 4

3. Do YOU or SOMEONE YOU LIVE WITH currently have:
   - Fever, cough, sore throat YES NO
   - Shortness of Breath / difficulty breathing YES NO
   - Chills or repeating shaking YES NO
   - Muscle pain or headache YES NO
   - RECENT loss of taste or smell YES NO
   - Have you been exposed to someone with Covid-19? YES NO
   - Any other abnormal symptoms YES NO

______________________ ______________________ ________

Patient/Authorized Rep Signature (print name) Date

Jerrold Zeitels MD Richard Tepper MD

955 S. Springfield Ave Suite 105 Springfield, NJ 07081 908.654.6540