ANTHONY G. ROSSI, MD

Registration – History Date

Patient's Name – Last First M.I Age

Address

City, State Zip - Home Phone

Cell Phone E-Mail

Soc. Sec.# Birth Date Sex

Race Language

Ethnicity- **PLEASE CIRCLE ONE** –(HISPANIC) (NON-HISPANIC) (DECLINED)
Guarantor/Bill to Relationship

Single____ Married____ Divorced____ Widowed____ Separated____

Spouse's Name Parent's Name**(if Minor)**

Person to Contact Emergency Number Cell Phone

Patient Employed By Position

Business Address

City, State Zip Bus. Phone

Spouse/Parent employed by Position

Business Address

City, State Bus. Phone

Primary Insurance ID #

Subscriber D.O.B SS #

Secondary Insurance ID #

Subscriber D.O.B SS #

Medical Doctor Phone #

Address

Whom may we thank for referring you?

ANTHONY ROSSI, MD

Patient's Name:_____

Height:_____ **WEIGHT:**_____

MEDICAL HISTORY

General (weight change, fatigue, fever, loss of appetite)	❑ Yes ❑ No	(Please specify)
Heart disease (heart attack, congestive heart failure, angina, irregular heartbeat/arrhythmia)	❑ Yes ❑ No	(Please specify)
High blood pressure or low blood pressure	❑ Yes ❑ No	(Please specify)
Lung disease, including asthma, emphysema or shortness of breath	❑ Yes ❑ No	(Please specify)
Blood disorder (including problems with bleeding, clotting or easy bruising)	❑ Yes ❑ No	(Please specify)
Diabetes or low blood sugar	❑ Yes ❑ No	(Please specify)
Thyroid disease	❑ Yes ❑ No	(Please specify)
Stroke	❑ Yes ❑ No	(Please specify)
Neurologic disorder (e.g., seizure, frequent headache, dizziness, fainting)	❑ Yes ❑ No	(Please specify)
Psychological/psychiatric disorder	❑ Yes ❑ No	(Please specify)
Gastrointestinal problems (including ulcer, diverticulitis, spastic colon , bleeding from rectum)	❑ Yes ❑ No	(Please specify)
Liver Disease	❑ Yes ❑ No	(Please specify)
Kidney or bladder disease	❑ Yes ❑ No	(Please specify)
Frequent infection (including pneumonia, bronchitis, urinary tract infection)	❑ Yes ❑ No	(Please specify)
Eye problems or diseases (e.g. glaucoma, cataract)	❑ Yes ❑ No	(Please specify)
Arthritis, muscle, bone disorder (including fracture)	❑ Yes ❑ No	(Please specify)

MEDICAL HISTORY CONTINUED

Immune system disorder (including lupus, HIV, AIDS)	❑ Yes ❑ No	(Please specify)
History of cancer	❑ Yes ❑ No	(Please specify)
Skin disorder (including hives, rash, swelling)	❑ Yes ❑ No	(Please specify)
Anesthetic complications (include dental anesthesia)	❑ Yes ❑ No	(Please specify)

Radiation Therapy Treatment_____**Site Treated**_____**Dose**_____

PAST SURGICAL HISTORY

ENT: ❑ Tonsillectomy/Adenoidectomy ❑ Ear Surgery ❑ Nose/Sinus Surgery ❑Tracheotomy

Heart: ❑ Bypass ❑ Stent ❑Valve Surgery ❑ Carotid Artery ❑ Pacemaker ❑ Other

Lung: ❑ Bronchoscopy ❑ Lung Surgery

GI: ❑ Surgery for reflux ❑ Stomach Surgery ❑ Intestinal Surgery ❑ Gall bladder

Orthopedic: ❑ Fracture ❑ Knee Replacement ❑ Hip replacement ❑ Back Surgery

Pelvic: ❑ Prostate ❑ Bladder ❑ D&C ❑ Gyn Surgery ❑ Kidney Surgery

Other: ❑ Breast ❑ Neurosurgery ❑ Dental ❑ Eye

FAMILY HISTORY

Mother Alive Age_____ Deceased Age_____
Father Alive Age_____ Deceased Age_____

SOCIAL HISTORY

Tobacco: No_____Yes_____ packs p/d_____ Former Smoker_____yr quit_____
Alcohol No_____Yes_____ Quantity_____

Are you pregnant?_____ Due Date_____Birth Control_____

ALLERGIES NONE PENICILLIN LOCAL ANESTHETIC MEDICATION SEASONAL

PLEASE LIST_____

My medical history can be discussed with_____Relationship_____

Signature_____Date_____

ANTHONY G. ROSSI, MD

Patients Name: _____

MEDICATIONS

MEDICATION/HERBAL	DOSAGE	FREQUENCY	USED FOR

Pharmacy Name_____

Street_____City,State_____

Phone Number_____

ANTHONY G. ROSSI, M.D.

CANFIELD OFFICE PARK
912 POMPTON AVENUE, SUITE A1
CEDAR GROVE, NEW JERSEY 07009
TELEPHONE (973) 239-5090
FAX (973) 239-3579

PATIENT LIABILITY/FINANCIAL POLICY

YOUR RESPONSIBLITY: This office participates with several insurance companies. It is *YOUR* responsibility to call your insurance company and verify that the doctor you are seeing is participating.

If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you; however, we will expect payment from you. If you do not have valid insurance information, or we cannot confirm coverage, we will consider you "self pay" and ask for full payment.

All co-payments or payments for non-covered services are the patient's responsibility and will be collected by our staff at the time of service.

IT IS IMPORTANT TO UNDERSTAND THAT HEALTH INSURANCE COVERAGE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY

REFERRALS: If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

MISSED APPOINTMENT FEE: Patients who do not show up on time for an appointment, or fail to reschedule or cancel with less than 24 hours notice will be charged a $25.00 fee. This charge will not be reimbursed by your insurance company.

PAYMENT FOR SERVICES PERFORMED:

1. Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement; we cannot bill you for these.
2. Our office accepts Visa, Mastercard, Discover, American Express, as well as Cash, Personal Check and Debit Cards for payment of services.
3. ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE. Should your account require the action of our collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.
4. THIS OFFICE CHARGES A FEE FOR A RETURNED CHECK

The reimbursement procedures of your insurance company are your responsibility. Regardless of your insurance company's particular policies and payment criteria, you are held directly responsible for settling your account with Dr. Anthony G. Rossi within a reasonable period of time. Interest charges of 1% per month on accounts over 120 days will be charged.

AUTHORIZATION FOR ACCESS OF ELECTRONIC PRESCRIPTION RECORDS:

I authorize Dr. Anthony G. Rossi to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions if applicable. I understand that my prescription history will become part of my medical record in this office.

CONSENT TO TREAT:

I, the undersigned, voluntarily consent to and authorize Dr. Anthony G. Rossi, MD, and/or outside agents to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgement of my physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

I have read this form,(my responsibility, referrals, missed appointments, payments, prescription records and consent to treat), my questions have been answered, and I understand and agree to its content.

_____ _____

Patient/Representative's Signature Date

_____ _____

Print Name/Authorized Representative Relationship

ANTHONY G. ROSSI, M.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 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 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 health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
You may request a copy of our 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 HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

ANTHONY G. ROSSI, M.D.

Canfield Office Park, 912 A1 Pompton Avenue, Cedar Grove, NJ 07009
Telephone: 973-239-5090 • Fax: 973-239-3579

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, _____ have received a copy of this office's *Notice of Privacy Practices.*

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt our *Privacy Practices*, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

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