

PATIENT REGISTRATION

DATE _____		FAMILY/REFERRING DR. _____	
PATIENT NAME _____		BIRTH DATE ____/____/____	
ADDRESS _____	CITY _____	STATE _____	ZIP _____
EMAIL _____	DRIVERS LICENSE _____		
PATIENT S.S. # _____	PHONE _____	AGE _____	
SEX M <input type="checkbox"/> F <input type="checkbox"/>	MARITAL STATUS S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>	Cell Phone _____	
PATIENT EMPLOYER & ADDRESS _____			
EMPLOYER PHONE _____			
REASON FOR VISIT _____		IS VISIT DUE TO AN INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	
REFERRED BY WHOM _____			

SPOUSE OR NEAREST RELATIVE _____	PHONE _____
ADDRESS _____	RELATIONSHIP _____

RESPONSIBLE PERSON NAME _____	S.S. # _____	
ADDRESS _____		
PHONE (H) _____	(W) _____	RELATIONSHIP _____
EMPLOYER & ADDRESS _____		

INSURANCE INFORMATION

PRIMARY CARRIER _____	Card Holder Name _____	
ADDRESS _____	Card Holder Date of Birth _____	
ID # _____	GROUP # _____	PLAN _____
SECONDARY CARRIER _____	Card Holder Name _____	
ADDRESS _____	Card Holder Date of Birth _____	
ID # _____	GROUP # _____	PLAN _____

I HEREBY AUTHORIZE ESSEX SURGICAL, LLC, AND /OR THE ANESTHESIOLOGIST TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE. I ALSO AUTHORIZE AND DIRECT PAYMENT FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE PREVIOUSLY NAMED PARTIES TO BE MADE TO HIM/THEM REGARDLESS OF MY INSURANCE BENEFITS. PHOTOCOPIES OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED. OUTSIDE LABORATORY FEES ARE THE PATIENTS RESPONSIBILITY.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. THIS MAY INCLUDE FAXING INFORMATION FOR HEALTHCARE PURPOSES AND BILLING, AS WELL AS LEAVING MESSAGES FOR APPOINTMENTS AND HEALTH CARE (PRE/POST OPERATIVE CALLS ARE INCLUDED).

NAME _____ DATE _____
PATIENT SIGNATURE/RESPONSIBLE PERSON

ALLERGIES, ILLNESSES AND MEDICAL PROBLEMS

YOUR NAME _____ DATE _____

	YES	NO	EFFECT		YES	NO	EFFECT
PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>	_____	TAPE	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER MEDICATION	<input type="checkbox"/>	<input type="checkbox"/>	_____	HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____
IODINE	<input type="checkbox"/>	<input type="checkbox"/>	_____	SHELL FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____
CONTACT ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	_____	SHELL FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____

EXPLAIN ALLERGIC EFFECTS: _____
 DATE OF LAST TETANUS SHOT: _____

ILLNESS & MEDICAL PROBLEMS:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	PNEUMONIA
<input type="checkbox"/>	<input type="checkbox"/>	OTHER HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ANESTHESIA PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER
<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	COLITIS
<input type="checkbox"/>	<input type="checkbox"/>	OTHER EYE TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	DIVERTICULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	EAR TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS
<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	MONONUCLEOSIS
<input type="checkbox"/>	<input type="checkbox"/>	DEAF OR HEARING IMP.	<input type="checkbox"/>	<input type="checkbox"/>	GALL BLADDER TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	NOSE BLEEDS	<input type="checkbox"/>	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	<input type="checkbox"/>	NOSE OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	SLEEP APNEA/DISORDERS
<input type="checkbox"/>	<input type="checkbox"/>	SWELLING IN NECK	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSIONS/SEIZURES
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HEALING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY / BLADDER PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HERNIAS	<input type="checkbox"/>	<input type="checkbox"/>	VARICOSE VEINS
<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BLEED EASILY
<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	EYE PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	BRUISE EASILY	<input type="checkbox"/>	<input type="checkbox"/>	PARALYSIS
<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	CANCER:
<input type="checkbox"/>	<input type="checkbox"/>	ANKLE SWELL	YEAR / TYPE _____		
<input type="checkbox"/>	<input type="checkbox"/>	MENTAL / NEUROLOGICAL CONDITION:	<input type="checkbox"/>	<input type="checkbox"/>	LUNG PROBLEMS:
		_____			_____
<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU HAD A MOLE SCREENING?			
		DATE: _____			
<input type="checkbox"/>	<input type="checkbox"/>	DO YOU HAVE ANY MOLES / BEAUTY MARKS WHICH ARE IREGULAR, MULTI-COLORED, OR HAVE CHANGED?			

WOMEN ONLY

<input type="checkbox"/>	<input type="checkbox"/>	TENDER BREASTS	<input type="checkbox"/>	<input type="checkbox"/>	LUMPS OR OR RECENT SIZE/COLOR CHANGE
<input type="checkbox"/>	<input type="checkbox"/>	FIBROCYSTIC DISEASE	PREVIOUS MAMMOGRAM YEAR: _____		
<input type="checkbox"/>	<input type="checkbox"/>	MENSTRUAL PROBLEM	LAST MENSTRUAL PERIOD: _____		
<input type="checkbox"/>	<input type="checkbox"/>	WERE YOUR CHILDREN BREAST FED	NUMBER OF CHILDREN: _____		
<input type="checkbox"/>	<input type="checkbox"/>	DO YOU PLAN TO HAVE CHILDREN?			

HAVE ANY OF THE ABOVE CONDITIONS APPEARED IN YOUR IMMEDIATE FAMILY? IF SO, SPECIFY:

MEDICAL HISTORY

YOUR NAME _____ **WEIGHT** _____ **HEIGHT** _____

SURGERY (OPERATIONS):

- 1. _____
- 2. _____
- 3. _____
- 4. _____

ADMISSIONS TO HOSPITALS:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

MEDICATIONS (ANY DRUG OR MEDICATION) YOU TAKE NOW:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

CONSUMPTION OF THE FOLLOWING:

Aspirin _____	Amount Daily _____	Amount Weekly _____
Alcohol _____	Amount Daily _____	Amount Weekly _____
Tobacco _____	Amount Daily _____	Amount Weekly _____

**BLEEDING PROBLEMS: (WITH CUTS? TOOTH EXTRACTIONS? PREGNANCY? SURGERY?)
EXPLAIN:**

**DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA:
EXPLAIN:**

**FAMILY HISTORY OR CONDITIONS UNDER TREATMENT BY A PHYSICIAN:
EXPLAIN:**

FAMILY HISTORY: ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

Mother _____	Father _____
Sister _____	Brother _____
_____	_____

Essex Surgical, LLC
776 Northfield Avenue West orange New Jersey 07052
Tel: (973) 324-2300 Fax: (973) 324-1421

Physician /Facility Notice

Please be advised that the following notice will apply to all future office visits and/or procedures performed by George C. Peck, Jr., MD, Richard E. Peck, MD, Robert Marini, MD, Frank Femino, MD, Stephen Ducey, MD, Seth Queler, MD, Mark Drzala, MD, Mitchell Reiter, MD, Kevin McCracken, MD, Prashant Patel, MD, Adam Lipson, MD, Shailendra Hajela, MD, Michael Kelly, DO, and Heidi Hullinger, MD, for services performed at Essex Surgical, LLC.

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (e) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under Medicare program standards, Medicare will deny payment for service. We believe, that in your case, Medicare will likely deny payment for **Cosmetic Surgery and /or Surgical Procedures not covered in an Ambulatory Care Facility** for the following reasons: Your procedure may not be authorized by Medicare as it may not be a covered procedure in an ambulatory care facility and/or may be deemed cosmetic in nature.

Beneficiary Agreement

I have been notified by my physician that, in my case, Medicare is likely to deny that he or she believes that, in my case, Medicare is likely to deny payment for the service(s) identified above, for the reason(s) stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed _____ Date _____

ESSEX SURGICAL, LLC
ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

Patient Name _____ Claim # _____

I hereby authorize **Essex Surgical, LLC** to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependants, to the facility/ physicians. I understand that I am responsible for any amount not covered by my insurance.

I am assigning all my rights unconditionally to **Essex Surgical, LLC** to pursue any medical bills, relating to treatment or care by this office in addition to the above.

Patient/Guardian Name (Print) Patient/Guardian Name (Signature) Date

Patient Address

Provider: Essex Surgical, LLC
776 Northfield Avenue
West Orange, New Jersey 07052

No FAULT AND/OR WORKERS COMPENSATION PATIENTS

I, _____, (Assignor) hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney:_____. I further authorize **Essex Surgical, LLC** to pursue payment of my bills.

I understand that all medical bills will be submitted to the responsible insurance carrier and will *only* be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, for which I am responsible.

I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependants and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I further understand that your attorney, if needed, will arbitrate my bills for payment.

ATTORNEY INFORMATION

Attorney Name: _____ **Attorney Phone#:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

I, _____, (Assignor) hereby assign to **Essex Surgical, LLC**, (Assignee) all rights and privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on _____, notwithstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits, or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a Law Enforcement Agency, The Department of Motor Vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a Civil Penalty not to exceed five thousand dollars and the value of the subject Motor Vehicle stated claim for each Violation.

Patient/Guardian (Print) Patient/Guardian (Signature) Date

Patient Address

Provider: Essex Surgical, LLC
776 Northfield Avenue
West Orange, New Jersey 07052

AMERICAN ANESTHESIOLOGY OF NEW JERSEY, PC
ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

Patient Name _____ Claim # _____

I hereby authorize **American Anesthesiology of New Jersey, PC** (AANJ) to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependants, to the facility/ physicians. I understand that I am responsible for any amount not covered by my insurance.

I am assigning all my rights unconditionally to **American Anesthesiology of New Jersey, PC** to pursue any medical bills, relating to treatment or care by this office in addition to the above.

Patient/Guardian Name (Print) Patient/Guardian Name (Signature) Date

Patient Address

Provider: American Anesthesiology of New Jersey, PC
25B Vreeland Road Suite 110
Florham Park, New Jersey 07932

No FAULT AND/OR WORKERS COMPENSATION PATIENTS

I, _____, (Assignor) hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney: _____. I further authorize **American Anesthesiology of New Jersey, PC** to pursue payment of my bills.

I understand that all medical bills will be submitted to the responsible insurance carrier and will *only* be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, for which I am responsible.

I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependants and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I further understand that your attorney, if needed, will arbitrate my bills for payment.

ATTORNEY INFORMATION

Attorney Name: _____ **Attorney Phone#:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

I, _____, (Assignor) hereby assign to **American Anesthesiology of New Jersey, PC**, (Assignee) all rights and privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on _____, notwithstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits, or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a Law Enforcement Agency, The Department of Motor Vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a Civil Penalty not to exceed five thousand dollars and the value of the subject Motor Vehicle stated claim for each Violation.

Patient/Guardian (Print) Patient/Guardian (Signature) Date

Patient Address

Provider: American Anesthesiology of New Jersey, PC
25B Vreeland Road Suite 110
Florham Park, New Jersey 07932



**New Jersey Department of Banking and Insurance
 CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT
 DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM
 APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS**

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

**CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM
 APPEALS AND ARBITRATION OF CLAIMS**

I, , by marking (or) and signing below, agree to:

representation by Essex Surgical, LLC in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____
Relationship to Patient: I am the Patient I am the Personal Representative (provide contact information on back)

 **New Jersey Department of Banking and Insurance**
NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF
UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE
OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

I hereby revoke my consent to representation by Essex Surgical, LLC and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID# _____ Date: _____
Relationship to Patient: I am the Patient I am the Personal Representative

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

**ESSEX SURGICAL, LLC
776 NORTHFIELD AVENUE
WEST ORANGE NEW JERSEY 07052**

I have received the following documents prior to my scheduled procedure date.

- Advanced Medical Directive Policy
- Notice of Ownership/Financial Policy
- Patient Rights
- Notice of Privacy Practice

By signing this form, I agree to review the documents that I have received prior to my surgery date. By proceeding with my scheduled procedure, I understand and agree with the policies stated on the forms that I have reviewed.

Print Patient Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of 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) _____.

Acknowledgment of Advance Directive Policy

All patients have the right to participate and make decisions regarding their own healthcare treatment and to make an advanced directive or execute powers of attorney that authorize others to make decision on their behalf based on the patient’s expressed wishes when the patient is unable to make or communicate their own decisions. Essex Surgical, LLC respects and upholds these rights.

However, unlike acute long-term hospital settings, the surgery center does not routinely perform ‘high risk’ procedures. While every surgical procedure carries a risk, the procedures performed at Essex Surgical, LLC are minimal risk. Your doctor will discuss the specific risks of your procedure and give you to opportunity to ask any questions.

It is the policy of Essex Surgical, LLC regardless of the contents of any Advanced Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measure and transfer you to an acute care hospital for further evaluation. The acute care hospital to continue with further treatment or withdrawal of treatment measures already begun according to your wishes, advance directive, or health care power of attorney. Your agreement with this policy, by your signature below, does not revoke or invalidate any current health care directive or health care power of attorney.

If you do not agree with this policy, we are pleased to assist you in rescheduling the procedure.

Please complete the following questions and sign.		Please Circle.	
Have you executed an advance directive, living will or health care power of attorney that authorizes someone to make health care decisions for you?	Yes	No	
If you answered ‘yes’ above, have you provided us a copy for your medical record?	Yes	No	
By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like additional information, I acknowledge receipt of that information.			
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Patient’s Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Patient’s Representative Signature		
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date Relationship to Patient: <input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> Health Care Surrogate <input type="checkbox"/> Attorney in Fact <input type="checkbox"/> Other:		