Please provide the following information:

Full Name:______________________________Social Security Number:________________

Date of Birth:________________________Marital Status:____________________________

Address: _______________________________City, State, Zip Code: _________________

Phone Number where you can be reached: ____

Race:______________________________ Ethnicity:_________________________________

Preferred First Language: ____

Birthplace: ____

Pharmacy: Name/Phone/ Address:____

Insurance Subscriber Name: ____________________________ Date of Birth:___________

Email Address: ____

Medications with dosage:____

____

____

Allergies:____

____

Surgery/Year:____

____

Emergency Contact:____

Reason for Today's Visit:____

____

Do you or have you ever smoked? Yes No If yes, how much?________ Drink? Yes No

General Health (Please circle all that apply)

Arthritis	Gout	Stroke	Ulcers
Diabetes(Type 1 or 2)	Asthma	High Blood Pressure	Lung
Diverticulitis	Kidney	Heart Attack	Hernia
Epilepsy	Cataracts	Emphysema	Dialysis
Tuberculosis	Glaucoma	Cancer (Type: ____________________)	

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Patient Name:	Date:
What is the reason for your visit today?	

In an ongoing effort to better serve you, our patient, we ask that you review the following list and check all items you have questions about or are interested in having done: Thank You!

○ Dermal Fillers	○ Facial redness	○ Hair loss
○ Facial fine lines/wrinkles	○ Brown spots/age spots/freckle	○ Size of abdominal area
○ Thin lips	○ Drooping eyelids	○ Size of Hips
○ Double chin	○ Nose size or shape	○ Skin care
○ Dropping brow	○ Facial fullness/drooping	○ Unwanted Hair
○ Neck wrinkles	○ Mole removal	○ Length/Fullness of Eyelashes
	○ Scar revision	○ Microdermabrasion
	○ Chemical peel	○ Blotchy skin

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerne3d, or very concerned about the appearance of my wrinkles/lines.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

- ○ Doctor
- ○ Newspaper
- ○ Friend or family member
- ○ Facebook
- ○ Billboard
- ○ Magazine
- ○ Instagram
- ○ Website

○ Approval to contact you.	Best phone number to reach you:
○ Approval to send you information on products and services (including special offers)	Email address:

○ I'm not interested in any additional services provided at this time.

Photographic and Video Consent

I, ____________________ do hereby give to Wayne P. Foster MD, FACS, his or her assigns, licensees, successors in interest, legal representatives, and heirs the irrevocable right to use my name (or any fictional name), picture, portrait, photograph or video in all forms and in all media and in all manners, without any restriction as to changes or alterations (including but not limited to composite or distorted representations or derivative works made in any medium) for advertising, trade, promotion, exhibition, or any other lawful purposes, and I waive any right to inspect or approve the photograph(s) or finished version(s) incorporating the photograph(s), including written copy that may be created and appear in connection therewith.

I hereby release and agree to hold harmless Wayne P. Foster MD, FACS, his or her assigns, licensees, successors in interest, legal representatives and heirs from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form whether intentional or otherwise, that may occur or be produced in the taking of the photographs, or in any processing tending toward the completion of the finished product, unless it can be shown that they and the publication thereof were maliciously caused, produced, and published solely for the purpose of subjecting me to conspicuous ridicule, scandal, reproach, scorn, and indignity. I agree that Wayne P. Foster MD FACS; owns the copyright of these photographs or videos and I hereby waive any claims I may have based on any usage of the photographs or works derived therefrom, including but not limited to claims for either invasion of privacy or libel. I agree to receive no compensation for these photographs or videos. I am of full age and competent to sign this release. I agree that this release shall be binding on me, my legal representatives, heirs, and assigns.

I have read this release and am fully familiar with its contents.

Patient Name:

Signature: ____

Address: ____

Date: __________

Ear Nose & Throat of NJ, PA / fostermd / The Surgicenter, LLC
500 Lakehurst Rd
Toms River, NJ 08755
(732) 914-2233

Telephone Consumer Protection Act (TCPA)

Patient Name: ___________________
Date of Birth: _____________Medical Record No: _________

I authorize, in order for us to service your account or to collect monies you may owe, Ear Nose & Throat of NJ, PA / fostermd / The Surgicenter, LLC, and/or our agents may contact you by telephone at any telephone number associated with your account. This may include wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

I have read this disclosure and agree that Ear Nose & Throat of NJ, PA / fostermd / The Surgicenter, LLC, its employees and/or agents may contact me as described above.

____ _________________

Responsible Party Signature Date

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Authorization for Use of Protected Health Information

Patient Name: ______________________________

Date of Birth: ____________________ Medical Record No.: ____________________

I authorize Ear Nose & Throat of NJ/Foster Facial Plastic Surgery to disclose my health information to (please check one):

2. ☐ Individual or entity authorized to receive my health information: ____________________

   ☐ Release to No One except as defined by law.

3. Purpose for which disclosure is to be made: ____________________

4. Information to be disclosed:

   - ☐ All Medical Records in my File
   - ☐ Radiation Oncology Progress Records and Treatment
   - ☐ History and Physical Exam
   - ☐ Radiology Reports
   - ☐ EKG
   - ☐ Billing Statements/Records
   - ☐ Clinical Office Chart Notes

   I understand that this will include health information relating to (check if applicable):

   - ☐ HIV (human Immunodeficiency Virus) infection
   - ☐ Mental Health
   - ☐ Treatment for Alcohol and/or Drug Abuse
   - ☐ Genetic Testing

5. I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, that the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Ear Nose & Throat of NJ/Foster Facial Plastic Surgery, its employees, and physicians from all liability arising from this disclosure of my health information.

6. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying (in writing) the Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

______________________________ ____________________
Signature of Patient or Legal Representative Date

______________________________ ____________________
Name of Personal Representative (if applicable) Relationship to Patient

Representative Identificiation: ______________________________
(A copy of the signed form will be provided to the patient upon request)

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Facial Plastic Surgeon

Notice of Privacy Practices

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 AND SIGN BELOW.

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization

- Treatment: We will disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to your referring physician or other physicians involved in your care and treatment to ensure that the physician has the necessary information to diagnose or treat you.
- Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for testing from your insurance company may require that your relevant protected health information be disclosed to the health plan to obtain the approval for diagnostic testing or therapeutic radiation oncology.
- Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment reviews, employee review activities, training of clinical and clerical staff, licensing and accreditation boards, conducting or arranging for other business activities. In addition, we may use sign-in sheets at the registration desk where you will be asked to sign your name. We may call you by name in the waiting room when the physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
- When release is required by law, including in judicial settings, health oversight regulatory agencies, public health issues as required by law, Communicable Diseases, Abuse, Neglect, FDA, medical examiners, funeral directors, organ and tissue donation organizations, legal proceedings, criminal activity, military activity, national security, Worker's Compensation, No-Fault. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of the federal privacy regulation, and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To your health plan
- Unless required by law, other uses and disclosures will be made only with your written authorization, which you may revoke at any time, in writing, except to the extent that we have acted in reliance on your permission.

Your rights: You have the following rights concerning your PHI:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: To register a complaint with us, contact our Privacy/Compliance Officer at telephone 732-914-1461. You may complain to us or the U.S. Department of Health and Human Services if you feel your privacy rights have been violated. The contact information is Office of Civil rights, U.S. Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza Suite 3312, New York, New York 10278 or call (212) 264-3313, Fax (212) 264-3039, TDD (212) 264-2355. You will not be retaliated against for filing a complaint.

Our duties: We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices. We must abide by the terms of this notice or any update of this notice.

Privacy contact: for more information about our privacy practices, please contact: Debra Teeple, Compliance Officer, at 732-914-2233.

Effective date: This notice was published and becomes effective on/or before **April 14, 2003.**

I hereby acknowledge that I have received a copy of Ear Nose & Throat of NJ, PA/Foster Facial Plastic Surgery, LLC Notice of Privacy Practices which discloses in detail my rights and Ear Nose & Throat of NJ, PA/Foster Facial Plastic Surgery, LLC legal duties with respect to uses and disclosures of my protected health information.

Sign:____________________________________ Date:____________

Print name of patient:____________________________________

If you are signing as the patient's representative:

Print your name:____________________________________

Describe your authority:____________________________________