CARTER G. ABEL, M.D.
Concourse at Beaver Brook
1465 Route 31 South
Annandale, NJ 08801
(908) 735-5100

_____

Dear _____,

Welcome to our practice! We look forward to seeing you on _____ at _____.

Enclosed you will find a *Patient Registration & Health Questionnaire, HIPAA Notice of Privacy Practices* and *directions to our office*. Please take a few minutes to fill out the information requested and **return it to us before your first visit**.

When you come to our office for an initial visit, please dress simply so that you can easily change. Also, please do not wear any earrings, cosmetics, perfume, cologne or aftershave.

If a biopsy or an excision of a lesion is necessary, please be advised that the fee for the dermatopathologist who reads the specimen will be a separate fee from our office's charge.

Also, please be sure to bring your current insurance card(s) and payments are accepted by cash, check and Visa/MasterCard.

If you have any questions or concerns please do not hesitate to contact our office.

Carter G. Abel, M.D. & Staff

P.S. Due to the high demand for *New Patient Exam* appointments, please notify our office at least **24 hours** in advance if you can not keep your appointment. Thank you.

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

DATE

NAME

MARITAL STATUS
S | M | W | D | SEP

DATE OF BIRTH

STREET ADDRESS

CITY STATE ZIP

PHONE (HOME) PHONE (WORK)

PHONE (CELL) E-MAIL ADDRESS

SPOUSE'S NAME EMPLOYER

IF UNDER 18, PARENT/GUARDIAN

EMERGENCY CONTACT (OTHER THAN SPOUSE) PHONE

PATIENT S.S. # REFERRED BY

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) PRIMARY INSURANCE COMPANY

SUBSCRIBER'S NAME I.D. # GROUP

SUBSCRIBER'S DATE OF BIRTH SUBSCRIBER'S SS#

2) SECONDARY INSURANCE COMPANY

SUBSCRIBER'S NAME I.D. # GROUP

SUBSCRIBER'S DATE OF BIRTH

CONSENT FOR BIOPSY, SURGERY OR PHOTOGRAPHY

I HEREBY AUTHORIZE THE PERFORMANCE OF SUCH SURGERY, PHOTOGRAPHY OR OTHER PROCEDURES AS MAY BE DEEMED ADVISABLE OR NECESSARY BY CARTER G. ABEL, M.D. UPON ME OR MY MINOR CHILD. I AM AWARE THAT ANY PROCEDURE CARRIES THE RISKS OF BLEEDING, INFECTION, SCARRING, PIGMENTATION PROBLEMS AND NERVE DAMAGE (IE. NUMBNESS OR PAIN) WHICH MAY VARY ACCORDING TO OPERATIVE PLAN.

Pt. Signature: _____ Witness: _____ Date: _____

*PLEASE DO NOT WEAR MAKE UP OR PERFUMES WHEN VISITING DOCTOR FOR SKIN EXAMS.

To be completed by patient - please print **HEALTH QUESTIONAIRE**

REASON FOR VISIT

FAMILY HISTORY

	ALIVE & WELL	DECEASED	FOLLOW THE LINES ACROSS THE PAGE AND MARK THE APPROPRIATE BOX CAUSE OF DEATH (AGE)	HIGH BLOOD PRESSURE	HEART DISEASE	EPILEPSY	DIABETES	CANCER	ASTHMA	KIDNEY DISEASE	GLAUCOMA	STROKE	HAYFEVER	ARTHRITIS	MENTAL ILLNESS	MIGRAINE	BLEEDS EASILY	ANEMIA	ALCHOHOLISM	PSORIASIS	ECZEMA
FATHER																					
MOTHER																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
MOTHER'S RELATIVES																					
FATHER'S RELATIVES																					

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

	NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN
LIST ALL MEDICATIONS YOU ARE NOW TAKING INCLUDING OVER THE COUNTER Rx						

DRUG ALLERGIES:

MEDICAL HISTORY

Mark (c) for current problems. Check (✓) box and indicate age when you had any of the following symptoms or diseases.

- ❑ HEARING PROBLEMS
- ❑ GLAUCOMA
- ❑ SINUS TROUBLE
- ❑ HAY FEVER
- ❑ HYPERTENSION
- ❑ MITRAL VALVE PROLAPSE
- ❑ IRREGULAR PULSE
- ❑ PHLEBITIS
- ❑ HEARTBURN
- ❑ COLITIS
- ❑ HEPATITIS A B C
- ❑ PROSTATE PROBLEMS
- ❑ HERPES
- ❑ CATARACTS
- ❑ NOSE BLEEDS
- ❑ HOARSENESS
- ❑ ASTHMA
- ❑ CORONARY HEART DISEASE
- ❑ BRUISE EASILY
- ❑ PALPITATIONS
- ❑ VARICOSE VEINS
- ❑ DIFFICULTY SWALLOWING
- ❑ PEPTIC ULCER DISEASE
- ❑ JAUNDICE
- ❑ KIDNEY STONES
- ❑ VENEREAL DISEASE
- ❑ GOUT
- ❑ CHLAMYDIA
- ❑ GONORRHEA
- ❑ RECENT WEIGHT LOSS
- ❑ ANEMIA
- ❑ CANCER
- ❑ DIABETES
- ❑ THYROID DISEASE
- ❑ SEIZURES
- ❑ STROKE
- ❑ MIGRAINE HEADACHES
- ❑ MENTAL ILLNESS
- ❑ TUBERCULOSIS
- ❑ ALLERGIES (NON DRUG)
- ❑ ALCOHOL - OZ./WEEK _____
- ❑ SMOKING - CIG/DAY _____
- # YEARS _____
- ❑ COFFEE/TEA - CUPS/DAY _____
- ❑ ARTHRITIS
- ❑ DEPRESSION

FEMALES

- REGULAR MENSTRUAL PERIODS ❑Y ❑N
- # OF PREGNANCIES _____
- # OF LIVE BIRTHS _____
- # OF MISCARRIAGES _____
- BIRTH CONTROL METHOD _____
- B.C. PILL (BRAND) _____
- MENOPAUSAL SYMPTOMS ❑Y ❑N

SKIN PROBLEMS

- ❑ ECZEMA ❑ PSORIASIS ❑ RASH
- ❑ HIVES ❑ ABNORMAL MOLES
- ❑ FREQUENT SUN EXPOSURE
- ❑ EXCESSIVE SCARRING
- ❑ SKIN CANCER
- ❑ RECENT OR PROGRESSIVE HAIR LOSS

HIPAA NOTICE OF PRIVACY PRACTICES

Patient's Name: _____

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.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred 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 health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sing-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your 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.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to your and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. YOUR RIGHTS
Following is a statement of your rights with respect to your protected health information.

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 of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes 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 may 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
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

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

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____ _____

Patient's Signature Date

CARTER G. ABEL, M.D.
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MEDICARE/MEDICAID PATIENT AUTHORIZATION FORM

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Carter G. Abel, M.D. for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services." Please be advised that this office is not a participating provider of Medicare/Medicaid and any unpaid balances will be the patient's responsibility.

_____ _____

Patient's Signature Date