



442 Bethel Road
Somers Point, N.J. 08244

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1966 ("HIPAA"), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, pen and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organizations the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payments or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name

Relationship to patient, if not patient

Signature



Jersey Shore Surgical Group, P.C.
442 Bethel Road
Somers Point, N.J. 08244
(609) 927-3030

Patient Insurance Confirmation and Authorization Form

I authorize Dr. Gosin and his office staff to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.

I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.

I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.

I authorize Dr. Gosin and his staff to act as my agent(s) in helping me obtain payment from my Insurance Companies.

I authorize payment of health benefits otherwise payable to me, directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

I confirm that my Health Insurance is correctly documented below.

-Primary Insurance Name and Policy #: _____

-Secondary Insurance Name and Policy #: _____

-Other Insurance: _____

Signature of Beneficiary, Guardian or Personal Representative

Date

Printed name

Relationship to Beneficiary

SHORE VASCULAR & VEIN CENTER

"University Quality Care at the Jersey Shore"



Living Will Documentation

Dear Patient,

The recent enactment of laws has placed a new focus on the value of "Living Wills." The New Jersey Legislature requires our office to ask the following:

Do you have a living will? YES NO

If you have a Living Will or if you do not have a Living Will please answer the following question:

Who is your Health Care Proxy?

A health care proxy is someone, a relative, a friend, or a spouse, who would be able to speak for you if for any reason you would not be able to speak for yourself regarding your health care decision making

Name: _____ Relation: _____

Address: _____

Telephone: _____

If you do have a living will, at your convenience please provide a copy for our medical records. At the present time, who, other than yourself, has a copy of your Living Will?

Name: _____ Relation: _____

Address: _____

Telephone: _____

Printed Name

Signature

Date

Witness

SHORE VASCULAR & VEIN CENTER

"University Quality Care at the Jersey Shore"



New Patient Welcome Letter

All of us here at Shore Vascular & Vein Center would like to welcome you to our practice. We know that you have a choice of physicians and we appreciate the trust and confidence that you put in Dr. Gosin and our entire team. We will all work hard to provide you with high quality, personalized and compassionate care. If there is anything that we can do to assist you or make your time with us easier, please do not hesitate to discuss it with any one of us. We are all here to help.

We ask that you please take a few minutes to complete the attached paperwork as completely as possible prior to your first visit to our office. This information will help us care for you in the best way possible. Completing it in advance will help to decrease the amount of extra time needed in the office. If you require assistance with these forms please call our office and we will help you in any way possible.

Again, thank you for entrusting us with your healthcare.

Printed Name _____

Patient Information Form-Continued

Current Medications (List medication name, dose and frequency taken. Include over-the-counter. May attach a separate list.)

Medication Name	Dose	Times taken

Medication Allergies _____

Family Medical History

Indicate if an immediate family member has had any of the following illnesses or conditions:

	Cancer	Diabetes	Heart Disease	Lung Disease	Stroke	High BP	Bleeding Disorder	Peripheral Artery Disease	Varicose Veins	Aneurysm	Blood Clots
Mother											
Father											
Brother											
Sister											

Other Family History Not Listed Above (Please describe below)

Signature _____

Date _____

Jersey Shore Surgical Group, P.C.
Shore Vascular & Vein Center

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Jersey Shore Surgical Group, P.C. / Shore Vascular & Vein Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO.) (Jersey Shore Surgical Group, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Jersey Shore Surgical Group, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to Jersey Shore Surgical Group, P.C. Privacy Officer at 442 Bethel Road, Somers Point, N.J. 08244.

With this consent Jersey Shore Surgical Group, P.C. may call my home or alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO. This includes appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Jersey Shore Surgical Group, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

I have the right to request that Jersey Shore Surgical Group, P.C. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form I am consenting to Jersey Shore Surgical Group, P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Jersey Shore Surgical Group may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Printed Name of Legal Guardian



Varicose Vein Patient History Form

Name _____ Date _____

Which leg is affected? Right Left Both

Is one leg worse than the other? Yes/No If yes, which one? Right/Left

Do you notice varicose or spider veins on your legs? Yes/No

Circle all symptoms that you experience:

Leg Pain Leg Burning Itching Numbness Leg Heaviness Leg Fatigue

Leg Swelling Leg Restlessness Night Cramps Skin Changes Leg Ulcers

Other _____

What worsens your symptoms? _____

What relieves your symptoms? _____

How long have you had the veins and/or the symptoms? _____

Have you had previous vein treatment? Yes/No

If yes, explain: _____

Have you worn compression or support stockings? Yes/No

What is your occupation? _____

Are your symptoms affected by your job, or do they affect your ability to do your job? Yes/No

Have you ever had a blood clot or phlebitis? Yes/No

Is there a family history of vein disease? Yes/No

If yes, explain: _____

Have you every been diagnosed with a bleeding or clotting disorder? Yes/No

Is there a family history of blood clots? Yes/No

If yes, explain: _____

Other information you would like to add: _____