□ Mohs Closure

□ Excision

Affiliated Ambulatory Surgery, P.C.

182 South Street, ***Suite 1B*** Morristown, NJ 07960
(973) 267-0300 (ext. 115, ext. 136, or ext. 116) rev.10/16/2017

You have been scheduled to have a procedure in our ambulatory surgery facility. Our team of surgeons includes: Dr. Kristyna Lee, Dr. Arlene Rogachefsky, Dr. Alexander Dane, Dr. Adriana Lombardi and Dr. Beirne. You may be seeing one or more surgeons at your surgical appointment.

PRE-OPERATIVE INSTRUCTIONS:

1. Please be sure to arrive AT LEAST 15 minutes prior to your appointment time.
2. Your procedure will be performed using a local anesthetic.
3. No aspirin or aspirin derivatives should be taken **10** days prior to your surgical procedure. This includes *ADVIL, ALEVE, EXCEDRIN, NAPROXEN, IBUPROFEN*, and *MOTRIN*. Please consult with your physician before stopping these medications if they were prescribed for you.
4. You may take TYLENOL or ACETAMINOPHEN. Vitamin E, Fish Oil, alcoholic beverages, and smoking should be avoided prior to your surgery.
5. If you are taking COUMADIN or any other blood-thinning medications the surgeons at Affiliated Ambulatory Surgery request that you consult with your primary care physician or cardiologist to determine the following: if appropriate lab tests are needed and if discontinuation or continuation of the medication is warranted.
6. Please bring a written list of all your current medications and dosages with you.
7. PLEASE NOTE: If you routinely pre-medicate (take an antibiotic) prior to any procedures, please check with your primary care provider, cardiologist or orthopedist in regards to pre-medicating for this procedure.
8. Procedures performed near the eyes: Please remove contact lenses prior to coming to the facility. In addition, if the surgical procedure is performed on the face, the dressing may interfere with your vision. Therefore, we do recommend a driver to be present.
9. **There is no need to fast prior to your procedure**.
10. The office will call to confirm your surgical appointment. If you need to cancel, please notify us at least 48 hours prior to your appointment. Time and planning have gone into your appointment to ensure optimal patient care.

POST-OPERATIVE INSTRUCTIONS: Complete post-operative instructions will be reviewed, and a copy will be given to you following surgery. Please be sure you have them in your possession prior to leaving our office.

1. A pressure dressing will be applied to the surgical site. This may include an elastic bandage around the extremities or head that is to be left in place for 24 to 48 hours.
2. As a rule of thumb, the wound line tends to be longer than the length of the original wound. This is done in an attempt to avoid unnatural puckering and dimpling of the skin that would result if the incision were not lengthened.
3. A certain amount of redness and bumpiness of the scar are to be expected, especially within the first two months after the surgery due to underlying sutures (which should dissolve) and wound contraction. Redness can persist for up to a year or more.
4. In general, a post-surgical scar improves with time and can take up to one year or more to fully mature.
5. Depending upon the location of the operative site, activities may be limited (i.e.: tennis, golf, aerobics, etc.) Lifting more than 10 pounds is also discouraged until the sutures or staples are removed or until directed by the surgeon.
6. You will need to return for suture or staple removal in approximately 7-14 days. You may have the option of having this done at one of our satellite offices with the surgeon's approval.

Your appointment is scheduled in our ***Ambulatory Surgery Center*** for: _____/_____/_____ Time: _____AM/PM

Your diagnosis is: _____

AFFILIATED AMBULATORY SURGERY, P.C. Rev. 10/18/16
182 South Street, Suite 1B
Morristown, NJ 07960
(973) 267-0300

Dear Patient,

You have been scheduled for surgery in our Ambulatory Surgery Center at our Morristown location. This facility is similar to those found at major medical center outpatient ambulatory centers. The use of this facility is reserved for the removal of lesions whose size and/or location requires the need for advanced closures and the repair of Mohs defects. Special attention is then given to providing the best reconstructive cosmetic result possible for our patients.

This surgical facility meets stringent standards set by the Federal Government through Medicare and the Board of Medical Examiners. We are a Medicare Certified Facility and we maintain accreditation with the Accreditation Association for Ambulatory Health Care (AAAHC). This facility meets the highest and most rigorous standards with regard to quality assurance, infection control, etc.

From your arrival for your surgery to your departure from our center, approximately one to three hours is set aside for your surgical procedure. During this period of time, the physician and nursing staff will review your chart, obtain vital signs, and go over medical information with you prior to the start of and completion of the procedure.

For your convenience we are providing you with all of the paperwork necessary for your upcoming visit, please be sure to *complete each form prior to your arrival so as not to delay your appointment.*

Included with this letter is:

- An optional Advance Directive (Living Will)
- A Patient Information Form for our facility
- A Protected Health Information Form
- And Pre-operative Instructions for your procedure

If you have an Advance Directive (Living Will), please bring a ***copy*** of it with you at the time of your appointment. Please note that this facility does not honor Do Not Resuscitate (DNR) orders.

If you wish to receive information and/or a New Jersey Advance Directive form, please refer to the following website:
http://www.state.nj.us/health/advancedirective

On the day of the surgery, please bring the following items with you:

- A current list of all medications and herbal supplements you take with their dosage and how often you take them
- Insurance and/or Medicare cards
- Advance Directive (Living Will) if available

The charges incurred for the procedure in this facility have been approved by Medicare and many other carriers. If you incur any charges you will see two bills: one for the surgical procedure by the physician, and one for the use of the operating room called a facility fee. As a courtesy to you, we will submit the charges to your insurance carrier.

Sincerely,

The Staff of Affiliated Ambulatory Surgery, P.C.

Affiliated Ambulatory Surgery, P.C.
Patient Disclosures

Patient Rights & Responsibilities

This is to ensure that all patients receiving care in this Center shall have his/her rights observed, respected, and enforced by the Health Care providers of this Center from Clinical Staff to Business staff and any other personnel that has contact and/or provides services to the Patient. The following are the rights of the patient receiving care in this Center.

1. The patient shall be provided in writing of his/her rights in before their procedure, in terms that the patient can understand. A signature acknowledging receipt of written notification of these rights shall be obtained on the day of the procedure; and will be obtained by the patient and or legal guardian and placed in the patient's chart as part of the permanent medical record.
2. The patient will be informed of the services offered at the Center, the names of the professional staff and their professional status of who is providing and/or responsible for their care, including information on the Center's provisions for emergency and after hours and emergency care.
3. The patient will be informed if requesting information of the fees and related charges, including the payment, fee, deposit, and refund policy of the Center and any charges not covered by third-party payers or by the Center's basic rate.
4. The patient will be informed of other Health Care and Educational Institutions participating in the patient's treatment.
5. The patient will be informed of the identity and the function of these institutions, and he/she has the right to refuse the use of such institutions.
6. The patient will be informed, in terms that the patient can understand, of his/her complete medical/health condition or diagnosis, the recommended treatment, treatment options, including the option of no treatment, risks of treatment, and expected results. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, then the information will be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly will be documented in the patient's chart.
7. The patient will participate in the planning of his/her care and has the right to refuse such care and medication. Upon refusal, it will be documented in the patient's chart and witnessed.
8. The patient will be included in experimental care if the patient has agreed to such and gives written and informed consent to such treatment, or when a guardian has consented to such treatment. The patient also has the right to refuse such experimental treatment, including the investigation of new drugs and medical devices.
9. The patient has the right to voice grievances or recommend changes in policies and services to the Center personnel, the Governing Authority, and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination, or reprisal.
10. The patient will be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a Physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of the Center's personnel.
11. The patient will be assured of confidential treatment of information about him/herself. Information in the patient's medical record shall not be released to anyone outside the Center without the patient's approval, unless another Healthcare Center to which the patient was transferred requires that information, or unless the release of the information is required or permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the State Department of Health for statutorily authorized purposes. The Center may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.
12. The patient will receive courteous treatment, consideration, respect and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when Center personnel are discussing the patient.
13. The patient will not be required to work for the Center unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules.
14. The patient has the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient.
15. The patient has the right to expect and receive appropriate assessment management and treatment of pain as an integral component of that person's care.
16. The patient has the right to information regarding the Credentialing process of Health Care Professionals at the Center.
17. The patient shall be informed by written notice on date of the procedure, of his/her Physicians financial interest or ownership in the Center; the signed copy of patient acknowledgement and notification of the Physician financial interest or ownership will be placed in the patient's chart as part of the permanent medical record.
18. The patient shall be provided in writing on the date of the procedure, information on the Center's policy on Advance Directives, including a description of applicable State and safety laws and, if requested, official State Advance Directive forms. The signed copy of patient acknowledgement and notification of the ASC policy on Advance Directives will be placed in the patient's chart as part of the permanent medical record.
19. The patient has the right to refuse any treatment and research, except as otherwise provided by law.
20. The patient will not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the Center.

21. The patient has the right to change their Healthcare Provider and reschedule their procedure.
22. The patient has the right to be informed about procedures for expressing suggestions, including complaints and grievances, including those regulated by State and Federal regulations.
23. The patient has the right not to be misled by marketing or advertising regarding the competence and capabilities of the Center.
24. The patient has the right to be provided with appropriate information regarding the absence of malpractice insurance coverage.
25. The patient has the right to receive care in a safe setting free from all forms of abuse and harassment.
26. A patient is responsible for reporting unexpected changes in his or her condition to the Health Care provider.
27. A patient is responsible for reporting to the Health Care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
28. A patient is responsible for following the treatment plan recommended by the Health Care provider.
29. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the Health Care provider or Health Care Center.
30. A patient is responsible for his or her actions if he or she refuses treatment or does not follow the Health Care provider's instructions.
31. A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
32. A patient is responsible for following Health Care Center rules and regulations affecting patient care and conduct.
33. A patient is responsible to provide complete and accurate information about his/her health, any medications, including herbals and over the counter supplements and any allergies or sensitivities.
34. A patient is responsible to follow the treatment plan prescribed by his/her Provider.
35. A patient is responsible to provide a responsible adult to transport him/her home from the Center (if the patient is receiving anesthesia) and remain with him/her for 24 hours if required by his/her provider.
36. A patient is responsible to inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
37. A patient is responsible to be respectful of all the Health Care providers and staff, as well as other patients.
38. If a patient is adjudged incompetent under applicable State laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.
39. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law

Complaints or Grievances:

Patients can communicate concerns about patient safety issues that occur before, during and after care is received by contacting the Administrator at:

Affiliated Ambulatory Surgery, P.C.
182 South Street
Morristown, NJ 07960
973-267-0300 ext. 111

Complaints may be also be lodged the following state offices:

Division of Health Facilities
Evaluation and Licensing
New Jersey Department of Health
PO Box 367
Trenton, NJ 08625-0367
800-792-9770

State of New Jersey
Office of the Ombudsman for the
Institutionalized Elderly
PO Box 808
Trenton, NJ 08625-808
609 943-4023, 877-582-6995 toll free

Medicare Ombudsman:

Information concerning Medicare and Medicaid coverage may be obtained from the Medicare Ombudsman. The Medicare Ombudsman is available to the public and the Center's patients to get information about the Medicare and Medicaid programs, prescription drug coverage, and how to coordinate Medicare benefits with other health insurance programs. Information about filing a grievance or complaint can be obtained from their website, by mail or via phone.

CMS Medicare Contact Information:

Telephone: 1-800-MEDICARE 24 hours 7 days including some federal holidays
TTY/TDD users can call 1-877 486 2048. This system is available 24 hours 7 days per week.

Mailing address:
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore MD 21244-1850
The website for the Medicare Ombudsman is:
https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Complaints may also be sent to:

Accreditation Association for Ambulatory Health Care (AAAHC)
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
Tel: 847.853.6060
Fax: 847.853.9028
Email: info@aaahc.org

Physician Financial Disclosure:

Public law/rule of the State of **NEW JERSEY** Board of Medical examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service.

Please Take Notice That Providers

1. Lauren Cooper, M.D. 182 South Street Morristown NJ 07960
2. Cheryl Fialkoff, M.D. 182 South Street Morristown NJ 07960
3. Kristyna Lee, M.D. 182 South Street Morristown NJ 07960

Have a financial interest in referring to: Affiliated Ambulatory Surgery, P.C. 182 South Street Morristown, NJ 07960

You may, of course, seek treatment at a Health Care Center of your own choice. A listing of alternative Health Care facilities can be found in the classified section of your telephone directory, by using the internet, or other reliable sources.

Advance Directives:

Affiliated Ambulatory Surgery, P.C. does not honor Do Not Resuscitate orders. Our facility would always attempt to resuscitate and transfer the patient to a hospital (Morristown Medical Center) in the event of deterioration.

Notice of Privacy Practices of
AFFILIATED AMBULATORY SURGERY, P.C..

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.

I. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

Pursuant to the Privacy Rules established by the Health Insurance Portability and Accountability Act of 1996, we are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short. It includes information that can be used to identify you and what we have created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in the main reception area. You can also request a copy of this notice from the contact person listed in Section V below at any time and can view a copy of this notice on our website at http://www.affiliatedambulatorysurgery.com.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses and disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclose your PHI without your authorization for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally-funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, if you are being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.

2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing staff and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

3. **For health care operations.** We may disclose your PHI, as necessary, to operate this organization. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. **For public health activities.** For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6. **For health oversight activities.** For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

7. **To coroners, funeral directors, and for organ donation.** We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death.

8. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

B. Uses and Disclosures Where You Have the Opportunity to Object:

1. **Disclosures to family, friends or others.** We may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your healthcare, unless you object in whole or in part.

C. All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated herein, we will not disclosure your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

D. Authorization for Marketing Communications. We will obtain your written authorization prior to using or disclosing your PHI for marketing purposes. However, we are permitted to provide you with marketing materials in a face-to-face encounter, without obtaining a marketing authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining a marketing authorization. In addition, as long as we are not paid to do so, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

E. Sale of PHI. We will disclose your PHI in a manner that constitutes a sale only upon receiving your prior authorization. Sale of PHI does not include a disclosure of PHI for: pubic health services; research; treatment and payment purposes; sale, transfer, merger or consolidation of all or part of our business and for related due diligence activities; the individual; disclosures required by law; any other purpose permitted by and in accordance with HIPAA.

F. Fundraising Activities. We may use certain information (name, address, telephone number, dates of service, age and gender) to contact you for the purpose of various fundraising activities. If you do not want to receive future fundraising request, please write to the Privacy Officer at the below address.

G. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosures are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

H. Business Associates. We may engage certain persons to perform certain of our functions on our behalf and we may disclose certain health information to these persons. For example, we may share certain PHI with our billing company or computer consultant in order to facilitate our health care operations or payment for services provided in connection with your care. We will require our business associates to enter into an agreement to keep your PHI confidential and to abide by certain terms and conditions.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. Notwithstanding the foregoing, you have the right to ask us to restrict the disclosure of your PHI to your health plan for service we provide to you where you have directly paid us (out of pocket, in full) for that service, in which case we are required to honor your request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. The right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have you PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request a copy of your information, we will charge you $1.00 per page or other reasonable fees for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance. Also note that you have the right to access your PHI in an electronic format (to the extent we maintain the information in such a format) and to direct us to send the e-record directly to a third party. We may charge for the labor costs to transfer the information; and charge for the costs of electronic media if you request that we provide you with such media.

** Please note, if you are the parent or legal guardian of a minor, certain portions of the minor's records may not be accessible to you. For example, records relating to care and treatment to which the minor is permitted to consent himself/herself (without your consent) may be restricted unless the minor patient provides an authorization for such disclosure. **

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for the purposes of treatment, payment, or healthcare operation, those made pursuant to your written authorization, or those made directly to you or your family. The list also will not include uses or disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003.

We will respond within 60 days of receiving your written request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12-month period without charge, but if you make more than one request in the same year, we will charge you $10.00 for each additional request.

To the extent that we maintain your PHI in electronic format, we will account all disclosures including those made for treatment, payment and health care operations. Should you request such an accounting of your electronic PHI, the list will include the disclosures made in the last three years.

E. The Right to Receive Notice of Breach of Unsecured PHI. You have the right to receive notification of a "breach" of your unsecured PHI.

F. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that you need to know about the changes to your PHI.

G. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

IV. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section V below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, please contact our HIPAA Privacy Officer at (973) 267-0300. Written correspondence to the Privacy Officer should be sent to Affiliated Ambulatory Surgery, P.C., 182 South Street, Suite 1, Morristown, NJ 07960.

VI. EFFECTIVE DATE OF THIS NOTICE

REVISED NOTICE – EFFECTIVE OCTOBER 2013.

AFFILIATED AMBULATORY SURGERY, P.C.

182 South Street Suite 1B
Morristown, NJ 07960

Dr. Lauren Cooper
Dr. Cheryl Fialkoff
Dr. Kristyna Lee
Dr. Arlene Rogachefsky
Dr. Adriana Lombardi
Dr. Alexander Dane
Dr. Audrey Beirne

Directions to Morristown

GOING NORTH ON ROUTE 287

- Take 287 North to Exit 35 for Madison Avenue and South Street.
- At the top of the exit ramp, turn left on to South Street.
- Continue straight. At the third traffic light, turn right on to Elm Street.
- We are the first parking lot on your right-hand side.

GOING SOUTH ON ROUTE 287

- Take 287 South to Exit 35
- At the top of the exit ramp, turn right on to Madison Avenue.
- At the traffic light, turn right on to South Street.
- Continue straight for 2 traffic lights. At the second light, make a right on to Elm Street.
- We are the first parking lot on your right-hand side.

From Route 78 East / Western New Jersey

- Take Route 78 East to Route 287 North.
- Take 287 North to Exit 35 for Madison Avenue and South Street.
- At the top of the exit ramp, turn left on to South Street.
- Continue straight. At the third traffic light, turn right on to Elm Street.
- We are the first parking lot on your right-hand side.

From Route 78 West / Eastern NJ / Holland Tunnel

- Take Route 78 West to Route 24 West.
- Take Route 24 West to Route 287 South.
- Take 287 South to Exit 35
- At the top of the exit ramp, turn right on to Madison Avenue.
- At the traffic light, turn right on to South Street.
- Continue straight for 2 traffic lights. At the second light, make a right on to Elm Street.
- We are the first parking lot on your right-hand side.

From Route 80

- Take Route 80 to Route 287 South.
- Take 287 South to Exit 35
- At the top of the exit ramp, turn right on to Madison Avenue.
- At the traffic light, turn right on to South Street.
- Continue straight for 2 traffic lights. At the second light, make a right on to Elm Street.
- We are the first parking lot on your right-hand side.

AFFILIATED AMBULATORY SURGERY, P.C.
182 South Street, Suite 1B
Morristown, NJ 07960

Patient Name: _____ Account #: _____ DOB: _____

ADVANCE DIRECTIVE FOR HEALTH CARE (LIVING WILL)

I, _____ , being of sound mind, hereby declare and make known my instructions and wishes for future health care in the event that, for reasons due to physical or mental incapacity, I am unable to participate in decisions regarding my care.

I understand that it is Affiliated Ambulatory Surgery's policy to provide all medically appropriate measures to sustain my life, regardless of my physical or mental condition. I will also be given appropriate medical care to alleviate pain and keep me comfortable.

After death, it may be possible to transplant human organs or tissues in order to save or improve the lives of others.

I wish to be an organ donor: _____ Yes _____ No
I wish to be a tissue donor: _____ Yes _____ No

Designation of a health care representative: I hereby designate the below named individual as my health care representative to make decisions about accepting, refusing or withdrawing treatment in accordance to my wishes as stated in this document. In the event my wishes are not clear, or a situation arises that I did not anticipate, my health care representative is authorized to make decisions in my best interests based upon what is known of my wishes.

_____
Name Relationship Telephone Number

_____
Street Address City, State Zip Code

Alternative Representative(s): If the person I have designated above is unable to act as my health care representative, I hereby designate the following person(s) to do so:

1. _____
Name Relationship Telephone Number

_____
Street Address City, State Zip Code

2. _____
Name Relationship Telephone Number

_____
Street Address City, State Zip Code

I have discussed my wishes with these persons and trust their judgement on my behalf. I understand the purpose and effect of this document, and I sign it knowingly and voluntarily after careful deliberation.

PLEASE DO NOT SIGN THIS FORM UNTIL YOU COME IN FOR YOUR SURGICAL APPOINTMENT

_____
Signature Date

Witnesses: (Cannot be a health care representative or alternative representative listed above; must be at least 18 years of age.) I declare that the person who signed this document did so in my presence, and that he or she appears to be of sound mind and free of undue influence.

_____ _____
Signature Date Signature Date

AFFILIATED AMBULATORY SURGERY, P.C.
182 South Street, Suite 1B
Morristown, NJ 07960

Patient Information Form

Patient Account Number: _____

Last Name: _____First Name: _____ Middle Name: _____

Date of Birth: _____Social Security #: _____ Sex: M / F / MTF / FTM / Other: _____

Race:	□ Asian	□ Black	□ Hispanic	□ White	□ Decline to Specify
Ethnicity:	□ Latino	□ Non-Latino			□ Decline to Specify
Language:	□ English	□ Spanish	□ Sign Language	□ Other	□ Decline to Specify
Marital Status:	□ Single	□ Married	□ Divorced	□ Widowed	□ Other

Street Address: _____ Apartment #: _____

City: _____State: _____ Zip Code: _____

Phone #: _____Cell #: _____ Work #: _____

Email Address: _____

Primary Care Physician: _____ Town of Practice: _____

If the patient is a minor, are the parents: □ Married □ Separated □ Divorced □ Other

Do you have medical insurance? □ Yes □ No

Primary Insurance Carrier: _____ Policy Number: _____

Subscriber's Name: _____ Group Number: _____

Subscriber's DOB: _____ Subscribers Social Security #: _____

Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Secondary Insurance Carrier: _____ Policy Number: _____

Subscriber's Name: _____ Group Number: _____

Subscriber's DOB: _____ Subscribers Social Security #: _____

Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Managed care/PPO/HMO/POS or Medicare patients: I assume responsibility for any service that is not approved on my referral (if such form is required by my plan); any service which is either cosmetic in nature and/or not covered by my insurer; any visit for which I have not presented a required referral form on the day of service or is ultimately not covered by my insurance plan. I assign payment benefits for my primary, secondary and/or Medigap plan to this provider. I am responsible for paying for all the noncovered and/or cosmetic services on the day they are provided to me. I understand that I am responsible for any DEDUCTIBLE, COPAY OR COINSURANCE designated by my plan as being my responsibility. I do hereby agree to pay to Affiliated Ambulatory Surgery, P.C., the full amount of any and all bills for services rendered to the above-named patient not covered by my insurance into which the physicians may have entered into an agreement. I hereby authorize the release of information necessary to file a claim with my insurer, and/or which is pertinent to my case to any insurance company involved in my care. A copy of this signature is valid as the original. If applicable: I hereby authorize you to evaluate and treat the above named minor child today and all future visits. If the patient is a minor: I am attesting that I have legal custody of my minor child.

Signature: _____ Today's Date: _____
SIGNATURE OF THE PATIENT OR LEGAL GUARDIAN IS REQUIRED

AFFILIATED AMBULATORY SURGERY, P.C.

Communications Regarding Protected Health Information

Patient Name: _____ Account #: _____DOB: _____

I understand that Affiliated Ambulatory Surgery, P.C. (the "Covered Entity") may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "Yes" below may be released.

Name: _____ Relationship: _____

Address: _____ Phone Number:_____

_____ Health Information: Yes / No Payment Information: Yes / No

Name: _____ Relationship: _____

Address: _____ Phone Number:_____

_____ Health Information: Yes / No Payment Information: Yes / No

Name: _____ Relationship: _____

Address: _____ Phone Number:_____

_____ Health Information: Yes / No Payment Information: Yes / No

Contact Information

I wish to be contacted in the following manner (please check all that apply):

☐ Home Telephone	☐ Detailed Message	☐ Call Back Number Only*
☐ Cell Telephone	☐ Detailed Message	☐ Call Back Number Only*
☐ Work Telephone	☐ Detailed Message	☐ Call Back Number Only*
☐ Mail to Home Address	☐ Mail to Work Address	

**If you check "Call Back Number Only" we will leave only a message to return the call, or a message confirming an appointment with no detailed health information.*

Acknowledgement of Receipt of "Notice of Privacy Practices"

I _____ [Patient Name] acknowledge receipt of the "Notice of Privacy Practices of Affiliated Ambulatory Surgery, P.C..

Signature: _____ Date: _____

Printed Name: _____

--- Office Use Only ---

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Reason: _____

_____

Signature of Covered Entity Representative: _____

Printed Name: _____ Date: _____