Laser & Aesthetic Medical Center, PC

KAILASH C. SINGHVI, MD
DOUBLE BOARD CERTIFIED PHYSICIAN

PATIENT INFORMATION

_____
Date

_____ _____ _____ _____
Patient's Last Name First Name M.I. Suffix (i.e, Jr., Sr.)

_____ _____ _____ _____
Street Address City State Zip Code

(_____)_____ (_____)_____ [ ]M [ ]S [ ]D [ ]W
Area Code Home Phone Area Code Cell Phone

_____ _____ [ ]M [ ]F
Date of Birth Age Sex

_____ _____ (____)_____
Emergency Contact (Name) (Relation) Emerg. Contact #

_____ (_____)_____
Name & Address of Patients Employer Work Telephone

_____
Occupation

_____ _____
Email Address Referral Source (How did you hear about us.)

Where can we reach you to confirm? [ ]Home Phone [ ]Cell Phone [ ]Work
Can we leave a message on your answering machine? [ ]Yes [ ]No
Are you interested in receiving information via email? [ ]Yes [ ]No
Can we text your appointment confirmation? [ ]Yes [ ]No

Reason for visit:

[ ]Botox [ ]Dysport [ ]Filler [ ]Laser Hair Removal [ ]Laser Resurfacing

[ ]Pearl Fraction [ ]Limelight [ ]Fungal Treatment [ ]Genesis

[ ]Titan [ ]Microdermabrasion [ ]Mole removal [ ]Leg Veins

[ ]Other – Please List_____

Height:_____ Weight:_____

Past Medical History:

[ ]None [ ]Asthma [ ]Cancer [ ]Coronary Artery Disease(CAD) [ ]Diabetes

[ ]Heart Disease [ ]High Blood Pressure [ ]Peripheral Vascular Disease/Circulation

[ ]Stroke (CVA) [ ]Other – Please List_____

_____

Past Surgical History:

[ ]None [ ]Yes – Please list procedures and date: _____

_____

Allergies:

[ ]No Known Drug Allergies

[ ]Penicillin [ ]Sulfa [ ]Codeine [ ]Aspirin

[ ]Other – Please List_____

[ ]Food Allergies Only – Please List_____

Current Medications:

[ ]None [ ]Yes – Please List Names and Dosage_____

_____

_____

Social History:

Tobacco Use: [ ]No [ ]Yes – Cigarettes Packs/Day _____ Year Started _____

Alcohol Use: [ ]No [ ]Yes – Frequency: [ ]Daily [ ]Weekends [ ]Monthly [ ]Rarely

[ ]Never

Family History:

[ ]None

[ ]High Blood Pressure _____ [ ]Heart Disease _____

[ ]Cancer _____ [ ]Diabetes _____

[ ]Asthma _____ [ ]Stroke _____

[ ]Kidney Disease _____ [ ]Other _____

I hereby authorize Kailash C. Singhvi, MD to release any information concerning my healthcare, condition, and treatment for the purpose of evaluating, administering, and appealing claims for insurance benefits. I also hereby assign and authorize payment of insurance benefits directly to Kailash C. Singhvi, MD. I understand that I am responsible for any amount not covered by insurance. I also understand that if I fail to pay any amount that I am responsible for, I will be charged no less than 1.5% interest per month compounded monthly. I also understand that for Worker's Compensation and No fault cases, if payment is not received, I am responsible to make full payment directly to the physician. Patient acknowledges and agrees that if the doctor must utilize the services of a collection agency or attorney to collect fees owed, that patient is also responsible for reasonable collection fees, attorney fees and costs of suit not to exceed 20% of the balance owed.

_____Signature of Patient/Responsible Party, if minor

Date _____

PATIENT ACKNOWLEDGEMENT FORM

This form is your acknowledgement that we have informed you how to get additional information on how we may use and disclose health information about you. This notice informs you to the fact that every patient has the right to review the Notice of Privacy Practices prior to signing this form. This notice is the outcome of HIPAA (Health Insurance Portability and Accountability Act of 1996), mandated by the federal government. The act will becomes law by April 14, 2003. The Notice of Private Practices insures that your personal health information is kept private between insurance companies, billing companies, doctors, hospitals and drug companies. HIPAA does not change the quality of your healthcare, it enforces your rights to the privacy of your health information.

The Notice contains a Patient Rights section describing your rights under the law. The terms of our notice may change, if we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to the restrictions, but if we do we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this consent, in writing,

signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The Practice provides this form to comply with government regulations.

The patient understands that:
Protected health information may be disclosed or use for treatment, payment or healthcare operations.

The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review that Notice.

The practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information by the Practice does not have to agree to those restrictions.

The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The practice may condition receipt of treatment upon the execution of this consent.

This Acknowledgement by: _____
Please Print – patient name

x_____
Signature/ Guarantor

_____ _____
Witness Date

Laser & Aesthetic Medical Center, PC
509 Stillwells Corner Road, Bldg. E, Unit 8, Freehold,
New Jersey. 07728

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to weather any medical service rendered under this contract were unauthorize or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as provided by state law/and that by lawful or court process except as therein constitutional rights to have any such dispute decided in court or law before a jury, and instead accepting the use of the arbitration.

Article 2: All claims Must Be Arbitrate: It is in the intention of the parties that this agreement bind all parties whose claims may rise out of or relate to treatment or service provided by provider including any spouse or heirs of the patient and any children whether born or unborn at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term 'patient' herein shall moan both mother and expected child.
All claims of monetary damage exceeding the jurisdiction limit of the small claims court against the provider and its partners, associates, corporation and the employees, agents and estates of nay of them, must be arbitrate, including without limitation, claims for loss of consortium. Wrongful death, emotional distress or punitive damages.

Article 3; Procedure and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select and arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties with thirty days (30) of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsil fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of judicial officer from civil liability when acting in the capacity of the arbitrator under this contract. This immunity shall supplement not supplant, any other applicable statutory or common law;

Either party shall have the absolute right to arbitrate separately by the issues of liability and damage's upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration to any person identity which would otherwise be a proper additional party in court action and upon such interaction any existing court action against such additional person or entity shall be stayed. The parties agree that provision of state law applicable to health care providers shall apply to dispute with the arbitration agreement. Any party may bring before the arbitrator's motion for summary judgement or summary adjudication. Discovery shall be conducted pursuant to applicable state law however, dispositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the series incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the dare notice thereof is received, the claim, if assisted in civil action, would be barred by the applicable statue of limitations, or (2) the claimants fails to pursue the arbitration claims in accordance with the procedure prescribe herein with reasonable diligence, With respect to any matter not herein expressly provided for, the arbitrators shall be governed by applicable laws relating to arbitration.

Article 5 Revocation: This Agreement may be revoking by written notice delivered to the provider. It is the intent of this Agreement to apply to all medical service rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to emergency surgery), patient should initial below: Effective as of the date of first medical service_____.
Patients or patient's representative's Initials_____. If any provision of the arbitration agreement is held invalid or unenforceable the remaining provisions shall remain in full force and shall not affected by the invalidity of any other provision. I unde=rstand that I have the right to receive a copy of this arbitration agreement, by my signature below, I acknowledge that I have receive a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL SEE ARTILCE 1 OF THIUS CONTRACT

SIGNATURE_____ **DATE**_____
RELATIONSHIP: (Circle one) PATIENT/SPOUCE/PARENT/GUARDIAN

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the right to review and receive a copy of medical information that may be used to make decisions about you care. Usually this includes medical and billing records. You must submit a written request to review and copy your medical information. We may change fee for the cost of supplying a copy of the records.

You have the right to ask to amend medical information that you feel is incorrect or incomplete. Your request for an amendment must be submitted in writing and must provide a reason that supports your request, we may deny your request for amendment. If it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information; 1) was not created by us; 2) is not part of the medical information kept by or for us; #) is not part of the information which you are permitted to inspect and copy; or 40 is not accurate or complete.

You have the right to request an 'accounting of disclosures' This is a list of disclosure we have made of medical information about you, with some exceptions. The exeptions are governed by federal healthy privacy law, and include; 1) routine disclosures for treatment, payment and operations conducted pursuant to your signed consent form; and 2) disclosure in you. You must submit a written request. The request must state a time period that may not be longer than six years and may not include dates before April 14, 2003, when current federal heath privacy laws becomes affective,

You have the right to request restrictions or limitations on the use or disclosure of medical information about you. You must submit a written request restriction that specifies: 10 what information you want to limit; 20 whether you want to limit our use, disclosure, or both: and 30 to whom you want the limits to apply. We reserve the right to refuse your restriction if it in conflict with providing you quality healthcare in an emergency situation.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as only at work or by mail. You must submit a written request for confidential communications restrictions, specifying how or where you wish to be contracted. We will accommodate reasonable request.

You have the right to possess a copy of this Privacy Notice upon request. You may receive a paper copy of thus notice, or you can also obtain a copy of this Notice at our offices.

You have the right to file a complaint of if you believe your right to privacy have been violated. All complaints must be submitted in writing. All complaints will be investigated. No personal issue will be raised for filling a complaint.

CHANGES TO NOTICE

We reserve the right to change the Notice of any time. We will post a copy of the current notice at our clinical site.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Laser & Aesthetic Medical Center Notice of privacy Practice provides information about how we may use and disclose your protected health information. In addition to the copy, we are providing you, copies of the current notice are available at our office.

I acknowledge that I have receive the Notice of Privacy Practice.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Print Name

(Staff Only) **WRITTEN ACKNOWLEDGEMENT NOT OBTAIN**

Please document your efforts to obtain acknowledgement and reason it was obtained

Notice of Practice Given- Patient Unable to Sign
Notice of Practice Given- Patient Declined to Sign
Notice of Practice and Acknowledgment to Patient

_____ _____

Signature of Representative Date