

Paul M. Littman, DO
Elizabeth Colaiocco, ANP, BC

70 Sparta Avenue, Suite 209
Sparta, NJ 07871
973-512-3222
FAX: 973-512-3161

616 Willow Grove Street
Hackettstown, NJ 07840

First Name _____ MI _____ Last Name _____

Address _____ City _____

State _____ Zip _____ Date of Birth _____ SSN _____ - _____ - _____

Home # _____ Cell # _____ Work # _____

E-mail _____ Marital Status _____

Occupation _____ Employer Name _____

Employer Address _____

Pharmacy _____ Phone Number _____ City/State _____

Primary Care Physician _____ Name _____ Phone Number _____ City/State _____

Emergency Contact _____ Relationship _____

Cell # _____ Work # _____ Home # _____

INSURANCE INFORMATION

Primary Insurance

Insurance Name _____

Insurance ID _____

Group# _____

Subscriber's Name _____

DOB _____ SSN _____ - _____ - _____

Relationship to Patient _____

Address _____

Phone _____

Secondary Insurance

Insurance Name _____

Insurance ID _____

Group# _____

Subscriber's Name _____

DOB _____ SSN _____ - _____ - _____

Relationship to Patient _____

Address _____

Phone _____

Patient or Responsible Party Signature: _____ Date: _____

Parent/Guardian, if Patient is Minor: _____ Date: _____

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.

Your Information, Your Rights, Our Responsibilities

Your Information

How We May Use and Disclose Medical Information About You

Treatment

We can use your health information and share it with other professionals who are treating you.

Payment

We can use and share your health information to bill and get payment from health plans or other entities.

Health Care Operations

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Health Care Information Organization

We may elect to use a health information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

Appointment Reminders, Treatment Alternative, Health-Related Benefits and Services

We may use and disclose medical information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options and health-related benefits and services that may be of interest to you.

Assist with Public Health and Safety Issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

For Research

We can use or share your information for health research

As Required By Law

We will disclose medical information about you when required to do so by federal, state or local law

Respond to Organ and Tissue Donation Requests

We can share health information about you with organ procurement organizations

Work with Coroner, Medical Examiner, or Funeral Director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies

Address Workers' Compensation, Law Enforcement, and Other Government Requests

- We can use or share health information about you
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

Military and Veterans

If you are a member of the armed forces of the United States or another country, we may release medical information about you as required by military command authorities

Respond to Lawsuits and Legal Actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena

Special Privacy Protections

If your medical information includes HIV-related information, alcohol or substance abuse, mental health or genetic information, special protections may apply to such information and you can contact us if you have any questions

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made with your written authorization, on an NUU authorization form. You may revoke such an authorization by writing us, and such revocation will be effective to the extent that we have not already released the information pursuant to the authorization or otherwise taken action in reliance on the authorization

Fundraising and Other Events

- We may contact you for fundraising efforts, but you can tell us not to contact you again
- We never share your information unless you give us written permission for marketing purposes, sale of your information, and most sharing of psychotherapy notes

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Right to Inspect and Copy

- You can request to see or get an electronic or paper copy of your medical record and other health information we have about you. This right does not include psychotherapy notes, information compiled for use in a legal proceeding, or certain information maintained by laboratories.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Right to Request Amendments

- You can request us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Right to Request Confidential Communications

- You can request us to contact you in a specific way (for example, home or office phone) or to send mail to different address.
- We will say "yes" to all reasonable requests.

Right to Request Restrictions

- You can request us not to use or share certain health information to someone who is involved in your care or the payment of your care, such as a family member or friend.
- If you pay for a service or health care item out-of-pocket in full, you can request us not to share that information for the purpose of payment or our operations with your health insurer.
 - We will say "yes" unless a law requires us to share that information.

Right to an Accounting of Disclosures

- You can request for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within the same 12 month period.

Right to a Paper Copy of this Notice

- You can request for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Right to Choose Someone to Act For You

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Right to be Notified of a Breach

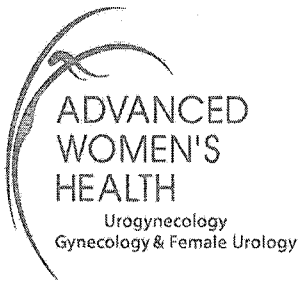
In the event of a breach of your Protected Health Information as defined by the Department of Health and Human Services (HHS), you will be notified by us in a manner specified by HHS.

Right to File a Complaint

- You can file a complaint if you feel we have violated your rights by contacting us or the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office or website



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Non-Medicare Financial Policy

It is our sincere desire to provide you with the best possible medical care. This involves mutual understanding among the patients, doctors and the staff. We encourage you, our patient, to discuss any questions you may have regarding our professional fees, this financial policy and your responsibility.

Payment is expected at the time of your visit for services not covered by your insurance plan. We accept cash, check, Visa, MasterCard, American Express or Discover.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. *Advanced Women's Health of NJ is not a party to that contract.*
2. If you are scheduled for surgery, our practice may be required to utilize the services of an assistant surgeon. This service may not be covered by your plan.
3. Surgery patients without insurance will be asked to pay the estimated surgical fees 7 days prior to surgery. Payment must be in the form of cash, bank check or credit card.
4. Any unmet patient responsibility (i.e., deductible or coinsurance) will be secured by a credit card provided at the time of your appointment.
5. We will not become involved in disputes between you and your insurance company regarding deductibles, coinsurance, covered benefits, secondary insurance, "usual, customary and reasonable charges", etc., other than to supply factual information as necessary.
6. In situations where a claim is pending for more than 60 days, you will be automatically billed for unpaid charges filed with your primary carrier. You will pay the entire surgical fee and seek reimbursement from your insurance company.
7. If your insurance company requires a referral and/or co-payment, it is mandatory that you provide this at the time of service.
8. If you have secondary coverage with an HMO, we will not submit a secondary claim to an HMO organization. You will be responsible for any unpaid charges for deductible, coinsurance, etc.
9. If you fail to inform this office of your secondary coverage other than HMO at the time you complete your insurance paperwork, we will not be able to bill your secondary carrier. You will be responsible for any unpaid charges for deductibles and/or coinsurance.
10. If you neglect to report to your carrier who is primary and who is secondary regarding your coverage, known as "Coordination of Benefits", you will automatically be responsible for all unpaid medical charges filed with your primary insurance carrier.
11. It is unethical and prohibited by law for the doctor to change diagnosis codes and/or procedure codes to meet the reimbursement requirements of your plan for medical service specifically excluded by your policy.
12. All returned checks will be subject to \$30.00 return fee.

I authorize payment of benefits be made on my behalf to Advanced Women's Health of NJ for any services furnished me by the provider. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits for services rendered.

If you have any questions please don't hesitate to speak to our Office Manager. Thank you for understanding our Financial Policy.

I have been presented with a copy of the Advanced Women's Health of NJ's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law.

Patient/Responsible Party Signature _____ Date _____

Print Patient Name _____



NJU ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practice which provides information about how we may use and disclose protected health information (PHI) about you. The notice details your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or from our website.

Please check the first box below and sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

- I acknowledge that I have received a copy of the NJ Urology Notice of Privacy Practices.
- We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the patient but it could not be obtained because: _____

Employee Signature/Date: _____ (For Office Use Only)

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so except for necessary instances allowing for disclosure as explained in our Notice of Privacy Practices. Please list below name(s) of the individual(s) (Family, Friends, etc.) with whom we may discuss your care. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

I authorize NJ Urology to disclose my Protected Health Information to these individuals:

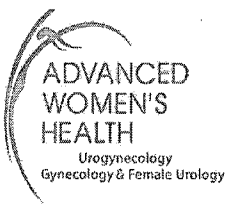
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
Name	Relationship to Patient	Phone Number

Name of Patient (print) _____ Date of Birth

Signature of Patient _____ Date

Signature of Patient Representative _____ Date
(Required if patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient _____ Print Name



MEDICAL HISTORY QUESTIONNAIRE

Name	Date of Birth	Age	Drug Allergies:	Reactions:
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Please describe the reason for your visit (chief complaint)

OBSTETRIC HISTORY

Number of Pregnancies:	Vaginal Deliveries:	Cesarean Deliveries:	Largest Baby Weight:
Forceps or Vaccum <input type="checkbox"/> Yes <input type="checkbox"/> No	Episiotomy <input type="checkbox"/> Yes <input type="checkbox"/> No		Laceration/Tear <input type="checkbox"/> Yes <input type="checkbox"/> No
Degree/Details		Other Complications or Prolonged Labor	

GYNECOLOGIC HISTORY

Gynecologist Name:	Do you experience any of the following? (check ones you have) <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Heavy menstrual periods <input type="checkbox"/> Pain with periods <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> "Falling" of pelvic organs or prolapse
Date of last menstrual period:	
Date of last PAP smear: Result:	
Date of last mammogram: Result:	
Have you ever had a sexually transmitted disease?	
Are you using contraception? What type:	
Are you sexually active? Describe any problems below:	
Are you presently taking, or have you taken in the past, hormone replacement therapy? If yes, medication and dose schedule, vaginal/oral:	

MEDICAL CONDITIONS AND MEDICATIONS

Please list ALL your medical conditions, the medication(s) you are taking for them (if any), how long you have been on the medication

Medical Condition	Name of Medication	Dosage	How often you take it	How long have you been on the medication
<i>Example - Hypertension</i>	<i>Tenormin</i>	<i>50 mg</i>	<i>1 daily</i>	<i>2 years</i>

Reviewed with Patient _____ / ____ / ____
Drs Initials & Date

Name	DOB	Date
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PAST SURGICAL AND HOSPITAL HISTORY: None Yes, if yes
Please describe your past experience with, **operations**, serious injuries, all and any hospitalizations and related treatments. Please include dates (month/year) of any surgeries.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FAMILY HISTORY

Are there medical events in your family's history, including diseases that may be hereditary or place you at risk?
Please circle **Y** or **N** for each condition (no blanks please 😊)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
Y	N	Asthma	Y	N	Diabetes	Y	N	Stroke
Y	N	Bleeding problems	Y	N	Heart disease	Y	N	Thyroid disease
Y	N	Ovarian Cancer	Y	N	High blood pressure	Y	N	Kidney Stones
Y	N	Breast Cancer	Y	N	Kidney disease	Y	N	Other:
Y	N	Other Cancer (indicate type)	Y	N	Adopted			

SOCIAL HISTORY

Marital Status Single Married Widowed Separated Divorced	Drug/Alcohol Use: Yes No Drinks/week	Current Smoker: <input type="checkbox"/> Yes # of cigarettes/day How many years have you smoked: Former Smoker : <input type="checkbox"/> Yes When did you quit: # of Cigarettes/day: Never Smoked: <input type="checkbox"/> Yes
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REVIEW OF SYSTEMS

Do you have or have you had any serious or chronic medical conditions?
Please Circle **Y** or **N** or any condition(s) you have had or that you have currently. (no blanks please 😊)

	Yes	No		Yes	No		Yes	No
Constitutional: Weight change	Y	N	Fatigue	Y	N			
Eyes: Blurry Vision	Y	N	Dry Eyes	Y	N			
Endocrine: Excessive Thirst	Y	N	Feelings of being cold	Y	N	Feelings of being hot	Y	N
Respiratory: Chest Pain	Y	N	Shortness of breath at rest	Y	N	Wheezing	Y	N
Cardiovascular: Difficulty lying flat	Y	N	Painful breathing with activity	Y	N			
Gastrointestinal: Nausea/Vomiting	Y	N	Change in bowel habits	Y	N	Bloody Stool	Y	N
Hematologic/Lymphatic: Easy Bruising	Y	N	Groin Mass	Y	N			
Neurological: Balance Difficulty	Y	N	Difficulty Speaking	Y	N	Seizures	Y	N
Psychiatric: Anxiety	Y	N	Depression	Y	N	Neuropathy	Y	N

Other Comments:

Patient Signature

Date

Reviewed with Patient _____ / _____ / _____
Drs Initials & Date