NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW ROBERT E. SUSSMAN, D.P.M. MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Robert E. Sussman, D.P.M. is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Robert E. Sussman, D.P.M. or received by Robert E. Sussman, D.P.M. from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Robert E. Sussman, D.P.M. will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

Robert E. Sussman, D.P.M. reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Robert E. Sussman, D.P.M. may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Robert E. Sussman, D.P.M. may determine that you require the services of a specialist. In referring you to another doctor, Robert E. Sussman, D.P.M. may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Robert E. Sussman, D.P.M. to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, Robert E. Sussman, D.P.M. will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the servjces provided to you.

Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Robert E. Sussman, D.P.M. may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Robert E. Sussman, D.P.M. may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Robert E. Sussman, D.P.M. is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

[1] This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- For workers' compensation.
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Robert E. Sussman, D.P.M. will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Robert E. Sussman, D.P.M. has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Robert E. Sussman, D.P.M. to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Robert E. Sussman, D.P.M. may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Robert E. Sussman, D.P.M. send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Robert E. Sussman, D.P.M. not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Robert E. Sussman, D.P.M. amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Robert E. Sussman, D.P.M. for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Robert E. Sussman, D.P.M. and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Robert E. Sussman, D.P.M., please contact the Privacy Officer at the following:

Privacy Officer
Robert E. Sussman, D.P.M.
182 C Highway 33
Neptune, NJ 07753
(732) 776-7260

It is the policy of Robert E. Sussman, D.P.M. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.

ROBERT E. SUSSMAN, D.P.M. | JOSEPH A. SUSSMAN, D.P.M.

PATIENT HISTORY FORMS

Last Name: _____ First Name: _____ MI _____

Street: _____ City/State: _____ Zip _____

Home Phone: _____ Cell Phone: _____

Dob: ____/____/_____ Age: _____ Sex: ❑ Male ❑ Female Email: _____

Ethnicity: _____ Primary Language: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced Occupation: _____

Employer: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

Primary Physician: _____ Address: _____

Date last seen: _____ Phone: _____

May we contact your Physician about your health? ❑ Yes ❑ No

Pharmacy Name: _____ Phone: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

❑ Physician ❑ Family Member ❑ Friend (Name _____) ❑ Internet _____ ❑ Website ❑ Facebook

Other: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Are you the Policy Holder? ❑ Yes ❑ No

If the patient IS NOT the policy holder/subscriber, please provide the following:

INSURED INFORMATION:

Subscriber Name: _____ Relationship: ❑ Spouse ❑ Child ❑ Other _____

Gender: ❑ Male ❑ Female Date of Birth: ____/____/_____

Secondary Insurance: _____

If you are NOT the policy holder/subscriber, please provide the following:

INSURED INFORMATION:

Subscriber Name: _____ Relationship: ❑ Spouse ❑ Child ❑ Other _____

Gender: ❑ Male ❑ Female Date of Birth: ____/____/_____

ADVANCED DIRECTIVES: ❑ Living Will ❑ DNR ❑ Durable Power of Attorney ❑ Surrogate Appointed ❑ None

Please read and sign:The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment Benefits) : I authorize payment of medical benefits to the practice and named above. (Relaease of Information): I authorize the release of any medical information necessary to process this claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practices Notices. (Medication History): I authorize the Doctor's office to retreive my medication history.

Patient Signature: _____ **Date:** _____

PRESENT FOOT CONDITION

Describe your foot problem: ❑ (Left) ❑ (Right) or ❑ (Both) _____

_____

How long has it been bothering you? _____

What makes it better or worse? *(Include prior medical treatments, medications, physical therapy, injections, etc.)*

_____

_____

Have you had any past problems with your feet or ankles? ❑ Yes ❑ No

Include Employment:_____Height: _____Weight: _____ Shoe Size: _____

FAMILY HISTORY

Please mark all that apply to members of your family

BUNIONS
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

CANCER
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

FLATFEET
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

KIDNEY DISEASE
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

HAMMERTOES
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

LUNG DISEASE
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

HEART DISEASE
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

RHEUMATOID ARTHRITIS
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

DIABETES
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

BLEEDING DISORDER
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

STROKE
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

HEPATITIS
❑ Mother ❑ Father
❑ Brother ❑ Sister ❑ Grandparents

Mother: ❑ Living ❑ Deceased
Cause of Death: _____

Sister: ❑ Living ❑ Deceased
Cause of Death: _____

Father: ❑ Living ❑ Deceased
Cause of Death: _____

Brother: ❑ Living ❑ Deceased
Cause of Death: _____

Please list unlisted diseases that a family member had:

_____

_____

_____

ALLERGIES

Please list any allergies:_____

_____

_____

PAST SURGICAL HISTORY

Please list any surgical procedures that you may have had in the past: _____

_____

_____

_____

SOCIAL HISTORY

Do you drink alcohol or beer? ❑ Yes ❑ No

❑ None ❑ Light Usage (1-2/week) ❑ Moderate (1-2 Day) ❑ Heavy (2 or more/day)

Do you smoke? ❑ Yes ❑ No _____Packs Per Day

How long have you been a smoker?_____ Did you previously smoke? ❑ Yes ❑ No

Stret Drug Use? ❑ Yes ❑ No; Type of Drug(s)? _____

Type of Employment (Please check one):

❑ Sits at job ❑ Stands at job ❑ Stands and walks at job ❑ Retired

MEDICAL HISTORY

Please check all that apply to you

- ❑ High Blood Pressure
- ❑ Heart Disease / Attacks
- ❑ Peripheral Vascular Disease
- ❑ Congestive Heart Failure
- ❑ Psoriasis
- ❑ Bleeding Disorder
- ❑ Blood Clot or DVT
- ❑ Diabetes
  ❑ Insulin or ❑ Non-Insulin
- ❑ COPD
- ❑ Asthma
- ❑ Cancer
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ HIV
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Stomach Ulcers
- ❑ Thyroid Disease
- ❑ Varicose Veins
- ❑ Lyme Disease
- ❑ Inflammatory Bowel Disease
- ❑ Gout
- ❑ Skin Conditions
  Describe: _____
  _____
- ❑ Gastric Reflux
- ❑ History of leg or foot Ulcers
- ❑ Multiple Sclerosis
- ❑ Hepatitis
- ❑ Neuropathy

Please list any medical conditions you may not have mentioned above:

_____

_____

_____

_____

_____

MEDICATIONS

Please list any medications that you are currently taking:

_____

_____

_____

_____

_____

_____

_____

ACKNOWLEDGEMENT OF INSURANCE AND PRIVACY ACT HIPPA

I have been given the Notice of Privacy Practices (HIPPA) form.

❑ YES ❑ NO

I hereby authorize payments directly to Robert E. Sussman, DPM & Joseph A. Sussman, DPM for surgical and/or medical benefits.

❑ YES ❑ NO

Please be advised that it is the patient's responsibility to familiarize themselves with the benefits and restrictions of their insurance company. The patient assumes responsibility for any co-payments, co-insurance, deductibles, or referrals required by their insurance company. I have read and do understand the above statement.

Signature: _____ **Date:** _____

I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIMS PURPOSES. I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signature: _____ **Date:** _____

MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to either me or on my behalf to Robert E. Sussman, DPM or Joseph A. Sussman, DPM for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative — Date

_____ _____
Plerase Print the name of Beneficiary, Guardian or Personal Representitive — Relationship to Beneficiary

PATIENT DESIGNATION OF PARTIES FOR RELEASE OF INFORMATION

As this office is in compliance with HIPPA requirements, we need you to designate any person or persons who you wish to allow access to your medical information in this office.

I hereby designate the following people to be allowed access to my medical information. I authorize Dr. Sussman, and office staff to release information on my condition to these parties:

1: _____ **Relationship:** _____

2: _____ **Relationship:** _____

3: _____ **Relationship:** _____

_____ _____
Signature of Patient or Authorized Representitive — Date

I hereby authorize Dr. Sussman & office staff to leave voice mail messages.

Confirming Appointments:

❑ Home Phone
❑ Business Phone
❑ Cell Phone

Regarding test/lab results within normal limits:

❑ Home Phone
❑ Business Phone
❑ Cell Phone

_____ _____
Signature of Patient or Authorized Representitive — Date