

**CARTER G. ABEL, M.D.**  
**Concourse at Beaver Brook**  
**1465 Route 31 South**  
**Annandale, NJ 08801**  
**(908) 735-5100**

\_\_\_\_\_  
Dear \_\_\_\_\_,

Welcome to our practice! We look forward to seeing you on \_\_\_\_\_ at \_\_\_\_\_.

Enclosed you will find a *Patient Registration & Health Questionnaire*, *HIPAA Notice of Privacy Practices* and *directions to our office*. Please take a few minutes to fill out the information requested and **return it to us before your first visit**.

When you come to our office for an initial visit, you will be given a full-body examination. Please dress simply so that you can easily change. Also, please do not wear any earrings, cosmetics, perfume, cologne or aftershave.

If a biopsy or an excision of a lesion is necessary, please be advised that the fee for the dermatopathologist who reads the specimen will be a separate fee from our office's charge.

Also, please be sure to bring your current insurance card(s) and payments are accepted by cash, check and Visa/MasterCard.

If you have any questions or concerns please do not hesitate to contact our office.

Carter G. Abel, M.D. & Staff

P.S. Due to the high demand for *New Patient Exam* appointments, please notify our office atleast **24 hours** in advance if you can not keep your appointment. Thank you.

**PATIENT REGISTRATION & HEALTH QUESTIONNAIRE**

DATE \_\_\_\_\_

NAME \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

**S** **M** **W** **D** **SEP**

DATE OF BIRTH \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_

ZIP \_\_\_\_\_

PHONE (HOME) \_\_\_\_\_

PHONE (WORK) \_\_\_\_\_

PHONE (CELL) \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_

EMPLOYER \_\_\_\_\_

IF UNDER 18, PARENT/GUARDIAN \_\_\_\_\_

EMERGENCY CONTACT (OTHER THAN SPOUSE) \_\_\_\_\_

PHONE \_\_\_\_\_

PATIENT S.S. # \_\_\_\_\_

REFERRED BY \_\_\_\_\_

***PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.***

1) PRIMARY INSURANCE COMPANY \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_

I.D. # \_\_\_\_\_

GROUP \_\_\_\_\_

SUBSCRIBER'S DATE OF BIRTH \_\_\_\_\_

SUBSCRIBER'S SS# \_\_\_\_\_

2) SECONDARY INSURANCE COMPANY \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_

I.D. # \_\_\_\_\_

GROUP \_\_\_\_\_

SUBSCRIBER'S DATE OF BIRTH \_\_\_\_\_

**CONSENT FOR BIOPSY, SURGERY OR PHOTOGRAPHY**

I HEREBY AUTHORIZE THE PERFORMANCE OF SUCH SURGERY, PHOTOGRAPHY OR OTHER PROCEDURES AS MAY BE DEEMED ADVISABLE OR NECESSARY BY CARTER G. ABEL, M.D. UPON ME OR MY MINOR CHILD. I AM AWARE THAT ANY PROCEDURE CARRIES THE RISKS OF BLEEDING, INFECTION, SCARRING, PIGMENTATION PROBLEMS AND NERVE DAMAGE (IE. NUMBNESS OR PAIN) WHICH MAY VARY ACCORDING TO OPERATIVE PLAN.

Pt. Signature: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

\*PLEASE DO NOT WEAR MAKE UP OR PERFUMES WHEN VISITING DOCTOR FOR SKIN EXAMS.

To be completed by patient - please print

# HEALTH QUESTIONNAIRE

## REASON FOR VISIT

## FAMILY HISTORY

	ALIVE & WELL	DECEASED	FOLLOW THE LINES ACROSS THE PAGE AND MARK THE APPROPRIATE BOX CAUSE OF DEATH (AGE)																	
			HIGH BLOOD PRESSURE	HEART DISEASE	EPILEPSY	DIABETES	CANCER	ASTHMA	KIDNEY DISEASE	GLAUCOMA	STROKE	HAYFEVER	ARTHRITIS	MENTAL ILLNESS	MIGRAINE	BLEEDS EASILY	ANEMIA	ALCOHOLISM	PSORIASIS	ECZEMA
FATHER																				
MOTHER																				
BROS / SIS																				
BROS / SIS																				
BROS / SIS																				
BROS / SIS																				
MOTHER'S RELATIVES																				
FATHER'S RELATIVES																				

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

	NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN
LIST ALL MEDICATIONS YOU ARE NOW TAKING INCLUDING OVER THE COUNTER Rx						

### DRUG ALLERGIES:

## MEDICAL HISTORY

Mark (c) for current problems. Check (✓) box and indicate age when you had any of the following symptoms or diseases.

- |  |   |  |                                     |  |
|--|---|--|-------------------------------------|--|
| <input type="checkbox"/> HEARING PROBLEMS      | <input type="checkbox"/> HOARSENESS             | <input type="checkbox"/> ANEMIA                      | <input type="checkbox"/> ARTHRITIS  | <b>FEMALES</b><br>REGULAR MENSTRUAL PERIODS <input type="checkbox"/> Y <input type="checkbox"/> N<br># OF PREGNANCIES _____<br># OF LIVE BIRTHS _____<br># OF MISCARRIAGES _____<br>BIRTH CONTROL METHOD _____<br>B.C. PILL (BRAND) _____<br>MENOPAUSAL SYMPTOMS <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> GLAUCOMA              | <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> CANCER                      | <input type="checkbox"/> DEPRESSION |  |
| <input type="checkbox"/> SINUS TROUBLE         | <input type="checkbox"/> CORONARY HEART DISEASE | <input type="checkbox"/> DIABETES                    |                                     |  |
| <input type="checkbox"/> HAY FEVER             | <input type="checkbox"/> BRUISE EASILY          | <input type="checkbox"/> THYROID DISEASE             |                                     |  |
| <input type="checkbox"/> HYPERTENSION          | <input type="checkbox"/> PALPITATIONS           | <input type="checkbox"/> SEIZURES                    |                                     |  |
| <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> VARICOSE VEINS         | <input type="checkbox"/> STROKE                      |                                     |  |
| <input type="checkbox"/> IRREGULAR PULSE       | <input type="checkbox"/> DIFFICULTY SWALLOWING  | <input type="checkbox"/> MIGRAINE HEADACHES          |                                     |  |
| <input type="checkbox"/> PHLEBITIS             | <input type="checkbox"/> PEPTIC ULCER DISEASE   | <input type="checkbox"/> MENTAL ILLNESS              |                                     |  |
| <input type="checkbox"/> HEARTBURN             | <input type="checkbox"/> JAUNDICE               | <input type="checkbox"/> TUBERCULOSIS                |                                     |  |
| <input type="checkbox"/> COLITIS               | <input type="checkbox"/> KIDNEY STONES          | <input type="checkbox"/> ALLERGIES (NON DRUG)        |                                     |  |
| <input type="checkbox"/> HEPATITIS A B C       | <input type="checkbox"/> VENEREAL DISEASE       |  |                                     |  |
| <input type="checkbox"/> PROSTATE PROBLEMS     | <input type="checkbox"/> GOUT                   | <input type="checkbox"/> ALCOHOL - OZ./WEEK _____    |                                     |  |
| <input type="checkbox"/> HERPES                | <input type="checkbox"/> CHLAMYDIA              | <input type="checkbox"/> SMOKING - CIG/DAY _____     |                                     |  |
| <input type="checkbox"/> CATARACTS             | <input type="checkbox"/> GONORRHEA              | # YEARS _____  |                                     |  |
| <input type="checkbox"/> NOSE BLEEDS           | <input type="checkbox"/> RECENT WEIGHT LOSS     | <input type="checkbox"/> COFFEE/TEA - CUPS/DAY _____ |                                     |  |

- SKIN PROBLEMS**  
 ECZEMA  PSORIASIS  RASH  
 HIVES  ABNORMAL MOLES  
 FREQUENT SUN EXPOSURE  
 EXCESSIVE SCARRING  
 SKIN CANCER  
 RECENT OR PROGRESSIVE HAIR LOSS

# HIPAA NOTICE OF PRIVACY PRACTICES

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Patient's Name: \_\_\_\_\_

**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.**

## 1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other permitted and required uses and disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization** at any time, in writing, except that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## 2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we may have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**CARTER G. ABEL, M.D.  
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***MEDICARE/MEDICAID PATIENT AUTHORIZATION FORM***

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Carter G. Abel, M.D. for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services." Please be advised that this office is not a participating provider of Medicare/Medicaid and any unpaid balances will be the patient's responsibility.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date