# New Patient Demographics

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>Full Name</td>
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<tr>
<td>Date of Birth</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Full Address</td>
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<td>State</td>
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<td>Zip</td>
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<tr>
<td>Home Phone</td>
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<tr>
<td>Cell Phone</td>
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<tr>
<td>Marital Status</td>
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<tr>
<td>Spouse/Next of Kin Name</td>
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<tr>
<td>Number</td>
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<tr>
<td>Emergency Contact</td>
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<tr>
<td>Number</td>
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<tr>
<td>Employer Name</td>
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<tr>
<td>Number</td>
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<tr>
<td>Primary Insurance</td>
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<tr>
<td>Group No</td>
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<td>Member ID</td>
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<tr>
<td>Guarantor’s Name</td>
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<td>Guarantor’s DOB</td>
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<tr>
<td>Insurance Address</td>
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<td>Secondary Insurance</td>
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<td>Group No</td>
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<td>Member ID</td>
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<tr>
<td>Insurance Address</td>
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<tr>
<td>Primary Care Physician</td>
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<tr>
<td>Phone No</td>
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<tr>
<td>Primary Care Physician Address</td>
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<tr>
<td>Referring Physician (if any)</td>
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<tr>
<td>Phone No</td>
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<tr>
<td>Referring Physician Address</td>
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<tr>
<td>Preferred Pharmacy</td>
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<tr>
<td>Phone No</td>
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<tr>
<td>Who can we thank for your visit</td>
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</tbody>
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Signature: ___________________________  Date: _______________
Patient Medical History

Patient Name: ___________________________________________ Date: _____________________________

Medical History (place X where applicable)

___ High blood pressure ___ High cholesterol ___ Coronary Artery Disease ___ Deep Vein Thrombosis ___ Stroke
___ Renal Insufficiency Syndrome ___ Diabetes ___ Thrombophlebitis ___ Aneurysm ___ Eczema ___ Thyroid Disorder
___ Peripheral Vascular Disease ___ Peripheral Neuropathy  Other (please explain): _____________________________________________

Family History: ☐ No knowledge of family history

Clotting Disorder  Y or N  Family member? _________  Bleeding Disorder  Y or N  Family member? _________
Coronary Artery Disease  Y or N  Family member? _________  Stroke  Y or N  Family member? _________
Aneurysm  Y or N  Family member? _________  Varicose Veins  Y or N  Family member? _________
Other family history: _____________________________

Surgical History: ☐ No past surgical history

Past Varicose Vein Surgery w/ Stripping  YES or NO

Social History:

Tobacco Use  Y or N  _______ packs per day  Alcohol Use  Y or N  _______ frequency
Sun Exposure  Y or N  _______ how often?  Are you currently pregnant/breastfeeding?  Y or N
Living Situation: (please circle one)  With Spouse  With Family  Alone  Nursing Home

Current Medications: (please include dosage and frequency)  ☐ Not currently on any medication

Blood thinners  YES or NO  Birth Control  YES or NO
Accutane  YES or NO  Retin A  YES or NO

Allergies: ☐ No known allergies  ☐ Sotradecol/Sodium tetradecyl  ☐ Polidocanol/Asclera
☐ Epinephrine  ☐ Latex  ☐ Sotradecol  ☐ Saline  ☐ Lidocaine  ☐ Penicillin

Other: ___________________________
Authorization for Release of Medical Information

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows this office to release your protected health information to a person or organization that you choose.

Patient Information:

Name: ___________________________ DOB: ___________________________
SS#: ____________________________
I, ____________________________, hereby authorize Chuback Medical Group to:

☐ Release my medical information
☐ Obtain my medical information

I authorize the following person(s) and/or organization to release/obtain the information:

Name of Person/Medical Office: ____________________________
Address: ________________________________________________
Phone Number: (____) _______ - _______
Reason for release of information: ____________________________

Information to be released:

a. ☐ Office visits                  ☐ History & Physical
b. ☐ Emergency Department Reports ☐ All clinical reports -including but not limited to:
c. ☐ Discharge Summary            ☐ Cardiac, Laboratory, Radiology
d. ☐ Operative Reports            ☐ Other _______

I understand that my treatment information released under this consent may be re-disclosed by the recipient of the information and may no longer be protected by Federal law.

This authorization will expire in one year from date signed, or sooner by choice, in which case this authorization will expire on _________________. I understand that I may revoke this authorization at any time by notifying, in writing, the Chuback Vein Center.

Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law.

Patient Signature: ___________________________    Date: ___________________________
Release of information

Patient Name: ___________________________________________ Date: __________________________

Please list the family members or other persons, if any, whom Chuback Medical Group may inform about your general medical condition and your diagnosis. (You may write “no one,” You may revoke this permission in writing at any time.)

________________________________________________________________________
________________________________________________________________________

Please print the e-mail where you would like to be contacted about your appointments, ultrasound results, other healthcare information or special offers.

* I am fully aware that e-mail is not a secure means of communication *
________________________________________________________________________

Please print the telephone number where you want to receive calls about your appointments, ultrasound results, or other healthcare information, if other than your home phone number.

* I am fully aware that a cell phone is not a secure and private line *
________________________________________________________________________

Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

YES ________ NO ________

Do you currently have a Power of Attorney (POA) or Living Will?

YES ________ NO ________

Patient/Guardian/POA Signature: ________________________________

Date: __________________________
Acknowledgement of Receipt of Notice of Privacy Practices

The Chuback Medical Group reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy of Privacy Practices for Chuback Medical Group.

_________________________________  ______________________________________
Patient Name  Patient Signature

_________________________________  ______________________________________
Signature of Patient Representative*  Relationship to Patient

_________________________________
Date

*Required if the patient is a minor or an adult who is unable to sign this form
Acknowledgement of Disclosures

I, __________________________acknowledge that Chuback Medical Group and the providers listed below are out-of-network with my health insurance plan. I also acknowledge the following disclosures:

➢ Prior to scheduling my appointment, I was informed that Chuback Medical Group was out-of-network and that the amount or estimated amount to be billed for services is available to me upon request;
➢ Upon request, Chuback Medical Group will disclose in writing the amount or estimated amount that it will bill you for the services and the CPT codes associated with the services (absent unforeseen medical circumstances that may arise);
➢ My out of network financial responsibilities may be in excess of the copayment, deductible, or coinsurance and I may be responsible for any costs in excess of those allowed by their carrier; and
➢ I should contact my carrier for further information or consultation on these costs.

➢ The following healthcare providers may perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with the care to be provided by Chuback Medical Group:

<table>
<thead>
<tr>
<th>Name</th>
<th>Practice name</th>
<th>Mailing address</th>
<th>Telephone number</th>
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</table>

➢ I should contact the coordinated care providers listed above directly to determine if they participate with my carriers and for information on the costs for their services.
➢ I should also contact my carrier for more information or consultation on the costs for the services of the coordinated care providers.

I acknowledge that I am knowingly and voluntarily accepting responsibility for any out-of-network financial responsibility associated with the health care services that I receive.

____________________________  ____________________
Patient Signature: Date:

____________________________
Patient Name:

Providers:  John A. Chuback, MD
       Jaime A. Bastidas, MD
       Kristen Socha, MS, PA-C
Financial Policy

Thank you for choosing Chuback Medical Group for your medical and surgical needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your overall treatment plan. The following is a statement of our Financial Policy, which we require every patient to read and sign prior to any treatment.

I ________________________________, assign Chuback Medical Group all of my rights and benefits under any insurance contract for payment for services rendered to me by Chuback Medical Group.

Please initial each statement

_____ I authorize Chuback Medical Group to file insurance claims on my behalf for service rendered.

_____ I request that payment from my insurance company be made directly to Dr. John A. Chuback.

_____ I direct that any and all payments go directly to Chuback Medical Group.

_____ I agree that in the event I receive any checks, or other payments subject to this Agreement, such payments will be held, endorsed to the Chuback Medical Group and forwarded to their office.

_____ I understand that Chuback Medical will not bill me in excess of what my insurance plan allows and that I am responsible for any charges that my insurance company deems my responsibility.

_____ I authorize Chuback Medical Group to release in writing or verbally, any medical information regarding treatment which may be needed for my care, or for processing medical insurance claims. This includes information directly related to obtaining precertification or predetermination of covered benefits by my insurance company.

_____ I authorize Chuback Medical Group to appeal any claims, precertification, and/or predetermination cases on my behalf.

_____ I certify that the insurance information that I have provided is correct.

_____ I agree that if I do not have health insurance, payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns regarding the above information. I have read the Financial Policy and I understand and agree to the Financial Policy.

Patient Name: ___________________________ Signature: _____________________________ Date: __________

205 Robin Rd. Suite 333
Paramus, NJ 07652
(201) 261-1772
Please share with us . . .

Here at Chuback Medical Group, we are passionate about helping you improve your total health and well-being. Tell us about any other areas of concern that you may have. Together we can achieve a new, incredible you.

Check any concerns that apply to you:

- Facial Lines and Wrinkles
- Facial Volume Loss
- Thin Lips
- Facial Rejuvenation
- Hand Rejuvenation
- Excessive Sweating
- Sun/Age Spots
- Suspicious Lesions
- Cellulite
- Unsightly Varicose Veins
- Unsightly Spider Veins
- Unwanted Hair
- Unwanted Fat
- Body Contouring
- Breast Augmentation/Reduction
- Buttock Augmentation/Reduction
- Tummy Tuck/Liposuction
- Skin Tightening
- Weight Loss
- Eyelash Enhancement
- Drooping Eyelids
- Hair Loss/Thinning Hair
- Other: ________________________________