Summit Surgical Institute

332 Summit Avenue, Hackensack, NJ 07601
Phone: (201) 488-6445 / Fax (201) 488-6441
390 Old Hook Rd., Suite 103., Westwood, NJ 07675
Phone: (201) 265-1588 / Fax: (201) 488-6441
410 Lakeville Rd., Suite 310, Lake Success, NY 11042
Phone: (516) 233-1952 / Fax (516) 233-1954
www.summitsurgicalinstitute.com

Roxana G. Kline, MD, FACS, RVT

Gary M. Kline, MD, MPH, FACS

Dear Patient,

We, at Summit Surgical Institute are committed to provide our patients with the highest quality and most comprehensive medical care. We want your first visit to our Office to be pleasant. Therefore, we have created this package of documents that you can read and complete at your leisure. This will help your first visit go smoothly. Also, please jot down any questions you may have and we'll go over them during your appointment.

INSTRUCTIONS:

1. Print this "Patient Registration Package."
2. Read the documents thoroughly.
3. Complete all blank fields and sign the documents.
4. Make a copy for yourself (if desired).
5. Bring the original documents with you to our Office on your first appointment but please keep the last 4 pages regarding "Notice of Privacy Practices" for your records.

*** KEY REMINDER ***

The following items are **REQUIRED** at the time of your Office visit:

1. INSURANCE CARD(S)
2. PHOTO IDENTIFICATION
3. WRITTEN REFERRALS FROM PRIMARY CARE PHYSICIAN (FOR ALL HMO INSURANCE)
4. OFFICE VISIT/SPECIALIST CO-PAYMENT*

* Our Office accepts cash, checks, and all credit cards.

Note: If you do **not** have the above with you at your scheduled office visit, **then the appointment will have to be rescheduled**.

Thank you for your cooperation,

Physicians at Summit Surgical Institute

INSURANCE ASSIGNMENT RELEASE

ASSIGNMENT RELEASE: I hereby authorize payment directly to Dr. Roxana G. Kline and Dr. Gary M. Kline for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Responsible Party Date

CANCELLATION NOTICE

Doctors Appointment:

Due to frequent no shows for appointments and late cancellations, we have been unable to accommodate patients in a timely manner. Therefore, we are instituting a policy of 24 hours in advance cancellation notification. If you do not cancel your doctor's appointment **at least 24 hours in advance** then you will be charged a fee of $25.00 for the appointment.

Vascular Lab Testing:

Summit Surgical Institute is instituting a policy of 24 hours in advance cancellation notification. If you do not cancel your testing appointment **at least 24 hours in advance** then you will be charged a fee of $50.00 for the appointment.

Surgical Procedures:

Summit Surgical Institute is instituting a policy of 48 hours in advance cancellation notification for any in office surgical procedures. If you do not cancel your appointment **at least 48 hours in advance** then you will be charged a fee of $100.00, prior to rescheduling surgical procedures.

I hereby agree and will be responsible for the fee if I do not abide to the cancellation policy notification. I understand that I will have to pay the fee before my next office appointment.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

PATIENT INFORMATION – 1

LAST NAME: _____FIRST NAME:_____SS#_____-_____-_____

DATE OF BIRTH: _____AGE:____SEX: M_____F_____ MARITAL STATUS: W__D__M__S__

ADDRESS: _____ APT#_____

CITY: _____STATE:_____ZIP:_____ PATIENT HOME #_____

BUSINESS # (_____) _____ -_____ CELL # (_____) _____- _____ FAX # (_____) _____ -_____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP_____

EMGERGENCY CONTACT # (_____) _____-_____ PATIENT E-MAIL _____

INSURANCE INFORMATION:

IS MEDICARE YOUR PRIMARY INSURANCE? YES_____NO_____MEDICARE ID# _____

WHAT IS YOUR PRIMARY INSURANCE: _____INSURANCE ID #_____

WHAT IS YOUR SECONDARY INSURANCE: _____INSURANCE ID #_____

WHOSE NAME IS INSURANCE UNDER? _____INSURANCE ID#_____

INSURED'S EMPLOYER_____

INSURED'S SS # _____-_____-_____ INSURED'D DATE OF BIRTH _____

YOUR RELATIONSHIP TO INSURED _____

REFERRING DOCTOR: NAME_____

ADDRESS_____

PHYSICIAN'S EMAIL: _____ # (_____) _____-_____ FAX # (_____) _____ - _____

FEDERAL REGULATIONS REQUIRE US TO OBTAIN YOUR PERMISSION TO DISCUSS YOUR PROTECTED HEALTH INFORMATION WITH ANYONE, INCLUDING FAMILY MEMBERS. PLEASE WRITE THE NAME AND TELPHONE NUMBER OF ONE FAMILY MEMBER OR FRIEND WITH WHOM YOU WISH US TO SHARE YOUR INFORMATION (OPTIONAL):

NAME: _____

TELEPHONE: _____

PATIENT INFORMATION – 2

IF YOU WISH ANY OTHER DOCTORS TO RECEIVE ANY REPORTS FROM US, PLEASE PROVIDE THE FOLLOWING INFORMATION:

	PHYSICIAN #1	**PHYSICIAN #2**	**PHYSICIAN #3**
NAME			
ADDRESS:			
ADDRESS:			
PHONE#			

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO BE RELEASED TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FIANANCING ADMINISTRATION OR ITS INTERMEDIARIES; CARRIERS OR ANY OTHER HEALTH INSURANCE COMPANY, ANY INFORMATION NEEDED FOR THIS OR RELATED MEDICAL CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST A PAYMENT OF MEDICAL INSURANCE BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT.

PATIENT SIGNATURE: _____ DATE: _____

Roxana G. Kline, MD, FACS, RVT
Gary M. Kline, MD, MPH, FACS
Summit Surgical Institute
Vascular, Thoracic and General Surgery

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____acknowledge that I have received a copy
(Name of Patient)

of Gary M. Kline, M.D. and Roxana G. Kline, M.D., LLC — Notice of Privacy Practices. This Notice describes how Gary M. Kline, M.D. and Roxana G. Kline, M.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
Signature of Patient or Personal Representative Date

_____
Relationship to Patient

PATIENT NAME: _____

DATE OF BIRTH: _____

SUMMIT SURGICAL INSTITUTE
PATIENT MEDICAL PROFILE – 1

CHECK ALL THE FOLLOWING THAT APPLY TO YOU:

Constitutional: _____ Fever ____ Chills _____ Night Sweats ____ Anorexia ____ Fatigue
____Weight Loss ____Cancer (Type/Status_____) ____Coagulation/Bleeding

Nutritional Status: _____ Excellent _____ Good _____ Poor

Neurological Status: ____Seizure/Epilepsy ____Stroke ____Lightheadedness ____Dizziness
____Balance Problems ____Headaches ____Transient Ischemic Attacks (TIA)

Eyes: ____ Double Vision ____ Blurred Vision ____ Cataracts ____ Glaucoma ____ Blindness

Ears, Nose, Mouth & Throat: _____Hearing Impairment (**Circle**): Right / Left / Both
_____ Hearing Aide _____ Difficulty Swallowing _____ Hoarseness

Cardiac: ____Heart Attack (years:___) ____Chest Pain/Angina ____Palpitations/Arrhythmia
____Pacemaker _____ Heart Murmur ____ High Blood Pressure ____High Cholesterol\
____Stress Test (when/where: _____) ____Aneurysm ___ CHF
____Carotid Stenosis ____Coronary Stent (PTCA) ____Deep Vein Thrombosis (DVT)
____ Stroke (Affected side ____Residual Symptoms ____Lightheadedness/Dizziness)

Pulmonary: _____ Pneumonia _____ Asthma _____ Cough _____ Coughing Up Blood
____Shortness of Breath (how much activity: _____) ____TB Exposure ____PPD+
_____02@ ____L/min ____Sleep Apnea ___Emphysema ____Oxygen Dependent
____Difficulty breathing when lying down (_____ # of pillows used)

Gastrointestinal: _____Heartburn _____ Ulcer Disease _____ Hepatitis _____ Nausea
_____Gall Bladder Problems/Stones _____ Bloody Stool _____ Vomiting
_____Blood from Rectum _____ Constipation _____ Diarrhea
_____Colonoscopy (List Dates:_____).

Genitourinary: _____ Kidney Disease _____ Blood in Urine _____ Difficulty Urinating
_____ Frequency _____ Urgency _____ Prostrate Problems ____Dialysis

Gynecologic: _____ Last Mammogram (date:_____) Result: ___Normal ___Abnormal
___Vaginal Bleeding / Other: _____

Musculoskeletal: ____Muscle Pain ____Bone Pain ____Joint Pain ____Arthritis ___Raynaud's
____Joint Swelling ____Arm/Leg Swelling ____Weakness ___Ulcerations ___Varicose Veins

Endocrine: ____Thyroid Disease ____Diabetes Melitus (____Age Diagnosed ____ Diet Controlled
____Insulin Dependent ____Oral Hypoglycemic Medication

Skin: ____Rashes ____Skin Cancer/Scleroderma

Psychiatric: ____Depression ____Anxiety

____Other Psychiatric Problems (Please List: _____)

Other Conditions not Indicated Above:_____
_____

PATIENT NAME: _____

DATE OF BIRTH: _____

SUMMIT SURGICAL INSTITUTE
PATIENT MEDICAL PROFILE – 2

Your occupation: _____Are you retired? ____Y ____N

Person to contact if you are unavailable:
Name: _____Telephone:_____
Relationship: _____Does this person live with you? ____Y ____N
Do you live in an apartment / house / mobile home / other_____
How many people live in your home? _____ How many stairs are there in your home? ____
Does anyone living in your home have a significant health problem? _____
If yes describe: _____
Do you have any of the following: (if you do, please bring a copy for our hospital chart).
_____ Advance Directive _____Living Will _____ Durable Power of Attorney

SOCIAL HISTORY:
Do you exercise? ____Y ____N. How often? _____Type of exercise:_____

Do you drink alcohol? _____Y ____N. Social _____ How often?____ How much?_____

Do you smoke cigarettes /cigars/pipe or chew tobacco? _____If yes, how may years? ____
Amount per day? _____ At what age did you start using tobacco? _____

Do you use recreational drugs? _____Y _____N If yes, what type? _____
How many years? _____

Do you have any blood relatives with a history of the following?
____ Peripheral Vascular Occlusive Disease ____Clotting problems ____Stroke
____ Heart Disease ____ Aneurysmal Disease ____ Venous Disease

PREVIOUS OPERATIONS AND HOSPITALIZATIONS: _____None _____Yes (describe below)

Date:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT NAME: _____

DATE OF BIRTH: _____

SUMMIT SURGICAL INSTITUTE
PATIENT MEDICAL PROFILE – 3

CURRENT MEDICATIONS

List all the medications you take below:
(include herbal and non-prescription drugs)

MEDICATION Please provide all information available.	**DOSE** Ex. 2pills-daily: 1 Tbsp. every 4 hrs.	**HOW OFTEN:** Note: Please indicate times per day.	**HOW LONG?**

ALLERGIES:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

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.**

I. What this Is This Notice? This notice describes the privacy practices of Roxana G. Kline, MD, FACS, RVT and Gary M. Kline, MD, MPH, FACS

II. Our Privacy Obligations

We are required by law to maintain the privacy of medical and health information about you **("Protected Health Information" or "PHI")** and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI in order to treat you, obtain payment for services provided to you and conduct our "health care operations" (e.g., internal administration, quality improvement and customer service) as detailed below:

- Treatment. We use and disclose PHI to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.

- Payment. We may use and disclose PHI to obtain payment for services that we provide to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care **("Your Payor"),** or to verify that Your Payor will pay for health care.

- Health Care Operations. We may use and disclose PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI to our office manager in order to resolve any complaints you may have and ensure that you have a pleasant visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Disclosure to Relatives Close Friends and Other Caregivers. We may use or disclose PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify the Office Manager

If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

C. Public Health Activities. We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

D. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

E. Health Oversight Activities. We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

F. Judicial and Administrative Proceedings. We may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

G. Law Enforcement Officials. We may disclose PHI to the police or other law enforcement officials as required or permitted or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

H. Decedents. We may disclose PHI to a coroner or medical examiner as authorized by law.

I. Organ and Tissue Procurement. We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

J. Research. We may use or disclose PHI without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure.

K. Health or Safety. We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

L. Specialized Government Functions. We may use and disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.

M. Workers' Compensation. We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

N. As required by law. We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Use and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described in Section III, we only may use or disclose PHI when (1) you give us your authorization on our

authorization form ("Authorization to Use and Disclose Health Information"). For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company, to your child's camp or school, or to the attorney representing the other party in litigation in which you are involved

B. Special Authorization. Confidential HIV-related information (for example, information regarding whether you have ever been the subject of an HIV test, have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have ever been potentially exposed to HIV) will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your medical care, and, in certain limited circumstances, to public health or other government officials (as required by law), to persons specified in a special court order, to insurers as necessary for payment for your care or treatment, or to certain persons with whom you have had sexual contact or have shared needles or syringes (in accordance with a specified process set forth in New York State law). HIV related information will not be disclosed under any other circumstances unless you sign a release form, which specifically authorizes the release of this information.

There is only one type of disclosure of confidential HIV related information which is permitted with the Authorization to Use and Disclose Health Information, as opposed to the HIV specific release form: disclosures to a third party payor for any reason other than obtaining payment for health care services rendered to you.

C. Marketing Communications. We must also obtain your written authorization prior to using your PHI to send you any marketing materials. (We can, however, provide you with marketing materials in a face-to-face encounter, without obtaining your authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining your authorization.) In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

V. Your Individual Rights

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to PHI, you may contact our Office Manager. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Office Manager will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Office Manager and submit the completed form to the Office Manager. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations. **Roxana G. Kline, MD, FACS, RVT and Gary M. Kline, MD, MPH, FACS will not send or receive PHI via e-mail.**

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us. All requests for access must be made in writing and must be notarized. If your request is sent via U.S. Mail it should be sent certified with a return receipt requested. Verbal requests and requests sent via fax will not be honored. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from the Office Manager and submit the completed form to the Office Manager. If you request copies, we will charge you [$0.75] for each page, payable in advance.

You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you (for example, records relating to venereal disease, abortion, or care and treatment to which the minor is permitted to consent himself/herself (without your consent) such as HW testing, sexually transmitted disease diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning services).

E. Right to Revoke Your Authorization. You may revoke your Authorization to Use and Disclose Health Information, 11W-related authorization, or marketing authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Office Manager identified below. [A form of Written Revocation is available upon request from the Office Manager].

F. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Office Manager and submit the completed form to the Office Manager. All requests for amendments must be in writing, notarized, and if mailed, should be sent certified with a return receipt requested.. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive An Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you [$25.00 per page, payable in advance] for the accounting statement

H. Right to Receive Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on April 14, 2003.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of the Practice. You may also obtain any revised notice by contacting the Office Manager.