Maryann Alessio, D.O., F.A.A.P.

PATIENT INFORMATION

Patient Name________________________________ Date of Birth____/____/______
Address________________________________ Home Phone______________
City______________ State______________ Zip Code________ Sex : Male Female
Work Phone______________ Cell Phone______________ Email______________
Social Security #______________ Marital Status : Single Married Widow Divorced Separated
Spouse______________ Date of Birth______________
Emergency Contact______________ Relationship______________
Home Phone______________ Cell Phone______________ Work Phone______________

RESPONSIBLE PARTY/SUBSCRIBER INFORMATION

Name______________ Relationship______________ DOB________ SS#__________
Address______________ City______________ State______________
Zip Code______________ Home Phone______________ Cell Phone______________

EMPLOYMENT INFORMATION

Company Name________________________________
Address________________________________ Phone__________
City______________ State______________ Zip______________

INSURANCE INFORMATION-PLEASE PRESENT CARD

Primary______________ Secondary______________
Subscriber______________ Subscriber______________
ID#______________ ID#______________
Group#______________ Group#______________
Co-Pay $______ Effective Date______________ Co-Pay $________ Effective Date__________
Referral Required Yes No Referral Required Yes No

Referred By________________________________

The above information is accurate and complete to the best of my knowledge. I will not hold my doctor or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

- I hereby consent to the treatment at this office. I realize that results of medical care cannot be guaranteed and that there may be complications resulting from treatment.
- I authorize my insurance company carrier to pay benefits to the medical provider and obtain records necessary to process claims.
- I realize I am responsible for all fees not covered by my insurance company.

Date__________ Signature________________________________ Relationship______________

Maryann Alessio, D.O., P.A.

MEDICAL HISTORY

CHIEF COMPLAINT

Main reason for visit today ____

____

____

MEDICATIONS

List of medications you are currently taking:

____

____

Pharmacy Name: ____________________

____

Phone: ____________________________

ALLERGIES

Drug Allergies: ____________________

____

____

Environmental Allergies: ____________

____

____

MEDICAL HISTORY

List any serious illness or operations (by year, if possible) ____________________

____

____

____

____

Women Only:

Are you pregnant: __ Yes __ No   Nursing? __ Yes __ No   Taking birth control pills? __ Yes __No

Check if you have or had any of the following:

__ Alcohol/Drug Dependency
__ Anemia
__Arthritis, Rheumatism
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Back Problems
__Blood Disease
__Blood Transfusion
__Cancer
__Chest Pain
__Chemotherapy
__Circulatory Problems
__Cortisone Treatments
__Constipation
__Concussion/Head Injury
__ Cough, Persistent
__ Cough up blood
__Diabetes
__Diarrhea
__Emphysema
__Epilepsy/Seizures
__Fainting
__Glaucoma
__Headaches/Migraines
__Heart Murmur
__Heart Problem
Describe__________
__Hemophilia
__Hepatitis
__High Blood Pressure
__HIV Positive
__ Kidney Disease
__ Liver Disease
__Mitral Valve Prolapse
__Nicotine Addiction
__Nervous Problems
__Pacemaker
__Psychiatric Care
__Radiation Therapy
__Rectal Bleeding
__Respiratory Disease
__Rheumatic Fever
__Sexually Transmitted Diseases
__Shortness of Breath
__Skin Rash
__Stroke
__ Swelling of Feet or Ankles
__Thyroid Problems
__ Toothache
__Tuberculosis
__Ulcer/Stomach Problems
__Urinating Blood
__Urinating Frequently
__Urinating Painfully
__Vaginal Discharge
__Vaginal Bleeding (irregular)
__Vision Problems
Glasses and/or Contacts
__Weight Loss (Recent)
__Other ______________

____

____

EXPLAIN: ____

____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date______________________   Signature________________________________

MARYANN ALESSIO, D.O.
349 PASSAIC AVENUE
NUTLEY, NEW JERSEY 07110

Protected Health Information

Due to Federal HIPAA Laws, we can no longer leave messages without your consent regarding your Protected Health Information (PHI). Please check off **ALL** that apply:

1. _____**Home Phone #** ____________________
   _____Yes, you may leave a detailed message
   _____Leave message with call back number only
   _____Leave message regarding appointment information only

2. _____**Cell Phone #** _____________________
   _____Yes, you may leave a detailed message
   _____Leave message with call back number only
   _____Leave message regarding appointment information only

3. _____**Written Communication**
   _____You may mail to my home address ______________________________

4. _____You may discuss my medical information with the following persons:

   Name:________________________________Relationship:___________

   Name:________________________________Relationship:___________

   Name:________________________________Relationship:___________

Appointment Cancellation Fees & Returned Check Fees

Effective March 1, 2004 we reserved the right to charge a missed appointment fee for appointments cancelled/missed without 24 hours notice. A message may be left on answering machine if office is closed. The fee for a routine/sick visit is $25.00 and the fee for physicals is $50.00 . Remember someone else could use that time who needs medical attention that day.

We reserved the right to charge a $25.00 service fee for all returned checks in addition to any Bank fee incurred. No checks will be accepted in the future. Cash or credit card only.

If you have any questions regarding the above office policy please feel free to discuss them with the office staff. Thank you in advance for your co-operation.

Patient Name: ____Date:_______________

Patient Signature:____

PATIENT CONSENT FORM

Maryann Alessio, D.O., P.A.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________

ITEM 070-5947/25941 © MAY 2002

New Jersey Department of Health and Senior Services
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-588-7512 (Fax 609-588-3642)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)

CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health and Senior Services (NJDHSS). The NJDHSS may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐Yes, I would like to participate in this program.

☐No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

Olde Towne Optimal Health

Maryann Alessio, D.O., F.A.A.P.
Board Certified Physician • Internal Medicine & Pediatrics

Dear Patients of Olde Towne Optimal Health:

Effective immediately, in an effort to provide efficient care and give our patients our fullest attention, we will reschedule patients who arrive **10 minutes or more** late for their scheduled appointment. You will be charged a missed appointment fee as agreed upon in your registration packet.

We will not see any patient without an appointment...Please call ahead if you would like an additional patient to be seen at the time of your appointment so we can better schedule you and other patients are not inconvenienced. Please understand that your time is scheduled for you so that you receive the attention you deserve and please refrain from asking medical advice or discussion of other family member's medical conditions at **your** scheduled appointment.

If you are scheduled for bloodwork only, you will not see the physician or nurse practitioner. If you need to be seen for any other complaints at that time, you will need to schedule an office visit with the physician or nurse practitioner. Any and all office visits including those with only the medical assistant will be required to pay a co-pay as per your insurance. Your co-pay is due at the time of your visit or services cannot be rendered.

Thank you for your co-operation.

Sincerely,

Maryann Alessio, D.O., F.A.A.P.

Effective June 15, 2011

____________________________ ____________________

Signature Date

349 Passaic Avenue, Nutley, N.J. 07110 • 973-667-8889 • Fax 973-667-5665

RECORDS RELEASE REQUEST

TO____

ADDRESS____

CITY___________________ **STATE**______________ **ZIP**________________

I hereby authorize the release of my medical records or copies of such and request that they are transferred to:

MARYANN ALESSIO, D.O., P.A.
349 PASSAIC AVE.
NUTLEY, N.J. 07110
973-667-8889
Fax# 973-667-5665

____
PATIENT NAME

____
PATIENT SIGNATURE