Welcome to the practice of Gary D. Schwartz, MD

If you are new to the medical practice of Gary D. Schwartz, we would like to take the time to welcome you and express our appreciation of your choosing this practice to provide you with your healthcare needs. If you are an established patient, we thank you for your continued selection of Gary D. Schwartz as your personal physician. Our practice functions as a Patient Centered Medical Home, what that means to you is that we incorporate a team based approach to your health care led by your physician to make it easier for you to access the care and assistance where and when you need it.

This letter contains the information needed about obtaining care through the practice of Gary D. Schwartz, MD, PC. If you are a new patient, our new patient forms can be printed directly from our website at garyschwartzmd.com. If you are unable to fill out the forms prior to your visit, we ask that you come in 20 minutes earlier than your scheduled appointment.

Office Hours

Monday 11:00am-6:30pm
Tuesday 9:00am - 5:00pm
Wednesday 9:00am - 3:00pm
Thursday 9:00am - 5:00pm
Friday 9:00am - 12:00pm
Saturday - One Saturday per month

Same Day Appointments

It is our goal to provide you with high quality medical care by our caring staff. Our office sets aside same day appointments for our patients on a daily basis. Depending upon the patients need and availability of these appointments, we will offer a same day appointment. Same day appointments are provided for sick visits, check ups, and if necessary, routine physical exams and pre-operative examinations. We do not recommend scheduling a visit for pre-operative examinations the day prior to surgery. Please note that these appointments may be taken rather quickly and we ask that if you need to see the physician on the same day, you call as early in the day as possible. Unscheduled walk-in appointments are highly discouraged, as you may have a very long waiting period. You may be asked to schedule an appointment for the next business day.
Cancellation of Appointments

We ask that you provide at least 24 hours notice to cancel an appointment. If, however, you are unable to provide us that much notice, please contact us as soon as possible so that we may accommodate another patient that requires medical care. Please also note that if you are more than 15 minutes late for your scheduled appointment, you may be asked to reschedule your appointment. This is to ensure that the doctor remains on time as much as possible and that we don’t keep our patients waiting.

Prescription Refills

If you require a refill other than at the time of your appointment, please contact your pharmacy and have them call our office. All refills are handled within a 24 hour period (electronically submitted to your pharmacy). Please make sure if you will run out of your medication over the weekend or on a holiday, you contact the pharmacy at least 48hrs prior. If you have not seen us within a year we will call in a 2 week supply but ask that you make an appointment within that time frame. This is to ensure your safety and it allows us to properly manage your care. Patients that are on maintenance medications should be seen at least every six months for check-ups.

Telephone Calls

If you feel the need to speak to Dr. Schwartz a message will be taken and given to him. He returns non emergent calls at the end of the business day after office hours. If the staff feels that the call is emergent, he will be asked to speak to the patient at the time of the call. It is preferred that any evaluation and treatment of a medical condition should be during a scheduled office visit, where you can receive the adequate care and attention.

After Hours Telephone Calls

Our physician is on call after hours for emergent and non emergent messages. Any patient that calls into our office after hours will be connected to our answering service. The answering service will then page the physician. The answering service will instruct the patient that a call should be returned to the within 15 minutes for emergent after hours calls and 1 (one) hour for non emergent calls. If the patient does not receive a call within 15 minutes for emergent calls, we ask that they contact the answering service again so they may re-page the physician. If you are concerned about whether or not to go to the ER or clinic, please contact the office and speak to the physician for medical advice. If the physician is unable to accommodate the patient after hours for non emergent care they are referred to the CVS Minute Clinic on Polify Road in Hackensack, NJ.

Coordination of Care for Specialists

Our physician will conduct a medical evaluation of your medical problem and your need for specialty care. If you believe you need to see a specialist, we ask that you make an appointment with Dr Schwartz so that he may evaluate the problem and make a determination of the need for, and nature of, the specialist. This allows us to send the proper reports and documentation to the specialist.
On behalf of Gary D. Schwartz, MD we thank you again for allowing us to participate in your health care needs and we look forward to continuing a relationship with you.

Sincerely,

Gary D. Schwartz, MD, Michele Baird, RMA, Office Manager, Alicia Kearny, CMA
INSURANCE AUTHORIZATION AND ASSIGNMENT
Date __/__/____

I authorize payment of medical benefits to undersigned physician of supplier for these services and full claims.

I authorize the release of any medical information necessary to process this claim and all future claims.

Signed (Insured or Authorized Person)

X

PATIENT INFORMATION

Last Name
First Name
Middle Initial
Street Address
City
State
Zip
Sex: (Circle one) Male Female
Date of Birth / / Age: 
Home Phone ( ) -
Social Sec No: - - -
Is the Patient currently employed? (Circle one) Yes No
Employer:
Employer Address:
Work Phone: ( ) -
Extension:
Cell Phone: ( ) -
Is the Patient a student? (Circle one) Yes No
Is the Patient? (Circle one) Single Married Separated Divorced Widowed
Email Address: Would you like access to MyMedicalLocker.com? Yes No
Race: (Circle one) American Indian Alaskan Native African American Native Hawaiian/Other Asian White Hispanic
Ethnicity: (Circle one) Greek Hispanic/Latino Italian Irish American Other
Primary Language: 
Do you suffer from any allergies? ______________________________________________

If you circled Married, please complete Spouse information below.

Spouse's Last Name
First Name
Middle Initial
Nickname
Date of Birth: / / 
Is the Spouse currently employed? (Circle one) Yes No
Employer:
Employer Address:
Work Phone: ( ) -
Extension:
Social Sec No: - - -

NEXT OF KIN INFORMATION

Give the name of nearest relative or of a close friend not living with you, to contact in case of emergency.
Name: 
Home Phone: 
Cell Phone: 
Relationship: 
Can we release medical information?: Yes No

Is this visit related to a work injury? (Circle one) Yes No
If Yes, Date of Injury: / /
Is this visit related to an auto accident? (Circle one) Yes No
If Yes, Date of Accident: / /

WORKER'S COMPENSATION OR NO FAULT INSURANCE ONLY

Insurance Company: ____________________________
Ins. Co. Address: 
City: State: Zip: 
Adjuster Phone: ( ) -
Employer: 
Claim No.:
Adjuster Name: ____________________________

Pharmacy Name: ____________________________
Pharmacy Phone: ____________________________

I allow Dr. Schwartz's office to download my E-Med electronic medication history.

X

Notice of Privacy:
The Department of health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations. You may request restrictions pertaining to parties you do want your PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment, or health care operations. If you have any questions, comment or objections to the privacy on this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our entire notice of privacy policies upon request.
Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<table>
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<tr>
<th>Immunizations</th>
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<tbody>
<tr>
<td>• Tetanus Date:</td>
<td>• Pneumonia Date:</td>
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<td>• Hepatitis Date:</td>
<td>• Chicken pox/Varicella Date:</td>
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<tr>
<td>• Influenza Date:</td>
<td>• MMR Date:</td>
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List any medical problems that you have been diagnosed with

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<th>Surgeries</th>
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<th>Hospitalizations</th>
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<th>Family Medical History</th>
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<tbody>
<tr>
<td>Mother</td>
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<tr>
<td>Father</td>
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<tr>
<td>Sister</td>
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<tr>
<td>Brother</td>
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</table>
# Gary D. Schwartz, MD, PC

## Patient Medication Log

### Patient Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Pharmacy Name &amp; Phone Number:</th>
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### Current Medications

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dosage</th>
<th>Times Per Day</th>
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<tbody>
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Do you give Gary D. Schwartz, MD consent to obtain your prescription history from your insurance company? Please initial.

YES________ NO________
Financial Policy

We are committed to providing you with the best possible care and your understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees and policies.

Due to rapid changes taking place in the health insurance industry, it is imperative that you are aware of the benefits and requirements of your insurance plan.

There is no way we can possibly know, or keep up to date with each insurance program's provisions. It is your responsibility to know and advise us of your plan's requirements in advance, each every time we provide service.

We will do our best to comply with your insurance company’s requirements. It is your responsibility to notify us of changes in information or insurance plans prior to seeing the physician.

Participating Plans: Patients are expected to pay the co-pay at the time of service. We will submit all claims to your insurance company.

Non Participating or Out of Network Plans: You are responsible at the time of service for your office visit unless other arrangements have been made. For your convenience we accept, cash, check, Amex, Visa, MC and Discover.

I acknowledge the original copy of this information.

Signature_________________________________________Date_________________

Print Name________________________________________________
Patient Confidentiality

Patient confidentiality is a prime concern in this practice. Please indicate below with whom our office can or cannot leave a message.

Please check where appropriate.

<table>
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<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Spouse</td>
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<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answering Machine</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

May we contact you at work?__________May we state who is calling?____________

Due to HIPAA regulations, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you.

Please list the people that we are able to discuss your situation.

1.
2.
3.
4.
5.

Print Name____________________________________

Please sign________________________________________Date:____________________
Gary D. Schwartz, MD PC
20 Prospect Avenue Suite 516
Hackensack, NJ 07601
(201) 488-8989 (551) 996-5765

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM
I hereby acknowledge that on ______________ I received the Notice of Privacy Practices from Gary D. Schwartz, MD PC, which sets forth the ways in which my personal health information may be used or disclosed by the practice of Gary D. Schwartz, MD, PC and outlines my rights with respect to such information.

________________________________________________________________
Patient's signature/Date
HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS YOUR INFORMATION. PLEASE REVIEW CAREFULLY.

OUR OBLIGATIONS:
We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you “Health Information) Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

FOR TREATMENT: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

FOR PAYMENT: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for treatment. You are also entitled to pay for your care without having a bill sent to your insurance company.

FOR HEALTH CARE OPERATIONS: We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES AND HEALTH RELATED BENEFITS and SERVICES: We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives of health-related benefits and services that may be of interest of you.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE: When appropriate, and unless you object, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

RESEARCH: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at record to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.
SPECIAL SITUATIONS:

**As Required by Law:** We will disclose Health Information when required to do so by international, federal, state or local law.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

**Business Associates:** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Transplant: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

**Psychotherapy Notes:** Any disclosure of Psychotherapy notes ad defined in 45 CFR 164.501 will require your authorization.

**Workers’ Compensation:** We may release Health Information for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may be exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities:** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement:** We may release Health Information if asked by a law enforcement official if the information is:

1. in response to a court order, subpoena, warrant, summons or similar process.  
2. limited information to identify or locate a suspect, fugitive, material witness, or missing person.  
3. about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person’s agreement.  
4. about a death we believe may result of criminal conduct. 
5. about criminal conduct on our premises.  
6. in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors:** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

**Inmates:** If you are an inmate of a correctional institution, we may release health Information to the correctional institution or law enforcement official. This release would be if necessary: 1. for the institution to provide you with health care; 2. to protect your health and safety or the health and safety of others; or 3. the safety and security of the correctional facility.
Fundraising: We may contact you as part of a fundraising effort. The information used for this purpose will not disclose any health condition, but may include your name, address, phone number, email address, etc. When contacted you may ask that we stop any future fundraising requests.

Marketing: Most of the uses and disclosures for marketing purposes, including subsidized treatment communications will require your authorization. In addition, most disclosures of your information that constitutes the sale of the information will require your authorization. We will obtain your authorization for any other use of your identifiable image that is unrelated to treatment, payment or health care operations.

WHEN WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES
Uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our office manager and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation. Any other uses not listed above will only be made with the authorization of the patient.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect a copy of this Health Information, you must make your request in writing, to the practice location where your care was provided. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records: If your Protected Health Information is maintained in an electronic format, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request. If it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you don’t want this form or format, a readable hard copy form will be provided. We may charge you a reasonable, cost based fee for the labor associated with transmitting the electronic medical record.

Right to Notification of a Breach: You must be notified following a breach of unsecured Protected Health Information.

Right to Amend: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing to the practice location where your care was provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member of friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to the practice
location where your care was provided. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out of pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Restriction on Service Paid Out Of Pocket: If you paid out of pocket (you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request in writing, to the practice locations where your care was provided. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website; wwwgaryschwartzmd.com.

Changes to this Notice: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future.

For More Information or to Report a Problem: If you have questions and would like additional information, you may contact the office at (201) 488-8989. If you believe your privacy rights have been violated, you can file a complaint directly with the Secretary of Health and Human Services in Washington (1-877-696-6775). There will be no retaliation for filing a complaint.

Effective Date 9/23/2014
RECORDS RELEASE AUTHORIZATION

To: ________________________________________________________________

Doctor or Hospital

I hereby authorize and request the release of my medical records to:

Gary D. Schwartz, MD PC 20 Prospect Avenue, Suite 516
Hackensack, NJ 07601
P: 201-488-8989 F: 551-996-5765

The complete history records in your possession, concerning my illness and/or treatment during the period from ______________ to ______________.

Name:______________________________________________________________

Address:____________________________________________________________

Signature________________________________________ Date:____________________