



Howard Anthony Rose, M.D.
Hospital for Special Surgery
535 East 70th Street
New York, New York 10021
212.606.1278



Patient Name: _____

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for Howard Anthony Rose, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have read and understand the Notice of Protected Health Information (PHI) Policy prior to signing this consent.

With this consent, my physician may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, my physician may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, my physician may e-mail to my home or other alternative location any items that will assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that my physician restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to my physician's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, my physician may decline to provide treatment to me.

This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

Patient or Guardian Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS/ AUTHORIZATION

I agree to provide Howard Anthony Rose, MD, PC with:

- Accurate and prompt information concerning my health insurance plan.
• Prompt notification, if any changes in my insurance plan or coverage occur during my course of treatment with Howard Anthony Rose, M.D.

I understand that I am financially responsible, in accordance with my subscriber contract and Doctor's plan participation contract:

- If my insurance plan denies payment because I fail to comply with its procedures, or
• If I provide incorrect information which causes a delay in submitting the claim, or
• If I fail to bring any referral forms or other documents which my insurance plan requires.

I hereby assign benefits to Dr. Rose and understand that in the absence of accepted insurance coverage, I/Legal guardian am responsible for full payment of services rendered and any attorney fees or collection fees.

Patient or Guardian Signature: _____ Date: _____

It is understood and agreed upon that my purpose of requesting an examination and treatment, is for medical purposes only, and not in connection with any pending, or proposed litigation. Should litigation arise, it is further understood, and agreed that the treating physician will not participate, in any way, in litigation, except to provide a true and accurate copy* of any medical records and/ or x-rays in the possession and control of this office pursuant to an authorization by the undersigned.

*Upon payment of customary copying charges

Patient or Guardian Signature: _____ Date: _____



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Name: _____ Height: _____ ' _____ " Weight: _____ LBS Date: _____

Pharmacy _____ Address: _____ Phone: _____

ALLERGIES TO ANY OF THE FOLLOWING:

	YES	NO
PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>
NOVACAINE	<input type="checkbox"/>	<input type="checkbox"/>
LATEX	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (NAME BELOW)	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY YES NO

DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>
GOUT	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE OR NERVE DISORDER	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS YES NO

BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
DIABETIC PILLS	<input type="checkbox"/>	<input type="checkbox"/>
OR SHOTS	<input type="checkbox"/>	<input type="checkbox"/>
CORTISONE	<input type="checkbox"/>	<input type="checkbox"/>
PLAVIX	<input type="checkbox"/>	<input type="checkbox"/>
COUMADIN	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (NAME BELOW)	<input type="checkbox"/>	<input type="checkbox"/>

PREVIOUS ILLNESSES (INCLUDE DATE/YEAR):

ALL PREVIOUS OPERATIONS (INCLUDE DATE/YEAR):

REVIEW OF SYSTEMS:

PULMONARY / CARDIOVASCULAR

	YES	NO
DO YOU SMOKE?	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, GIVE # PACKS/DAY AND DURATION OF HABIT:		
CHRONIC COUGH	<input type="checkbox"/>	<input type="checkbox"/>
PRODUCTIVE OF SPUTUM	<input type="checkbox"/>	<input type="checkbox"/>
SHORT OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>
PALPITATION	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>
COUGH UP BLOOD	<input type="checkbox"/>	<input type="checkbox"/>
PREVIOUS HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>
PNEUMONIA	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL YES NO

DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>
CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD IN STOOL	<input type="checkbox"/>	<input type="checkbox"/>
DIVERTICULITIS	<input type="checkbox"/>	<input type="checkbox"/>
BLACK STOOL	<input type="checkbox"/>	<input type="checkbox"/>
ABDOMINAL PAIN	<input type="checkbox"/>	<input type="checkbox"/>
NAUSEA/ VOMITING	<input type="checkbox"/>	<input type="checkbox"/>
HISTORY OF ULCERS	<input type="checkbox"/>	<input type="checkbox"/>
RECENT WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>
CHANGE IN BOWEL HABITS	<input type="checkbox"/>	<input type="checkbox"/>
HISTORY OF JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>

BLEEDING HISTORY YES NO

HISTORY OF BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>
NOSE BLEEDS	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD IN URINE	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL YES NO

HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>
FAINTING	<input type="checkbox"/>	<input type="checkbox"/>
WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>

ORTHOPEDIC HISTORY YES NO

PAIN AT NIGHT	<input type="checkbox"/>	<input type="checkbox"/>
STIFFNESS IN JOINTS	<input type="checkbox"/>	<input type="checkbox"/>
DOES ASPIRIN HELP?	<input type="checkbox"/>	<input type="checkbox"/>

FEMALE PATIENTS YES NO

ARE YOU PREGNANT? YES NO

DATE OF LAST PERIOD _____

MENOPAUSE YES NO

BLEEDING SINCE MENOPAUSE YES NO

DATE OF LAST PAP SMEAR _____

IS THERE A LAWSUIT PENDING? YES NO

IF YES, DATE OF SUIT: _____