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	❑	❑
NOVACAINE	❑	❑
LATEX	❑	❑
OTHER (NAME BELOW)	❑	❑

_____

MEDICATIONS	YES	NO
BLOOD PRESSURE	❑	❑
DIABETIC PILLS	❑	❑
OR SHOTS	❑	❑
CORTISONE	❑	❑
PLAVIX	❑	❑
COUMADIN	❑	❑
OTHER (NAME BELOW)	❑	❑

_____
_____

FAMILY HISTORY	YES	NO
DIABETES	❑	❑
ARTHRITIS	❑	❑
GOUT	❑	❑
MUSCLE OR NERVE DISORDER	❑	❑

PREVIOUS ILLNESSES (INCLUDE DATE/YEAR):

_____
_____
_____
_____

ALL PREVIOUS OPERATIONS (INCLUDE DATE/YEAR):

_____
_____
_____
_____

REVIEW OF SYSTEMS:

PULMONARY / CARDIOVASCULAR

	YES	NO
DO YOU SMOKE?	❑	❑

IF YES, GIVE # PACKS/DAY AND DURATION OF HABIT:

_____

CHRONIC COUGH	❑	❑
PRODUCTIVE OF SPUTUM	❑	❑
SHORT OF BREATH	❑	❑
PALPITATION	❑	❑
CHEST PAIN	❑	❑
COUGH UP BLOOD	❑	❑
PREVIOUS HEART ATTACK	❑	❑
PNEUMONIA	❑	❑
HIGH BLOOD PRESSURE	❑	❑

BLEEDING HISTORY	YES	NO
HISTORY OF BLEEDING	❑	❑
NOSE BLEEDS	❑	❑
BLOOD IN URINE	❑	❑

ORTHOPEDIC HISTORY	YES	NO
PAIN AT NIGHT	❑	❑
STIFFNESS IN JOINTS	❑	❑
DOES ASPIRIN HELP?	❑	❑

IS THERE A LAWSUIT PENDING? **YES**❑ **NO**❑

GASTROINTESTINAL	YES	NO
DIARRHEA	❑	❑
CONSTIPATION	❑	❑
BLOOD IN STOOL	❑	❑
DIVERTICULITIS	❑	❑
BLACK STOOL	❑	❑
ABDOMINAL PAIN	❑	❑
NAUSEA/ VOMITING	❑	❑
HISTORY OF ULCERS	❑	❑
RECENT WEIGHT LOSS	❑	❑
CHANGE IN BOWEL HABITS	❑	❑
HISTORY OF JAUNDICE	❑	❑

NEUROLOGICAL	YES	NO
HEADACHES	❑	❑
FAINTING	❑	❑
WEAKNESS	❑	❑
SEIZURES	❑	❑

FEMALE PATIENTS	YES	NO
ARE YOU PREGNANT?	❑	❑
DATE OF LAST PERIOD_____		
MENOPAUSE	❑	❑
BLEEDING SINCE MENOPAUSE	**YES** ❑	**NO**❑

DATE OF LAST PAP SMEAR_____

IF YES, DATE OF SUIT: _____