

**A. JOSHUA ZIMM M.D., P.C.**  
FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M: \_\_\_ F: \_\_\_

Do you want to receive special offers and/or promotional emails from us? (Y/N)

Email Address: \_\_\_\_\_

Marital Status: Married: \_\_\_ Single: \_\_\_ Widowed: \_\_\_ Divorced: \_\_\_

Employer's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Social Security: \_\_\_ - \_\_\_ - \_\_\_ Allergies To Medicine: \_\_\_\_\_

Primary Care Doctor (first and last name): \_\_\_\_\_ Address: \_\_\_\_\_

Referring physician: \_\_\_\_\_ Referral Phone: \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

**Parent / Guardian / Spouse Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Primary Insurance**

Name of Insurance: \_\_\_\_\_

ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Insured's SS#: \_\_\_ - \_\_\_ - \_\_\_

Insured's Name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

**Secondary Insurance**

Name of Insurance: \_\_\_\_\_

ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Insured's SS#: \_\_\_ - \_\_\_ - \_\_\_

Insured's Name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

**Private Insurance Authorization for Assignment of Benefits/Information Release:**

I, \_\_\_\_\_, understand that office visit charges are payable on the day the service is rendered I authorize Dr. Zimm to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Zimm and myself.

\_\_\_\_\_  
Patient, Parent, Or Guardian Signature (if child is under 18 years old)

\_\_\_\_\_  
Date

# Health Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

1. Have you suffered from?

Yes No

Heart Disease	___	___
High Blood Pressure	___	___
Heart Attack	___	___
Emphysema	___	___
Asthma	___	___
Blood Disease	___	___
Kidney Disease	___	___
Glaucoma	___	___
Anemia	___	___
Diabetes	___	___
Jaundice/Hepatitis	___	___
Cancer	___	___
Anxiety	___	___
Depression	___	___
Easy Bruising	___	___
Facial Trauma	___	___
Dry Eyes	___	___
Eating Disorder	___	___
Elaborate as needed _____		

8. What medications do you use?

\_\_\_\_\_  
\_\_\_\_\_

9. Family History of Medical Conditions

___ Asthma	___ Heart
___ Cancer	___ High Blood Pressure
___ Diabetes	___ Stroke
___ Emphysema	___ Other: _____

10. Have you ever been hospitalized? \_\_\_ Y \_\_\_ N  
Please describe \_\_\_\_\_

11. Have you had cosmetic surgery? \_\_\_ Y \_\_\_ N  
Please describe \_\_\_\_\_

12. Have you had any other surgery? \_\_\_ Y \_\_\_ N  
Please describe \_\_\_\_\_

2. Do you take?

St. John's Wort	___	___
Aspirin	___	___
Ginko	___	___
Vitamin E	___	___

13. Have you ever had any of the following habits?

Smoking \_\_\_ Y \_\_\_ N Frequency \_\_\_\_\_  
Alcohol \_\_\_ Y \_\_\_ N Frequency \_\_\_\_\_  
Recreational Drugs \_\_\_ Y \_\_\_ N Frequency \_\_\_\_\_

3. Have you ever taken?

Fen Fen	___	___
Accutaine	___	___

14. Do you have any caps, crowns, bridges, or loose teeth? \_\_\_\_\_

15. Are you currently undergoing any dental work?  
\_\_\_\_\_

4. What medication(s) are you allergic to?  
\_\_\_\_\_

16. How did you hear of our office?

___ Google	___ Ask.com
___ Yahoo	___ Facebook
___ AOL	___ Makemeheal.com
___ MSN/Bing	___ Other website
___ Friend/Family	___ Physican _____

5. Do you have any other medical problems?  
\_\_\_\_\_

6. Any other psychiatric history?  
\_\_\_\_\_  
\_\_\_\_\_

7. Are you pregnant? \_\_\_ Y \_\_\_ N

\_\_\_\_\_ **Financial Policy:**

I authorize A. Joshua Zimm, M.D., P.C. (“Dr. Zimm”) to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, and to any other insurance or managed care company covering me or my dependents or insurance beneficiaries, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare, insurance or managed care benefits for services rendered to me (my dependents or insurance beneficiaries, as applicable), be made directly to Dr. Zimm. If my insurance plan will not assign benefits to Dr. Zimm, then I understand that I am responsible for payment of all charges, regardless of whether or not I am later reimbursed by my insurance plan. I understand that I am responsible for all deductible, co-payment and co-insurance amounts and for all non-covered services. I further understand and agree that if my insurance plan sends payment to me rather than Dr. Zimm, I will immediately endorse the check to Dr. Zimm and forward it to Dr. Zimm to be cashed and applied to my account.

\_\_\_\_\_ **Health Information:** I hereby consent and authorize Dr. Zimm to use and disclose my health information, which includes all or any part of my medical records and any other information concerning my diagnosis or treatment, by and to its workforce members, health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of Dr. Zimm.

\_\_\_\_\_ I understand that, for example, my health information may be used or disclosed by Dr. Zimm to: provide for my care and treatment, including the filling and supplying of prescriptions; communicate among various health care professionals who are involved in my care or treatment; obtain payment for care and treatment provided by Dr. Zimm; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations.

\_\_\_\_\_ I have read and understand Dr. Zimm’s HIPAA Notice of Privacy Practices, which is available in the office and contains information on the uses and disclosures of my protected health information. I understand that Dr. Zimm has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, Dr. Zimm will post a new notice in the office. I may contact Dr. Zimm at any time to obtain a current copy of the HIPAA Notice of Privacy Practices.

\_\_\_\_\_ I agree that Dr. Zimm may disclose my protected health information to a family member, close personal friend, or other caregiver, who is involved with my healthcare and/or payment relating to my healthcare. In that case, Dr. Zimm will disclose only information that is directly relevant to the person’s involvement with my healthcare and/or payment relating to my healthcare unless I request otherwise. I agree that Dr. Zimm may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist Dr. Zimm in carrying out its business and healthcare operations including, but not limited to, appointment reminders, insurance items, any clinical care matters and laboratory results. Dr. Zimm may also mail such information to my home or other designated locations.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

# A. JOSHUA ZIMM M.D., P.C.

FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Email is one of several options available for doctor-patient communication. The main advantage of email is convenience. The main disadvantages are a potentially slow response time and a potential lack of privacy. Accordingly, email should not be used for communication of sensitive or private information or matters that require prompt attention.

Patients of A. Joshua Zimm, M.D., P.C. have the option of communicating with Dr. Zimm or the office staff by email. Prior to doing this, you need to read through this policy sheet carefully and sign it below. First of all, **you must always include your full name and date of birth in any email messages.**

Occasionally, emails are not received due to spam filters and other computer and internet issues. Accordingly, if you do not receive a response to your email, please call the office. It generally takes 1-2 business days for Dr. Zimm to answer emails. If this is too long for you to wait for an answer, then please call the office at 212-327-4600. If Dr. Zimm's response will take longer than normal due to something like being away at a conference, the automatic notice will let you know.

Email is only appropriate for certain types of doctor-patient communication. Specifically, email is useful for fairly simple, non-urgent questions. For example, an appropriate email question is asking if an over the counter medicine is okay to take with your prescription medications so long as you do not require an immediate response. Email may also be used to request a routine medication refill. **Under no circumstances should email be used if the matter is urgent or in an emergency.** If the matter is urgent or an emergency exists, please call the office or 911 or seek medical attention at a hospital emergency room.

Dr. Zimm has the exclusive right to decide what is and is not appropriate for email. If Dr. Zimm decides that your question is not appropriate for email, you will be informed. This will generally be by email but may be by phone or some other method.

Dr. Zimm is generally the only one who will read emails sent to his email address. Sometimes, however, other members of the office staff may become involved in answering your question. Only the staff of Dr. Zimm will be reading messages sent to the "[info@drjoshuazimm.com](mailto:info@drjoshuazimm.com)" email address. For example, Dr. Zimm may ask one of the other staff members to look up some information to help answer your question.

Email messages travel through the internet. This means that the message is passed along a series of computers. This is not secure and it is possible for someone to read the email as it passes between computers. This is unlikely, but it is possible. Do not put anything into an email that you feel must remain confidential between you and your doctor. Email to and from Dr. Zimm is not encrypted.

If you have any questions about these policies, please ask Dr. Zimm or an office staff member. If you feel that you understand all of these policies and you would like to add email to the ways you communicate with Dr. Zimm, then sign and date below and return this form to the office.

Name \_\_\_\_\_

Signed \_\_\_\_\_

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 READ IT CAREFULLY.

This Notice will tell you about the ways we may use and disclose health information that identifies you (“Health Information”). We also describe your rights and certain obligations we have regarding the use and disclosure of Health Information. We are required by law to maintain the privacy of Health Information that identifies you; give you this Notice of our legal duties and privacy practices with respect to your Health Information and follow the terms of our Notice that are currently in effect. This Notice covers A. Joshua Zimm, M.D., P.C. (“Dr. Zimm”) including its healthcare providers and support staff.

### **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.**

The following categories describe different ways that we may use and disclose Health Information.

#### **For Treatment**

We may use Health Information about you to provide you with medical treatment or services. We may disclose Health Information to doctors, nurses, technicians, or other personnel who are involved in taking care of you.

#### **For Payment**

We may use and disclose Health Information so that we may bill for treatment and services you receive at Dr. Zimm and can collect payment from you, an insurance company or other third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for such treatment. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. In the event a bill is overdue we may need to give Health Information to a collection agency as necessary to help collect the bill or may disclose an outstanding debt to credit agencies.

#### **For Healthcare 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 for our operation and management purposes. For example, we may use Health Information to review the treatment and services you receive to check on the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians and other personnel for educational and learning purposes.

#### **Appointment Reminders/Treatment Alternatives/Health Related Benefits and Services**

We may use and disclose Health Information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

#### **Individuals Involved in Your Care or Payment for Your Care**

We may release Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend. We also may notify your family about your location and general condition or disclose such information to an entity assisting in a disaster relief effort.

#### **Research**

Under certain circumstances, we may use and disclose Health Information for research purposes. Before we use or disclose Health Information for research, however, we will ask for your specific written permission if the researcher will have access to your name, address or other information that reveals who you are.

### As Required by Law

We will disclose medical information about you when required to do so by international, federal, state or local law.

### To Avert a Serious Threat to Health or Safety

We may 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. Any disclosure, however, will be to someone who may be able to prevent the threat.

### Business Associate

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, under contract with us, 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 Donation

If you are an organ donor, we may release Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

### Military and Veterans

If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

### Worker's Compensation

We may release Health Information for worker's compensation or similar programs. Those 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: a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; 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 have been 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 and the patient agrees or we are required or authorized by law to make such disclosure.

### 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, governmental 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 for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; limited information to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are able to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or identity, description or location of the person who committed the crime.

#### National Security and Intelligence Activities and Protective Services

We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We also may disclose Health Information to authorized federal officials so they may conduct special investigations and provide protection to the President, other authorized persons and foreign heads of state.

#### Coroners, Medical Examiners and Funeral Directors

We may release Health Information to a coroner, medical examiner or funeral director so that they can carry out their duties.

#### How to Learn About Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about the protections.

#### Other Uses of Health Information

Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to us will be made only with written permission at any time by submitting a written request to our office, except to the extent that we acted in reliance on your permission.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights, subject to certain limitations, regarding Health Information we maintain about you.

### Right to Inspect and Copy

You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request.

### Right to Request Amendments

If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information and you must tell us the reason for your request. You have the right to request an amendment for as long as the information is kept by or for Dr. Zimm. A request for amendments must be submitted, in writing, to the office at the address provided in this Notice.

### Right to an Accounting of Disclosures

You have the right to request an “accounting of disclosures” of Health Information. This is a list of certain disclosures we made of Health Information. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.

### 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 about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

### 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. 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 request a copy of this Notice at any time from the office.

### How to Exercise Your Rights

To exercise your rights described in this Notice, contact the office.

### Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective for Health Information we already have as well as any information we receive in the future.

### Complaints

If you believe your privacy rights have been violated, you may file a complaint with Dr. Zimm or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.