

**Patient Information**

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Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First M

Mailing Address: \_\_\_\_\_  
Street City State Zip

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_ How do you wish to be contacted?  Home Phone  Cell Phone  
 Work Phone  Email  By Mail

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

Employer's Address: \_\_\_\_\_

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

Spouse's Work Phone: (\_\_\_\_) \_\_\_\_\_

In case of emergency, who should we contact?

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

**For Minor Patients Only**

Responsible Parties Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First

Mailing Address: \_\_\_\_\_  
Street City State Zip

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relation to Patient:  Mother  Father  Legal Guardian

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

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

**Insurance Information** **I do not have insurance (initial)**

Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relation to Patient:  Self  Spouse  Parent

**Accident Information**

Is this due to an accident?  Yes  No Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_

Nature of Accident:  Car Accident  Occurred at Work  Dog Bite  Other: \_\_\_\_\_

To who have you made a report of your accident?  None  Auto Insurance  Workman's Comp  Other: \_\_\_\_\_

**Referral Source**

Were you referred by a Doctor?  Yes  No If yes, by whom? \_\_\_\_\_

Were you referred by a friend or relative?  Yes  No If yes, by whom? \_\_\_\_\_

If none of the above, please check who referred you:

- Newstalk 1230       B101.5       Mary Wash. University
  - Free Lance Star       Moss Clinic       Reputation       Yellow Pages       Our Website
  - Locate A Doc       Internet Search       Geico       Spots. Co. Schools       Mary Washington Hospital
  - American Society of Plastic Surgeons       News Story: \_\_\_\_\_
- Social Media: Face Book  Twitter  Google +  Other: \_\_\_\_\_

Are you planning for a special Event?  Yes  No

If yes, which type of event:  Wedding  Reunion  Vacation/Trip  Other: \_\_\_\_\_

Please check here if you prefer NOT to receive upcoming promotions by mail or email.

Please mark any problems you have now OR have had in the past.  **None Apply**

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Recent Cold/Flu	<input type="checkbox"/> Radiotherapy	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Frequent Heartburn
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Emotional Disorder
<input type="checkbox"/> Angina	<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting/Blackouts	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Leg Cramps/Pain	<input type="checkbox"/> Seizures	<input type="checkbox"/> Migraine/Headaches	<input type="checkbox"/> Steroid Use
<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Nerve Injury	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Sickle Cell
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Loose/Chipped Teeth	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Back Injury	<input type="checkbox"/> False Teeth/Caps	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Neck Injury	<input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Clotting problems
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Difficulty Opening Mouth
<input type="checkbox"/> Asthma	<input type="checkbox"/> Weakness	<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Other Problems not Listed: _____			<input type="checkbox"/> Unable to Exercise due to _____	

**Do you or have you ever suffered from a psychiatric illness?**  **Yes**  **No**  
**If yes please give us the Doctors name:** \_\_\_\_\_ **Doctors phone number** \_\_\_\_\_

Patient's Height: \_\_\_\_\_ feet \_\_\_\_\_ inches      Patient's weight: \_\_\_\_\_ pounds      BMI \_\_\_\_\_  
 Gastric Bypass patient?  Yes  No      If yes, when? \_\_\_\_\_ Have you lost more than 75 pounds in one year?  Yes  No  
 Reason for consultation? \_\_\_\_\_  
 Are you currently under a physician's care?  Yes  No      Reason? \_\_\_\_\_  
 Could you be pregnant?  Yes  No      Date of last Menstrual period: \_\_\_\_\_  
**Do you have Sleep Apnea?**  **Yes**  **No**      How is it being treated? \_\_\_\_\_  
**Do you use tobacco?**  **Yes**  **No**      \_\_\_\_\_ Packs/Day for \_\_\_\_\_ Years.  
 Do you drink alcohol?  Yes  No      \_\_\_\_\_ Drinks/Week.  
 Do you use "street" drugs?  Yes  No      What types? \_\_\_\_\_

**Have you experienced any of the following during or after receiving anesthesia?**  None

<input type="checkbox"/> Allergic Reaction	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hoarseness/Sore Throat	<input type="checkbox"/> Headaches
<input type="checkbox"/> Delayed Awakening	<input type="checkbox"/> Prolonged Weakness	<input type="checkbox"/> High Temperature	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Muscle Soreness	<input type="checkbox"/> Nausea and Vomiting	<input type="checkbox"/> Difficulty with Breathing Tube	

<b>Previous Surgeries/Procedures:</b>	<b>Date:</b>
_____	_____
_____	_____
_____	_____
_____	_____

<p><b>List Your Drug Allergies and Allergic Reactions</b>      <input type="checkbox"/> <b>If None check here</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Latex Allergy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Soybean Allergy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>List Your Current Medications, Vitamins, and Herbs</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Hormone Replacement?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Birth Control Pills</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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I hereby agree that the above information is correct and I hereby authorize Drs. Heppe, and Bautista to release any and all medical information to my insurance carrier or attorney for purposes of claims administration. This authorization is valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign Drs. Heppe, and Bautista all money to which I am entitled for medical and/or surgical expense relative to the services rendered by Drs. Heppe, and Bautista.

**Patient or Guardian's Signature:** X \_\_\_\_\_ **Date:** \_\_\_\_\_

## PLASTIC SURGERY SERVICES OF FREDERICKSBURG OFFICE AND FINANCIAL POLICY

Thank you for choosing Plastic Surgery Services of Fredericksburg. We are pleased to be of service to you and we are committed to providing you with the best care possible. Please review the following policies and feel free to discuss your questions with our staff. A copy of these policies will be provided at your request.

**Insurance:** We do participate with some insurance plans; however, we wish to emphasize the fact that your health insurance policy is a contract between you and your insurance carrier. It is important that you read and understand your policy and its requirements for coverage including pre-authorization of services. If we cannot obtain pre-authorization you will be responsible for any claims denied as a non-covered service. Filing your primary insurance is a service we provide if we participate with your primary insurance plan, but all charges are your responsibility from the date of service rendered. It is your responsibility for payment of any medical or surgical services provided by this office. If you provide outdated or incorrect insurance information, you will be responsible for any denied claims. Most plans have a timely filing period, so it is important that the information you provide our practice is the most current available. In the event we do not participate with your primary insurance plan, our office will not file your insurance claim and payment will be expected at time of services or two weeks prior to any surgical procedure. We will be pleased to supply you with the appropriate billing codes as well as other necessary documentation so you can successfully file the claim with your plan, with the exception of cosmetic procedures.

**Secondary Insurances:** We do not file secondary insurances.

**Breast Reconstruction:** If we are not contracted with your insurance, we will be considered Out-of-Network by your insurance plan. If your insurance plan requires a referral from your primary care physician, it is your responsibility to make sure you have it prior to your appointment. If no referral has been obtained, it is your option to pay for the visit in full at time of treatment or reschedule. PSSF will obtain authorization, if needed, from your insurance for surgical procedures related to breast reconstruction. PSSF will bill your insurance plan and accept usual/customary allowable from your insurance for breast reconstruction.

**Copays, Deductibles and Co-insurances:** Per your insurance company, your copay, deductible and co-insurance must be paid at the time services are rendered.

**Non-Elective Surgery:** In the event we do not participate with your insurance or the service is non-covered or deemed not a medical necessity, full payment is due two weeks prior to surgery. Deductibles and co-insurance are due two weeks prior to surgery. If we participate with your insurance, PSSF will assist you with pre-authorization for surgical procedures.

**Cosmetic Surgery:** Elective procedures, such as cosmetic surgery, require a deposit and must be paid in full two weeks prior to the surgical procedure. Patients will receive a price quote that outlines payment and terms for cosmetic surgical services. Personal checks are accepted three weeks prior to surgery. A reschedule fee of \$200 will be charged if you reschedule less than two weeks prior to your procedure.

**Forms of payment:** We accept cash, check, Visa, MasterCard, Discover and Care Credit. In Matters of dispute of payment or failure to pay, you waive your right to privacy under the HIPAA guidelines. If a check is returned, you will be charged a non-sufficient funds fee of \$50.00 and PSSF will no longer accept your personal checks. In the event of non-payment, you will bear the cost of collection, and/or court costs and reasonable legal fees should this be required.

**Appointments:** Our phones are answered during office hours from 8:30 am - 5:00 pm, Monday-Friday. After 5:00 pm you may leave a message with our answering service. Non-emergency messages will be returned on the next business day. Our on-call provider will return emergency calls as soon as possible.

**Late Policy:** Every effort will be made to fit you into the schedule if you are more than 15-30 minutes late. If we are running behind, we will do our best to notify you and assist you in rescheduling your appointment, if you so desire.

**Missed Appointments:** If you need to reschedule or cancel your appointment, please give us at least 24-hour notice. Failure to do so will result in a fee.

**Test Results:** Patients are called with **abnormal** test results. This includes tests performed in the office or ordered by this office. If you have not been called, but would like your results reviewed with you, please call the office. Keep in mind the following: Blood tests require 3-5 days Cultures require 5-7 days Pathology (biopsies) require at least 1 week.

**Prescriptions:** If you need a prescription refill or if you have lost your prescription, please leave a message with one of our staff. We will make every effort to call in or write your prescription within 48 hours of your phone call. When calling, you will be asked for your first and last name, your home/office number including a cell phone if available, the name of the prescription, and the name, phone number and address of your pharmacy. Please note, your insurance may not cover prescriptions that are related to cosmetic services. We will not pre-authorize prescriptions related to cosmetic services. Plastic Surgery Services of Fredericksburg may access information contained in the Virginia Prescription Monitoring Program files on all Schedule II, III or IV prescriptions dispensed to a patient.

**Fee for Completion of Forms or Letters:** A fee of \$20.00 per form will be charged for completion of forms or letters such as FLMA or Disability paperwork.

**VHI Reporting:** The Virginia Assembly passed HB2743 in 2001 which is a law requiring ambulatory surgical centers, hospitals, and physicians to provide certain information on outpatient surgical procedures. Your Social Security Number is required to be reported.

**Medical Record Requests:** Our fee for this service is based on Virginia code 8.01-413B which require that records be provided within 15 days for a charge not to exceed fifty cents per page for the first 50 pages and twenty-five cents for each additional page and a fee not to exceed ten dollars for searching, handling and mailing the records.

**Labs or Outside Tests:** Our providers may order blood work, pathology, EKG or chest x-ray to be done after your visit today. You will receive a bill from the laboratory or radiologist that performed the studies requested. Please call the laboratory or radiologist regarding these bills. They have their own billing offices and you should contact the telephone number on your bill. In addition, there may be some tests that your insurance will not cover. You will be billed by the laboratory/radiologist upon denial of your insurance. If you feel that laboratory/radiologist may not have all of your insurance information or incorrect insurance information, please call the billing telephone number on your laboratory/radiology bill.

**Delinquent Accounts:** Account balances in excess of 90 days may be turned over to a collection agency due to failure of payment. You will be responsible for all collection, court, and or attorneys' fees.

I have read Plastic Surgery Services of Fredericksburg financial and office policies. By signing below I agree to all terms set fourth by Plastic Surgery Services of Fredericksburg that apply to my account.

Patient/Guarantor Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

I understand that Plastic Surgery Services of Fredericksburg may use and disclosed my protected health information (PHI) for purposes of treatment, payment, and health care operations. In Matters of dispute of payment or failure to pay, you waive your right to privacy under the HIPAA guidelines. **I also acknowledge I have received, have been offered, or have received in the past, a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice and individuals involved in my care in the Practice may use and discloses my PHI.** As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at 540-371-7730. I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed PHI reliance on my prior consent. I understand that after 6 six years from my last office visit, the Practice may destroy my medical records. I understand in the case of a minor patient, the Practice will retain the medical record until the minor patient reaches 18 years of age and for a minimum of six years.

**X** \_\_\_\_\_ / / \_\_\_\_\_  
**Patient or Legal Surrogate Signature** Date Witness Signature

I further authorize the following to have access to my records pertaining to billing and treatment:  No One Authorized  
First and Last Names of Individual(s): Relation to Patient:

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

You **will** be contacted by our facility to remind you of any appointments, healthcare treatment options, billing inquiries, or other healthcare services that may be of interest to you. Please select at least one mode of communication where we can also leave a voicemail message.

May we contact you at home?  Yes  No Can we leave a message for you at home?  Yes  No  
May we contact you at work?  Yes  No Can we leave a message for you at work?  Yes  No  
May we contact you via Cell phone?  Yes  No Can we leave a message for you on your cell?  Yes  No  
May we contact you via e-mail?  Yes  No

Can a message be left with our Doctor's name and what the call is in reference to?  Yes  No

Is there anyone we can leave a message with?  Yes  No  
First and Last Names of Individual(s):

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

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only.  Yes  No  
First and Last Names of Individual(s):

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

If you pursue surgery, who can we discuss information pertinent to your procedure such as your post-operative care?  
First and Last Names of Individual(s):

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

Plastic Surgery Services of Fredericksburg, PC has provided me with a copy of my rights as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

**X** \_\_\_\_\_ / / \_\_\_\_\_  
**Patient or Legal Surrogate Signature** Date Witness Signature

Printed Patient's Name: \_\_\_\_\_ Chart# \_\_\_\_\_

# Plastic Surgery Services of Fredericksburg Consent for Blood Testing (HIV, Hep B, Hep C)

I understand that under Virginia Law, if while examining or treating me, any person employed by or under the direction and control of Plastic Surgery Services is directly exposed to my body fluids in a manner which may transmit HIV, Hepatitis B, or Hepatitis C, I will be deemed to have consented to testing for HIV, Hepatitis B, Hepatitis C infection and to the release of the test results to the exposed person.

X

\_\_\_\_\_  
**Patient or Legal Surrogate Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature



**CONSENT FORM FOR ePRESCRIBE PROGRAM**

**ePrescribe Program**

Plastic Surgery Services of Fredericksburg is enrolled in an electronic prescribing program. ePrescribing is a way for doctors to electronically send accurate, and legible prescriptions from the doctor’s office to the pharmacy.

**Consent**

By signing this consent form, you are giving consent to Plastic Surgery Services of Fredericksburg to utilize electronic prescribing and use your prescription medication history from other healthcare providers for treatment purposes.

**Initials** \_\_\_\_\_

By initialing above, I agree that Plastic Surgery Services of Fredericksburg may request and use prescribing medication history from other health care providers and send my prescriptions electronically to the pharmacy of my choice.

**Your Name (please print)**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

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

Drug Allergies: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all the above, I hereby provide informed consent to Plastic Surgery Services of Fredericksburg to enroll me in this ePrescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Print Patient Name \_\_\_\_\_

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_