Patient Information

Patient Information

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**

□ High Blood Pressure	□ Sinus Problems	□ Chemotherapy	□ Heart Disease	□ Jaundice
□ Recent Cold/Flu	□ Radiotherapy	□ Vertigo	□ Hiatal Hernia	□ Frequent Heartburn
□ Heart Attack	□ Emphysema	□ Liver Problems	□ Hepatitis	□ Tuberculosis
□ Chest Pain	□ Irregular Heartbeat	□ Pneumonia	□ Ulcers	□ Emotional Disorder
□ Angina	□ Anemia	□ Fainting/Blackouts	□ Stroke	□ Thyroid Disorder
□ Rheumatic Fever	□ Leg Cramps/Pain	□ Seizures	□ Migraine/Headaches	□ Steroid Use
□ Bleeding Tendency	□ Nerve Injury	□ Kidney Problems	□ Cancer	□ Sickle Cell
□ Hemophilia	□ Paralysis	□ Loose/Chipped Teeth	□ Bronchitis	□ Diabetes
□ Easy Bruising	□ Back Injury	□ False Teeth/Caps	□ Shortness of Breath	□ Glaucoma
□ Blood Transfusion	□ Neck Injury	□ Neck Pain/Stiffness	□ Breathing Problems	□ Clotting problems
□ Chronic Cough	□ Herniated Disc	□ Hoarseness	□ Heart Murmur	□ Difficulty Opening Mouth
□ Asthma	□ Weakness	□ Arthritis		

□ Other Problems not Listed: _____ □ 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

□ Allergic Reaction	□ Excessive Bleeding	□ Hoarseness/Sore Throat	□ Headaches
□ Delayed Awakening	□ Prolonged Weakness	□ High Temperature	□ Jaundice
□ Muscle Soreness	□ Nausea and Vomiting	□ Difficulty with Breathing Tube	

Previous Surgeries/Procedures:	**Date:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List Your Drug Allergies and Allergic Reactions □ **If None check here**	**List Your Current Medications, Vitamins, and Herbs**
_____	_____
_____	_____
_____	_____
_____	_____
Latex Allergy? □ Yes □ No	**Hormone Replacement? □ Yes □ No**
Soybean Allergy? □ Yes □ No	**Birth Control Pills □ Yes □ No**
	I am aware that if I pursue surgery, I will be required to stop taking hormone replacement / birth control 1 month prior to surgery _____ Initial

I hereby agree that the above information is correct, and I hereby authorize Drs. Heppe, Bautista, and Aflaki 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, Bautista, and Aflaki all money to which I am entitled for medical and/or surgical expense relative to the services rendered by Drs. Heppe, Bautista, and Aflaki.

Patient or Guardian's Signature: X_____ Date: _____

PLASTIC SURGERY SERVICES OF FREDERICKSBURG OFFICE AND FINANCIAL POLICY

Insurance: We do not participate with any insurance plans. It is your responsibility for payment of any medical, cosmetic, or surgical services provided by this office. Our office will not file your insurance claim and payment will be expected at time of service or two weeks prior to any surgical procedure. Any documentation and quotes are cosmetic and are not considered medically necessary by insurance companies.

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 cosmetic price quote that outlines payment and terms for cosmetic surgical services. Personal checks are accepted three weeks prior to surgery. A reschedule fee 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 Monday-Friday. After working hours, 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.

Cancellation Policy: If you need to cancel or reschedule your appointment, please give us at least 48-hour notice. Failure to do so will result in a fee. All prepaid consult deposits will be forfeited by you if you fail to cancel or reschedule at least 48-hours in advance of your scheduled appointment. Multiple no shows or multiple cancellations less than 48-hours will result in a deposit being taken prior to scheduling any appointment.

Late Policy: Every effort will be made to fit you into the schedule if you are more than 10 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.

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, please leave a message with one of our staff. We will make every effort to send your prescription electronically to your pharmacy on file within 48 hours of your phone call. 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.

Electronic Prescriptions: Plastic Surgery Services of Fredericksburg is enrolled in an electronic prescribing program per Federal Law. ePrescribing is a way for doctors to electronically send accurate and legible prescriptions from the doctor's office to the pharmacy of your choice. By signing this 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.

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, chest x-ray, CT Scan or MRI to be done after your visit today. You may receive a bill from the laboratory, imaging center or radiologist that performed the studies requested since your insurance company may not cover these tests related to cosmetic surgery.

Telemedicine Consultations: Telemedicine involves the use of electronic communications to enable health care providers evaluate, diagnosis, manage and treatment of a number of health care problems. Providers may include primary care practitioners, specialists, and or subspecialists. I give my permission to participate in telemedicine consultations with at Plastic Surgery Services of Fredericksburg. I understand that the consulting health care provider will be at a different location from me. I understand that telemedicine may involve electronic communication of my personal medical information. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent. Drs. Heppe, Bautista, Aflaki and such assistants will communicate by interactive video conferencing. I understand, and hold harmless PSSF, the potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that any quote given to me is only an estimate and not a guarantee of price or procedure until a complete medical exam may be performed by my physician.

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 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 those diseases and to release of the test results to the exposed person.

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.

Pharmacy Name: _____Phone #: _____

Pharmacy Address: _____

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 of 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 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# _____