TODAY'S DATE ***Tallahassee Plastic Surgery Clinic***

Last Name	First Name	Middle Initial	Marital Status S M W D	Sex _____ **M** _____**F**	Social Security #

Date of Birth	Age	Race	Home Phone __Preferred ( )	Cell Phone __Preferred ( )	Work Phone ___Preferred ( )

Street Address	City	State	Zip
Mailing Address (if different from above)	City	State	Zip

Employer Name	Employer Address	Job Title/Retirement Date	Email Address

Referring Doctor	Family Doctor Name and Phone #	Emergency Contact (Name and Phone #)

If patient is a Minor or you are the Guardian of Patient, please provide your information below:
GUARANTOR (FINANCIAL RESPONSIBILITY OF PATIENT) _____ IF legal guardian, please check if other than parents

Name	Relationship	Date of Birth	Social Security

Address	Phone # ( )

City	State	Zip Code

Employer (Company Name)	Job Title or Retirement Date	Phone # ( )

INSURANCE INFORMATION (please provide insurance cards)

Primary Insurance	Phone # ( )	ID #	Group #

Policy Holder's Name	Date of Birth	Social Security #

Policy Holder's Address(if Different)	***If AUTO, WORK, or Other related injury, please provide date*** / /

Secondary Insurance	Phone # ( )	ID #	Group #

Policy Holder's Name / Address (if Different)	Date of Birth	Social Security #

IMPORTANT PLEASE READ AND SIGN ***INFORMATION RELEASE***
Physicians and staff of the Tallahassee Plastic Surgery Clinic consider all patient information confidential. List all individuals with whom we may discuss your medical condition, test results, and/or treatment plan. Please sign below indicating you have given this authorization. **YOU MAY DISCUSS MY TREATMENT AT THE TALLAHASSEE PLASTIC SURGERY CLINIC WITH:**

1.	Relationship
2.	Relationship
Patient's Signature (if minor, parent/legal guardian signature)	Date

Patient's Signature↓ (if minor, parent/legal guardian signature) **Date↓** **Med Rec #↓** **Received by _____ Entered by _____**

_____ _____ _____ _____**Rawlings** _____**Harper** _____**Paredes**

TALLAHASSEE PLASTIC SURGERY CLINIC

Please note the following billing policies: We are providers for Aetna (Commercial-PPO, HMO, POS, MCR Advantage, First Health Rental PPO, Auto Service Products), CHP, Cigna, Coventry (HMO, POS,PPO, Healthy Kids), Florida Blue/BCBS(PPC,PPS,Network Blue, Medicare PPO, Federal), Medicare,Tricare, Beechstreet (Multi-Plan),Vocational Rehabilitation, United Healthcare (PPO, POS, HMO & Medicare Plans), Staywell/Wellcare (HMO, Medicare, Medicaid)

**You will be responsible for any co-payments required by your insurance company at the time of service. CHP (some procedures), Coventry, Tricare Prime, United Healthcare (HMO) and Vocational Rehabilitation may require you to have an authorization for each visit. Please make sure that you have received your authorization prior to your visit. **
Please Initial _____

If your insurance company was not listed above or if you do not have insurance, please be aware that you will be responsible for your office visits. We will be happy to file an insurance claim on your behalf provided we have all the correct information.

Office Visits - Payment / Co-payment is required on the day of the visit for any health plan.
Surgery - We will file for a non-cosmetic surgery and will wait sixty (60) days for your insurance company to pay. If we do not receive payment by that time, you will be responsible for payment.

Please be aware that we send all tissue specimens for pathological examination and you will be billed directly by the Pathology Department. Anesthesiology and hospital charges will also be billed separately
MEDICARE PATIENTS ONLY- Please sign the following lifetime authorization

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information for this or a related Medicare claim. I request that payment of authorized benefits be made on my Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization furnishing the services to submit a claim to Medicare for payment to me.

_____ _____
Patient Signature **Date**

ALL OTHER INSURANCE COMPANIES-Please sign the following lifetime authorization

I authorize payment of medical benefits to the undersigned physician or suppliers for service described and authorize the use of this signature for all insurance submissions.

_____ _____
Patient Signature (If Minor-Parent or Legal Guardian) **Date**

COSMETIC/PRIVATE PAY PATIENTS-Please sign

I certify that I have read the information above and will comply with financial obligations.

_____ _____
Patient Signature (If Minor-Parent or Legal Guardian) **Date**

***REASON FOR VISIT*:** _____

_____

Have you ever been to our office before? Yes _____ No _____ If yes, please give reason and date you were previously seen

_____

How did you hear about us? Please Check One: Doctor _____ Newspaper/Magazine_____ Other_____

Internet_____ Friend_____ Name_____

If Injury, date you were injured _____ Were you injured at work?_____ Were you involved in an auto accident? _____. If so, please provide all insurance information to our front desk to help process your claim.

*****MEDICATIONS – PLEASE REFER TO ATTACHED PAGE TO LIST CURRENT MEDICATIONS*****

ARE YOU ALLERGIC TO ANY MEDICATIONS?

Name of medication _____ Reaction _____

Name of medication _____ Reaction _____

Name of medication _____ Reaction _____

Date of last physical exam _____ Date of last tetanus shot _____

Have you ever been under the care of a psychiatrist/psychologist or had counseling? Yes _____No _____

Date of last mammogram _____ Location _____ Ordering Physician _____

Are you pregnant or have reason to suspect that you may be pregnant? Yes _____ No _____

Due Date: Month/Year _____Name of OB doctor? _____

PERSONAL HABITS	**Please explain:**	
Do you drink alcohol?	Yes ___ No ___	How much? _____
Do you smoke?	Yes ___ No ___	How much? _____
Have you ever smoked?	Yes ___ No ___	When did you stop? _____
Do you use drugs, such as:		
Marijuana, cocaine, heroin?	Yes ___ No ___	How much? _____

Are you at risk for AIDS or are you HIV positive? Yes ___ No ___

REVIEW OF BODY SYSTEMS: Do you now or have you ever had any of the following? Please explain:

Problems with eyes, ears, nose, throat, mouth	Yes ___	No ___
Heart or cardiovascular disease	Yes ___	No ___
Shortness of breath, respiratory/lung problems	Yes ___	No ___
Change in bowel habits, intestinal problems	Yes ___	No ___
Kidney/bladder problems, blood in urine	Yes ___	No ___
Muscle problems, broken bones	Yes ___	No ___
Skin problems, rash, cancer, etc.	Yes ___	No ___
Breast problems	Yes ___	No ___
Neurological problems, epilepsy, stroke	Yes ___	No ___
Diabetes, thyroid disorder	Yes ___	No ___
Stroke	Yes ___	No ___
Bleeding tendency	Yes ___	No ___
Sleep Apnea	Yes ___	No ___
Other	Yes ___	No ___

WEIGHT _____

HEIGHT _____

FAMILY HISTORY: Does anyone in your immediate family (not yourself) have a history of any of the following? Please explain:

	(Circle one)	
Heart disease	Yes or No	(Relationship)
High blood pressure	Yes or No	(Relationship)
Diabetes	Yes or No	(Relationship)
Stroke	Yes or No	(Relationship)
Cancer (Location)	Yes or No	(Relationship)
Bleeding disorder	Yes or No	(Relationship)
Other	Yes or No	(Relationship)

MEDICAL HISTORY:

Illnesses (Kind)	Date(s)	Were you hospitalized?
		Yes_____No_____
		Yes_____No_____
		Yes_____No_____
Surgeries		
		Yes_____No_____
		Yes_____No_____
		Yes_____No_____

I understand, and have, as correctly as possible, answered the above questions. I give my permission for the taking of photographs and these photographs may be used (if necessary) for submission to my insurance company, and agree to the taking of photographs during the remainder of my treatment as may be necessary for medical or legal purposes. I agree to cooperate fully with all planned and agreed upon care.

Patient Name _____ **Patient Signature** _____**Date**_____
(If minor, parent/legal guardian signature)

YOU will be required to provide us with a photo ID or Driver license with current address; current health insurance card; social security ID no. or social security card. If patient is a minor, parent or guardian must provide this information.

Staff Notes: _____

_____

_____

HIPPA Privacy Notice

I acknowledge that I have received a copy of the Notice of Privacy Practice for Tallahassee Plastic Surgery Clinic.

Patient Name _____ **Patient Signature** _____
(If minor, parent/legal guardian)

If you are a legal representative of the patient, please give us patient's name and describe your authority below:

_____

_____

The patient was unable / refused to sign.

_____
Office Staff of Tallahassee Plastic Surgery Clinic
+

Medication List_

Patient Name: _____ DOB:_____Date:_____
Preferred Pharmacy:_____
May we obtain your medication history from your Pharmacy? _____ Yes _____No_____

Medication	Dose	Frequency	Reason	Inactive –Initial/Date

Patient's Signature_____Date_____
(if minor, parent/legal guardian signature)

**********IF NONE, PLEASE WRITE N/A**********

-

Consent to Use or Disclose Information for Treatment, Payment or Healthcare Operations

I consent to the use or disclosure of my individually identifiable health information (Protected Health Information) by Tallahassee Plastic Surgery Clinic, herein after referred to as TPSC, for the purpose of treatment, payment or healthcare operations as their terms are defined in the federal HIPAA privacy rules.

My protected Health Information means health information, including my demographic information, collected from me and created or received by my health care provider, another healthcare provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have the right to review TPSC's Privacy Notice. I have the right to request restrictions. I have the right to revoke this consent. Such revocation must be submitted to TPSC in writing. The revocation shall be effective except to the extent that TPSC has already taken action in reliance on the consent.

TPSC may refuse to treatment if I (or an authorized representative) do not sign this consent form (except to the extent that the facility is required by law to treat individuals). If I (or authorized representative) sign this consent form then revoke consent, TPSC has the right to refuse to provide further treatment to me as of the time of revocation (except to the consent that TPSC is required by law to treat individuals).

I have read and understand this information. I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

_____ _____

Signature of Patient or Authorized Representative **Date**

_____

Please Print Name

Informed Consent Telemedicine

INSTRUCTIONS

This document explains the purpose of telemedicine – also known as "telehealth" and referred herein, collectively, as "telemedicine" – and outlines the benefits and risks of telemedicine.
It is important that you read the whole document carefully. Please initial each page. Doing so means you have read the page. Signing the consent agreement means that you agree to a telemedicine session with your doctor or one of the doctor's assistants (i.e. nurse practitioner, physician assistant, etc.).

GENERAL INFORMATION

Telemedicine is the distribution of health-related services and information via electronic and telecommunication technologies, such as computers and mobile devices, to access and manage health care services remotely. Telemedicine may include technologies you use from home or that your doctor uses to improve or support health care services. Telemedicine allows out-of-office patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions. Examples of telemedicine include videoconferencing, teleconferencing, transmission of images, e-health including patient portals, and remote monitoring of vital signs.

ALTERNATIVE METHODS OF MEDICAL CARE BESIDES TELEMEDICINE

In-person care is an alternative method of medical care to telemedicine.

BENEFITS OF TELEMEDICINE

The benefits of telemedicine include the following:

- Make health care accessible to people who live in rural or isolated communities.
- Obtain expertise of specialists.
- Provide support for self-management of health care.
- Quick and efficient medical evaluation and management.

RISKS OF TELEMEDICINE

As with any medical care options, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and assistant(s);
- Security protocols could fail, causing a potential breach of privacy and/or inadvertent disclosure of personal identifying information and/or protected health information;
- Lack of access to complete medical cords may result in adverse drug interactions, allergic reactions or other judgment errors;
- Overuse of medical care
- Unnecessary or overlapping of care.

CONSENT FOR THE USE OF TELEMEDICINE

1. I understand that the purpose of telemedicine is to provide health care services.
2. I permit my doctor and the doctor's assistants to use telemedicine in my care.
3. I understand that telemedicine means using phone and/or video to communicate with my health care team instead of seeing my team in person (face-to-face).
4. I understand that reasonable efforts will be made to protect my privacy, though there may be risk of inadvertent disclosure of my personal identifying information and/or protected health information.
5. I understand that I can ask questions and discontinue the use of telemedicine at any time I choose.
6. I understand that telemedicine does not replace other types of medical assessment and care. If I am not improving and have serious health concerns, I will seek immediate medical attention at an emergency facility.
7. ALL OF MY QUESTIONS REGARDING TELEMEDICINE WERE ANSWERED, AND THE FOLLOWING WAS EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:

a. THE CONCEPT OF TELEMEDICINE
b. RISKS AND BENEFITS OF THE USE OF TELEMEDICINE
c. ALTERNATIVE METHODS OF MEDICAL CARE

I CONSENT TO THE USE OF TELEMEDICINE IN MY MEDICAL CARE AND THE ITEMS THAT ARE LISTED ABOVE (1-7). I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS.

_____

Patient or Person Authorized to Sign for Patient Date/Time
Witness _____Date/Time_____

I have been offered a copy of this consent form (patient's initials) _____