

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 ()		Cell Phone ()		Work Phone ()		
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)

<u>Primary Insurance</u>		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 / /					
<u>Secondary Insurance</u>		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	

OFFICE USE ONLY

Has patient ever been at TMH? ___ Yes ___ No		Today's Date		Pre-Op Date / Time		Scheduled Date	
Proposed Patient Type ___ Outpatient ___ Inpatient ___ Recurring				Hospital Service			
Diagnosis/ICD-9 Code			Procedure / CPT Code				
Admitting MD			Primary Care Physician				

Surgery Information

Surgery Site		Est OR Time		Height		Weight		Difficult IV Access?	
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Patient's Signature ↓ (if minor, parent/legal guardian signature) Date ↓ Med Rec # ↓ Received by _____ Entered by _____

Hill Harper Paredes

TALLAHASSEE PLASTIC SURGERY CLINIC

Please note the following billing policies: We are providers for **CHP, VISTA(HMO, POS), BCBS(PPC,PPS,Network Blue, Medicare PPO, Federal), Medicare, Medicaid (Buena Vista), Tricare, Beechstreet, Vocational Rehabilitation, United Healthcare and Universal Healthcare insurances.**

****You will be responsible for any co-payments required by your insurance company at the time of service. CHP, Vista, Buena Vista, Tricare Prime, and Vocational Rehabilitation ALL require you to have your 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 ___

Other Yes ___ No ___

WEIGHT _____

HEIGHT _____

FAMILY HISTORY: Does anyone in your immediate family have a history of any of the following? Please explain:

Heart disease	Yes _____	No _____
High blood pressure	Yes _____	No _____
Diabetes	Yes _____	No _____
Stroke	Yes _____	No _____
Cancer (Location)	Yes _____	No _____
Bleeding disorder	Yes _____	No _____
Other	Yes _____	No _____

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** _____
 (if minor, parent/legal guardian signature)

HIPPA Privacy Notice

I acknowledge that I have received a copy of the Notice of Privacy Practice for Tallahassee Plastic Surgery Clinic. I understand that I may refuse to sign this acknowledgment.

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.

TALLAHASSEE PLASTIC SURGERY CENTER
2452 Mahan Drive, Suite 102
Tallahassee, Florida 32308

DISCLOSURE OF OWNERSHIP

Please be advised that the following physicians own an investment interest in Tallahassee Plastic Surgery Center, whose address is listed above:

Larry L. Harper, M.D.
Alfredo A. Paredes, Jr., M.D.

You are entitled to obtain the items or services for which you have been referred to Tallahassee Plastic Surgery Center from the provider or supplier of your choice, including the Tallahassee Plastic Surgery Center.

The names and addresses of alternate sources of the items or services for which you have been referred are as follows:

1. Tallahassee Single Day Surgery, 1661 Phillips Road, Tallahassee, Florida 32308.
2. Tallahassee Memorial Hospital, 1300 Miccosukee Road, Tallahassee, Florida 32308

ACKNOWLEDGMENT BY PATIENT:

I acknowledge disclosure of ownership to me by Tallahassee Plastic Surgery Center of the information set forth above.

WITNESS:

SIGNATURE OF PATIENT/LEGAL GUARDIAN:

Witness Signature

Signature

(Printed Name)

(Printed Name)

Date: _____

Date: _____

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 HIPPA 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 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