

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	

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 _____

____ 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

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 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

NOTICE OF LIMITED LIABILITY PURSUANT TO
SECTION 1012.965, FLORIDA STATUTES

I, ON BEHALF OF MYSELF, MY CHILD, AND/OR MY WARD,
ACKNOWLEDGE THAT I HAVE BEEN NOTIFIED THAT:

1. I, MY CHILD, AND/OR MY WARD, *WILL RECEIVE CARE PROVIDED BY
EMPLOYEES OF THE FLORIDA STATE UNIVERSITY BOARD OF TRUSTEES*
(HEREAFTER REFERRED TO AS "FSU") AT ONE OR MORE OF THE FOLLOWING
HEALTH CARE FACILITIES WHERE FSU EMPLOYEES PROVIDE PATIENT CARE:

TALLAHASSEE MEMORIAL HEALTHCARE

TALLAHASSEE PLASTIC SURGERY CLINIC

ALAMARCON HOLDINGS, LLC D/B/A
TALLAHASSEE PLASTIC SURGERY CENTER

2. I, ON BEHALF OF MYSELF, MY CHILD, AND/OR MY WARD, UNDERSTAND
THAT THE EMPLOYEES OF FSU ARE NOT EMPLOYEES OR AGENTS OF TALLAHASSEE
MEMORIAL HEALTHCARE, TALLAHASSEE PLASTIC SURGERY CLINIC OR
TALLAHASSEE PLASTIC SURGERY CENTER.

3. ADDITIONALLY, I, ON BEHALF OF MYSELF, MY CHILD, AND/OR MY WARD,
UNDERSTAND THAT LIABILITY, IF ANY, THAT MAY ARISE FROM THE CARE PROVIDED
BY THESE FSU EMPLOYEES IS LIMITED AS PROVIDED BY LAW. THE LAW PROVIDES
THAT "NEITHER THE STATE NOR ITS AGENCIES OR SUBDIVISIONS SHALL BE LIABLE
TO PAY A CLAIM OR JUDGMENT BY ANY ONE PERSON WHICH EXCEEDS THE SUM OF
\$200,000 OR ANY CLAIM OR JUDGMENT, OR PORTIONS THEREOF, WHICH, WHEN
TOTALLED WITH ALL OTHER CLAIMS OR JUDGMENTS PAID BY THE STATE OR ITS
AGENCIES OR SUBDIVISIONS ARISING OUT OF THE SAME INCIDENT OR
OCCURRENCE, EXCEEDS THE SUM OF \$300,000" (SECTION 768.28(5), FLORIDA
STATUTES).

PRINTED NAME OF PATIENT

PRINTED NAME OF AUTHORIZED
REPRESENTATIVE/GUARDIAN

DATE

SIGNATURE OF PATIENT OR
AUTHORIZED REPRESENTATIVE/GUARDIAN

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 (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
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_____	_____	_____	<input type="checkbox"/> Inactive-Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive-Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive- Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive- Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive- Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive- Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive- Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive- Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive- Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive-Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive-Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive-Initial/Date
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_____	_____	_____	<input type="checkbox"/> Inactive-Initial/Date
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Patient's Signature

Date

(if minor, parent/legal guardian signature)

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