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?

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 ___ **WEIGHT** ___________

Breast problems Yes ___ No ___

Neurological problems, epilepsy, stroke Yes ___ No ___

Diabetes, thyroid disorder Yes ___ No ___ **HEIGHT** ___________

Stroke Yes ___ No ___

Bleeding tendency Yes ___ No ___

Other Yes ___ No ___

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** ______________________**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: ____

____

____

CONSENT TO TRANSFER

I understand should a surgical and/or diagnostic procedure be performed on me at Tallahassee Plastic Surgery Clinic, it will be done as an outpatient basis and that Tallahassee Plastic Surgery Clinic does not provide 24-hour patient care. If my attending practitioner or any other duly qualified physician in his/her absence shall find it necessary or advisable to transfer me from Tallahassee Plastic Surgery Clinic in case of emergency or need for hospitalization, I consent and authorize the employees of Tallahassee Plastic Surgery Clinic to arrange for and effect the transfer to Tallahassee Memorial Hospital and to obtain verbal and written information regarding my medical care at the inpatient facility. I also understand that my attending practitioner has admitting privileges at Tallahassee Memorial Hospital.

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

____ □ Inactive-Initial/Date

____ □ Inactive- Initial/Date

____ □ Inactive- Initial/Date

____ □ Inactive- Initial/Date

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____ □ Inactive-Initial/Date

____ □ Inactive-Initial/Date

Patient's Signature ________________________________ Date ____________

(if minor, parent/legal guardian signature)

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