



MEDICAL HISTORY

Name _____ Date _____

Birthdate ____/____/____ Age _____ Height _____ ft. _____ in. Weight _____ lbs. BMI _____
(office use only)

Do you presently or have you ever experienced the following? **Y=yes, N= no** (circle one)

- | | | |
|-------------------------|---------------------------|-----------------------------|
| Y N - abnormal bleeding | Y N - abnormal clotting | Y N - artificial valves |
| Y N - asthma | Y N - cancer* | Y N - diabetes |
| Y N - emphysema | Y N - fever blisters | Y N - glaucoma |
| Y N - heart disease* | Y N - high blood pressure | Y N - mitral valve prolapse |
| Y N - pacemaker | Y N - seizures | Y N - sinusitis |
| Y N - skin condition* | Y N - stomach ulcers | |

*EXPLAIN: _____

Please list any other serious medical conditions that you have experienced: _____

Laser patients: Have you ever taken Accutane? Yes No If yes, how long ago? _____

Female patients: # Pregnancies _____ # Children _____ # Children breastfed _____

Last mammogram (approx. date) _____ Results Normal Abnormal

If considering breast surgery: Current bra size _____

Please list **ALL** previous surgeries you have had including cosmetic surgeries or procedures.

Surgery	mm/yy	Physician	Surgery	mm/yy	Physician
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please list all medications you are taking (including ibuprofen, aspirin, herbal supplements, etc)

Medication	Dosage	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

IF NECESSARY, CONTINUE MEDICATION LIST ON NEXT PAGE

MEDICAL HISTORY CONTINUED

Medication

Dosage

How Often

Are you **ALLERGIC** to any of the following? **Y=yes, N= no** (circle one) *SPECIFY BELOW

Y N - aspirin*	Y N - codeine*	Y N - demerol*
Y N - erythromycin*	Y N - iodine*	Y N - morphine*
Y N - penicillin*	Y N - sulfa drugs*	Y N - tetracycline*

***REACTION** _____

List additional drugs/items that cause allergic reactions (including tape, latex, jewelry, food, etc)

Do you consume alcohol? Yes No Socially? Yes No How Much? _____

FAMILY HISTORY

Breast cancer: No Yes Relationship _____

Skin cancer: No Yes Relationship _____

Bleeding disorders: No Yes Relationship/Specify _____

Other pertinent family history _____

I affirm that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status.

Patient/Guardian Signature _____ **Date** _____

ATTENTION SMOKERS

Do you smoke? Yes No If yes, how much _____

Did you smoke in the past? Yes No If yes, how long have you been smoke-free? _____

It is mandatory and medically necessary for patients who smoke to QUIT A MINIMUM OF TWO WEEKS PRIOR TO SOME SURGICAL PROCEDURES AND A MINIMUM OF TWO WEEKS AFTER THOSE PROCEDURES. PLEASE DISCUSS WITH YOUR SURGEON IF YOU CANNOT REFRAIN FROM SMOKING.

Yes, I can refrain from smoking _____ No, I cannot refrain from smoking _____

Patient/Guardian Signature _____ **Date** _____



INSURANCE INFORMATION QUESTIONNAIRE

ALTHOUGH YOUR PROCEDURE MAY BE COSMETIC AND NOT COVERED BY INSURANCE, PVPS REQUESTS TO HAVE YOUR INSURANCE INFORMATION ON FILE IN THE EVENT YOU HAVE AN INSURANCE PRODECURE IN THE FUTURE (IE. LESION REMOVAL)

Date _____

***PRIMARY INSURANCE COMPANY** _____ Ph# _____

Address _____

Policy # _____ Group # _____

Name of Insured _____ Relationship _____

***SECONDARY INSURANCE COMPANY** _____ Ph# _____

Address _____

Policy # _____ Group # _____

Name of Insured _____ Relationship _____

ACCIDENTS/INJURIES

Is your visit due to an injury? Yes / No

If Yes: (circle one) Work Injury Auto Accident Other (please specify) _____

Where did your injury occur? _____

Date of Injury _____ Type of Injury _____

Claims # _____ Auto Adjuster _____ Ph# _____

Workman's Comp Carrier _____ Ph# _____

I attest that the above information is true and complete:

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____



FINANCIAL DISCLOSURES AND AUTHORIZATIONS

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENT IDENTIFICATION

A current government issued photo ID and insurance card (if you are requesting us to bill your insurance) must be present at the initial visit. Failure to provide either of these may require us to collect our standard billed charges accrued on the day the services were rendered rather than the patient's out-of-pocket alone. It is our practice policy to photocopy your ID and insurance card(s) for our files. Patients must fill out patient information forms prior to seeing the physician.

APPOINTMENTS

24 hours notice must be provided in the event you cannot keep an office visit or consultation appointment at the discretion of each office. Should you not provide this notice; a cancellation fee of \$50 will then be added to your account, additionally.

REFERRALS

If your insurance plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be required to pay for the services rendered at the time of service.

EXPECTED AMOUNT DUE

By law we MUST collect your carrier designated co-pay/co-insurance and/or deductible. This payment is expected at the time of service. Please be prepared to pay the expected amount due at each visit. We will not bill an insurance company if we do not have a copy of your current card and a valid photo ID at the time of visit.

We bill primary and secondary insurances only, as a courtesy. If we are unable to verify your benefits, then you will be responsible for following up with your insurance.

MEDICARE

We will submit claims to Medicare for covered services. The patient will be responsible for the deductible and the 20% co-insurance for covered services, which can be billed to a secondary insurance if you have one.

TRICARE/MEDICAID RECIPIENTS

Our practice does not participate with these programs; therefore, you are responsible for services rendered.

FOLLOW UP CARE

If you have a surgical procedure that is billed to your insurance company, that procedure includes 90 days of follow-up care. Although additional SURGICAL care is not included, you will not be asked to pay co pays or coinsurances for follow-up visits received within the 90 days. If you are seen for a condition other than the one treated, your insurance company may be billed for this added condition and in turn, you could be billed for the out-of-pocket.

OUT OF NETWORK PLANS

You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges, if the UCR is in accordance with the American Medical Association's guidelines. All patients will be responsible for their co-pay, co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 90 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the appropriate provider's office.

PATIENT BALANCES

Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. All arrangements made for services will require an agreement signed by both patient and administrative staff. In the event you default on your account, collection proceedings will begin and you will be responsible for any additional collection charges incurred.

SHORT-TERM DISABILITY OR FAMILY MEDICAL LEAVE ACT PAPERWORK (FMLA)

Effective April 15, 2010, there will be a \$25 fee for each page of disability and FMLA paperwork that require our physicians and/or staff to complete on your behalf. Unfortunately, due to the time consuming nature of these forms, we have no choice but to impose this fee. Please feel free to speak with one of our staff members if you have questions regarding this matter.

PLASTIC AND RECONSTRUCTIVE PROCEDURES

Your insurance company requires that we bill our services to you using a coding system known as CPT (Current Procedural Terminology). Many codes that surgeons use to describe the service performed are found in the "surgery" section of the CPT code book. This does not mean that you had an operation. This is merely the way the CPT book is organized for ease of use by both the insurance companies and physicians. Your Insurance Company may cover the care rendered for "surgical" codes differently than for office visits. Therefore, your insurance explanation of benefits may reflect that the service was paid as a surgical procedure, with deductible and co-insurance guidelines applied. We encourage all of our patients to check with your insurance company and verify your benefits. You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

We accept cash, checks, MasterCard, Visa, American Express, Discover or CareCredit. REFUNDS: Payments made with cash or checks are refunded by check. Payments made by credit card are refunded to the same credit card used for payment.

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I have read and fully understand the above and authorize payment of the insurance benefits directly to Ponte Vedra Plastic Surgery/Ponte Vedra Ambulatory Surgery Center and my surgeon. I realize that I am responsible for any charges not covered by insurance. The signature furnished below shall suffice for all insurance forms on a continuing basis.

Patient/Guardian Signature _____ **Date:** _____



PATIENT AUTHORIZATION AND DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

INFORMATION DISCLOSURE AUTHORIZATION

I, _____ (name of patient) hereby give authorization to Ponte Vedra Plastic Surgery for the release of information concerning the status of my health care including appointments, test results, and operative status on surgery day, with:

- | | |
|--|-------------------------|
| 1) _____ | _____ |
| Name of authorized individual (i.e. friend or family member) | Relationship to patient |
| 2) _____ | _____ |
| Name of authorized individual (i.e. friend or family member) | Relationship to patient |

ACKNOWLEDGEMENT OF NOTICES

By initialing on each line item, I acknowledge that I have received a copy of the following notices:

- _____ Patient's Bill of Rights and Responsibilities
- _____ Ownership Notice to Patients
- _____ Notice of Policy Regarding Advanced Directives
- _____ Privacy Practices / HIPAA

Patient/Guardian Signature

Patient/Guardian Printed Name

Date

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Section 381.026, Florida Statutes

A PATIENT HAS THE RIGHT TO:

- Be treated with courtesy and respect, with appreciation of his/her dignity, and with protection of privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and is responsible for his/her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his/her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternative risks, and prognosis
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of a understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for the purpose of experimental research and to give his/her consent or refusal to participate in such research.
- Express complaints regarding any violation of his/her rights.

A PATIENT IS RESPONSIBLE FOR:

- Giving the health care provider accurate information about present complaints, past illness, hospitalizations, medications, and any other information about his/her health.
- Reporting unexpected changes in his/her condition to the health care provider.
- Reporting to the health care provider whether he/she understands a planned course of action and what is expected of him/her.
- Following the treatment planned recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His/her action if treatment is refused or if the patient does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

FILING COMPLAINTS

- If you have a complaint against a hospital or ambulatory surgical center, call the Consumer Assistance Unit at 1-888-419-2456 (press 1) or write to the address below:

AGENCY FOR HEALTHCARE ADMINISTRATION
CONSUMER ASSISTANCE UNIT
2727 MAHAN DRIVE, BUILDING 1
TALLAHASSEE, FLORIDA 32308

- If you have a complaint about a health care professional and want to receive a complaint form, call the Consumer Services Unit at 1-888-419-3456 (press 2) or write to the address below:

AGENCY FOR HEALTHCARE ADMINISTRATION
CONSUMER SERVICES UNIT
P.O. BOX 14000
TALLAHASSEE, FLORIDA 32317-4000

Agency for Health Care Administration
Visit us at www.FloridaHealthFinder.gov
Medicare Ombudsman, 1-800-MEDICARE

OWNERSHIP NOTICE TO PATIENTS

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has an ownership interest, Florida passed a law (the “Patient Self-Referral Act of 1992,” FL Statute Section 455.654). Under this law, I must disclose my ownership in this facility and tell you about alternative places where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care. You have the right to obtain healthcare items or services at a location or from a provider or supplier of your choice, including the facility in which I am owner. I assure you that you will not be treated differently if you do not chose the facility listed below in which I have an ownership interest.

Drs. C. Cayce Rumsey, Robert W. Burk, Paul J. Scioscia, and Brett J. Snyder

have an ownership interest in:

Ponte Vedra Ambulatory Surgery Center

Alternative facilities in which we do not have ownership:

Baptist Beaches Outpatient Surgery Center

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES

Advance directives **are not honored** at this facility and in the event of an emergency or life-threatening situation, advanced cardiac life support procedures **will be instituted** in every instance and patients will be transferred to a higher level of care.