Affiliates in Plastic Surgery, LLC

Patient Information ***To maintain compliance with the changes in health care and the electronic medical record, we are required by Meaningful Use Criteria to ask for the following information using the Centers for Medicare and Medicaid terminology.***

Name: _____

Mailing Address: _____

City:_____ **State:**_____**Zip Code:**_____

Preferred Email Address: _____

I expressly permit the Ambulatory Plastic Surgery Center Associates, Chtd, Michael P. Vincent, MD, FACS, and /or Practice Fusion.com (our EMR) to contact me using my preferred email as listed above. This will allow email reminders for appointments, applicable preventative care information, and your notice that you should be able to access your electronic medical record within 4 business days.

Home Phone:_____**Cell:**_____**Work:**_____

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ All

Okay to Text: ☐ Yes ☐ No

Birthdate:_____**Age:**_____**Gender:**_____**Marital Status:**_____**Preferred Language:**_____

Race:

☐ American Indian or Alaskan native
☐ Asian
☐ Black or African American
☐ White
☐ Native Hawaiian or other Pacific Islander
☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to Specify

Employer:_____**Occupation:**_____

Reason for Visit:_____**Who Referred You:**_____

Date of Injury:_____**Worker's Comp?:** ☐ Yes ☐ No **Auto Accident?:** ☐ Yes ☐ No

Emergency Contact

Name:_____**Relationship:**_____

Home Phone:_____**Cell:**_____**Work:**_____

Insurance Subscriber if other than self: Primary / Secondary (circle one or both)

Name:_____**Relationship:**_____

Birthdate:_____**Home Phone:**_____**Cell/Work:**_____

Assignment of Benefits/Authorization for Treatment

I hereby authorize treatment and authorize the provider of medical services to release information regarding these services for treatment, payment, and healthcare operations. Please refer to the Notice of Privacy Practices for specific information regarding this practice's use of protected healthcare information. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges incurred by me not covered by my insurance and also all legal, collection and returned check fees and or charges.

Signature:_____**Date:**_____

******PLEASE SIGN ABOVE: Patient or Authorized Representative (over 18 years of age) ******

Medical History **Patient Name:** _____

Height:_____Weight:_____Family Physician:_____

Previous Cosmetic Surgery:_____

Prior Surgery/Hospitalizations:_____

_____

List your medications, exact dosages, and how often taken:

_____

_____

List your allergies, age of onset of allergy, and specify the exact type of allergic reaction:

_____

_____

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

Have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____

Personal Medical History (Please identify relevant history with an "x")

Blood/Bleeding Disorders_____☐ Genital/Urinary Disorders_____☐ Heart Disease_____☐

High Blood Pressure_____☐ Kidney Disease_____☐ Liver Disease_____☐

Lung Disease_____☐ Neurological Disorder_____☐ Diabetes_____☐

Venereal Disease_____☐ Asthma_____☐ Hepatitis_____☐

Cancer_____☐ Ulcers_____☐ HIV_____☐

Growths_____☐ Tumors_____☐ Anesthesia Concerns_____☐

Please describe fully any positive responses: _____

_____

_____

Specify any significant FAMILY Medical History (list relationship of family member and specific diagnosis-be as exact as possible): _____

_____

_____

Affilates in Plastic Surgery, LLC

15245 Shady Grove Rd., Suite 155
Rockville, MD 20850

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Affiliates in Plastic Surgery, LLC appreciates the confidence you have shown in choosing us to provide for your health care needs. Our practice participates with almost all insurance plans. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage, preauthorize your surgery as possible and bill your insurance carrier on your behalf. Please note that preauthorization is not an absolute guarantee of payment and that you will be responsible for charges not covered by your insurance company.

Your health insurance policy is a contract between you and your health insurance company or your employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for ***referrals***, pre-certifications, pre-authorizations, limits on outpatient charges and any requirements for specific physicians, labs and/or hospitals to use. We encourage you to contact your insurance company if you have any questions regarding your benefits, copays, or deductibles.

You are responsible for payment of any ***deductible and co-payment/co-insurance*** as determined by your contract with your insurance carrier. Some insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. Our office includes a fully accredited surgical center that meets the same strict outpatient standards similar to hospitals***. Just like at the hospital, there will be a separate facility fee for all surgical procedures.***

I have read the above policy regarding my financial responsibility to **Affiliates in Plastic Surgery, LLC** for providing services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my primary insurer and/or secondary/tertiary insurer to pay any benefits directly to **Affiliates in Plastic Surgery, LLC** or my physician, the full and entire amount of bill incurred by me or the above-named patient.

I understand that I am financially responsible for all charges incurred by me not covered by my insurance and any and all legal/collection fees that may be required in their collection.

Patient/Guarantor Signature: _____Date: _____

Advanced Directives

Do you have an executed Advanced Directive? Yes ☐ No ☐

If you answer yes to the above, you are encouraged to bring the Directive with you. Every patient and/or patient representative has the right to make informed decisions regarding your patient care and/or the care of the patient that you represent. Our office can assist you with a copy of the Maryland Directives Form and Planning Guide. However, our center does not recognize advance directives. If an untoward event were to occur, our policy is to perform full CPR per ACLS guidelines and transfer the patient to the nearest hospital (Adventist HealthCare Shady Grove Medical Center).

Patient/Guarantor Signature: _____Date: _____

Affiliates in Plastic Surgery, LLC

15245 Shady Grove Road, Suite 155
Rockville, MD 20850
Phone 240-912-4708 FAX 240-912-6992

Use and Disclosure of Protected Health Information
PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Acknowledgement of Notification

Our **Notice of Privacy Practices** provides information about how **Affiliates in Plastic Surgery, LLC** may use and disclose protected health information about you and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and recent changes effective September 23, 2013.

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office. Our **Notice of Privacy Practices** is made available to you in our office and on our website, **www.plasticsurgerycare.com.**

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement.

*By signing below, you acknowledge the ability to review and/or the receipt of our **Notice of Privacy Practices.***

Patient's Signature _____ Date _____

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance Carrier benefits be made on my behalf to **Affiliates in Plastic Surgery, LLC** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient's Signature _____ Date _____

Print Full Name _____

FOR MORE INFORMATION OR TO REPORT A PROBLEM: PLEASE CONTACT THE HIPAA POLICY OFFICER FOR THIS PRACTICE. IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A WRITTENT COMPLAINT WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES. THERE WILL BE NO RETALIATION FOR FILING A COMPLAINT.

Affiliates in Plastic Surgery

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

_____ **Initials. CONSENT FOR TREATMENT:** By this document, I do hereby request and authorize AIPS (Affiliates in Plastic Surgery), its medical practices and providers to perform evaluation, treatment services and procedures as necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

_____ **Initials. CONSENT TO THE USE OF TELEMEDICINE:** I consent to the use of telemedicine, including various video and audio transmission, for interaction with my physician. I understand that there are risks that include security failure and breach of privacy and of personal medical information, in addition to poor transmission quality and the resulting limitation of evaluation and judgment. I also agree to disclose the geographic state in which I am present during a telemedicine visit.

_____ **Initials. INSURANCE AUTHORIZATION AND ASSIGNMENT**: I request that payment of authorized medical benefits is made on my behalf directly to AIPS for service(s) furnished to me. I authorize AIPS to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to AIPS. I hereby authorize that photocopies of this form to be valid as the original. I authorize AIPS and/or its legitimate agents to act on my behalf in requesting and filing an appeal regarding the rejection/denial medical services rendered. I acknowledge I am responsible for all charges for services provided which are not covered by my health insurance carrier or for which I am responsible for payment under my health insurance plan including (but not limited to) co-pays, co-insurances and deductibles. I also understand and acknowledge that in the case of out of network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge(s), and in the event my insurance plan does not reimburse these services provided to me, I will be responsible for any remaining balance.

_____ **Initials. REQUIRED REFERRAL:** Some insurance companies require a referral or authorization for office visits. If required, it is the responsibility of the patient to obtain and provide referral to our office; a $100 fee may be charged to patient if it is later determined referral was required.

_____ **Initials. PHOTOGRAPHIC CONSENT:** I consent to the taking of photographs or video of me or parts of my body in connection with the plastic surgery procedure(s) intended or performed. I understand that such photographs, videos or case histories may be published in print, visual or electronic media for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that in some circumstances these may portray features that shall make my identity recognizable. I understand that I have the right to revoke this authorization in writing at any time and that refusal to sign will have no effect on my medical treatment. I release and discharge Affiliates in Plastic Surgery, LLC. from all rights that I may have in the photographs, video, or case histories and from any claim that I may have relating to such use in publication.

_____ **Initials. INJECTABLE FEES:** Fees for in-office treatments such as Botox®, Dysport®, Restylane®, Juvederm®, chemical peels, and other similar procedures are payable in full at the time of your appointment and are non-refundable.

_____ **Initials. SURGICAL FEES:** For cosmetic procedures, a 50% deposit of the physician's fee is due at the time of scheduling surgery. The remaining 50% is due two weeks prior to the procedure or the surgery will be cancelled.

_____ **Initials. CANCELLATION/NO-SHOW FOR APPOINTMENTS:** Cancellation notice of 24 hours is required for all in office appointments. If proper notice is not given you may be subject to a rescheduling fee of $100.

_____ **Initials. CANCELLATION/NO-SHOW FOR IN OFFICE PROCEDURES:** Due to the large block of time reserved for in office procedures, cancellation notice of 3 business days is required or forfeiture of 50% deposit may occur.

_____ **Initials. CANCELLATION/NO-SHOW FOR SURGERY:** Due to the large block of time reserved for a surgery, last minute cancellations can create access-to-care problems as well as significant expenses for the office. If you need to cancel your surgery, please notify our office at least 14 days in advance. If you fail to do so, you will be charged a $250 administrative fee. This fee is not covered by your insurance and must be paid in full prior to rescheduling your procedure.

_____ **Initials.** We accept Visa, MasterCard, American Express, Discover, Debit, Cash and Check. Checks returned for insufficient funds (NSF) will incur a $50 charge (cash only). Payment for NSF funds must be made within 2 business days. We do not accept post-dated checks.

_____ **Initials. RELEASE OF INFORMATION:** I may authorize the use or disclosure of my protected health information to an individual or entity. A Medical Records Release form will be provided upon my request.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____ _____

Signature of Patient or Parent/Legal Guardian/Authorized Representative Date

Affiliates in Plastic Surgery

KAREO PATIENT PORTAL CONSENT FORM

The undersigned agrees and authorizes Affiliates in Plastic Surgery, LLC to send an email regarding the patient portal information to the below email. Additionally, I give my expressed consent for my medical and billing information to be made available using the Kareo Patient Portal. I understand I have the right to obtain a copy of this consent upon completion.

Patient Name: _____

Patient Date of Birth: _____

Email address: _____

If the email address does not belong to the patient, please complete the following:

Patient Representative: _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Representative ☐ Other: _____

I understand that my medical information is protected by both federal and state law. This consent may give the requesting user access to sensitive information related to the testing, diagnosis, or treatment for conditions including, but not limited to, HIV/AIDS or other communicable diseases, drug and alcohol abuse; mental, psychotherapy, or other behavioral health; genetic testing; or any condition expressly protected by Law. This consent will remain in effect unless I deactivate my account or provide written notice to the healthcare organization. If I am removed as a user from the account, I will no longer have access to the medical information communicated between the practice and patient.

I understand that my login credentials are unique to me and will not share this information with another individual. If I share this information, I further understand that health information disclosed may not be protected under federal or state law as it could be released by the individual gaining access. I acknowledge that I have read and fully understand this consent form.

☐ I wish to enroll in the Kareo Patient Portal ☐ I **decline** to enroll in the Kareo Patient Portal

_____ _____

First and Last Name Relationship to Patient

_____ _____

Signature Date