PENNSYLVANIA PLASTIC SURGERY ASSOCIATES, P.C.

_____Howard S. Caplan, M.D. _____Francine A. Cedrone, M.D. Account #_____

PATIENT INFORMATION QUESTIONNAIRE

Patient Name_____
Address_____
_____
City, State, Zip_____
Home Phone _____
Cell/Work Phone_____
Employer_____
Occupation_____
Birthdate_____Age_____Sex_____
S.S.#_____Marital Status_____

Resp. Party/Spouse_____
Address_____
_____
City, State, Zip_____
Home Phone_____
Cell/Work Phone_____
Employer_____
Occupation_____
Birthdate_____Age____Sex___
S.S.#_____

Email Address:_____

How did you hear about us?_____

Family Physician_____
(Name, Address & Phone #)

Referring Physician_____
(Name & Phone #)

Referring Family Member/Friend_____

Reason for Being Seen_____
( ) Insurance Visit ( ) Cosmetic Consult ( ) Second Opinion ( ) IME/Legal

INSURANCE COMPANY INFORMATION

Primary Insurance Company_____ ID# _____
Group #_____ Specialist Co-Pay Amount _____
Person Insured (name) _____
Medicare #_____
Secondary Insurance_____ID#_____

Check whichever applies:

( ) Auto Accident ( ) Workman's Compensation ( ) Attorney ( ) N/A

Employer/Attorney Name_____
Address_____
Claim #_____ Policy #_____
Date of Accident/Injury_____
Notes_____

Pennsylvania Plastic Surgery Associates, P.C.

Patient's Name_____ Date_____

Height_____Weight_____ Do you smoke?_____If yes, how much?_____

Alcohol use?_____ How much?_____

Are you allergic to any pills, drugs, or medications? (Y___) (N___) If yes, please list below.

_____

_____

Please circle yes or no to each of the following. <u>All questions must be answered</u>.

1. Have you ever had a reaction to a general anesthetic (being put to sleep)? YES NO
2. Have you ever had a reaction to local anesthesia (novacaine, etc.): YES NO
3. Do you have high blood pressure: YES NO
4. Do you have heavy scars? YES NO
5. Do you have frequent infections or boils? YES NO
6. Have you ever had excessive bleeding problems? YES NO
7. Have you ever had any significant emotional problems? YES NO
8. Have you ever been hospitalized for any reason (mental, emotional or physical)? YES NO
   Explain:_____
9. Have you ever had to seek Psychiatric or Psychological care? YES NO
10. Have you seen other Plastic Surgeons about the same problem that brings you here? YES NO
11. Have you had, or do you have, any chronic viral illness or immune problems? YES NO

Local Problems: Have you had any serious illness of the following? (Place a check on the line that applies.)

Brain	_____	Intestine	_____	Nervousness	_____
Eyes	_____	Abdomen	_____	Extremities	_____
Nose	_____	Kidney	_____	Endocrine (Thyroid)	_____
Breasts	_____	Urinary	_____	Jaundice	_____
Lungs	_____	Reproduction	_____	Bleeding Problems	_____
Heart	_____	Diabetes	_____	HIV	_____
MRSA	_____	Other	_____		

If you answered yes, please explain_____

_____

_____

If caused by injury, date of injury_____Motor Vehicle_____Pedestrian_____
Animal Bite_____ At Work_____Other_____

Maternal History: Have you ever been pregnant?_____ If yes, how many times?_____
How many children do you have?_____Are you pregnant now?_____

Previous Surgeries: Please list any operations, the year and if there were any complications._____

_____

_____

Serious Injuries: Please describe and give the year in which the injury occurred._____

_____

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List of Medications

Please include birth control, water pills, blood pressure, heart, tranquilizers, hormones, steroids, cortisone, blood thinners, aspirin, ibuprofen, etc.

Medication	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Pennsylvania Plastic Surgery Associates, P.C.

Patient Name:_____ Date:_____

ASSIGNMENT OF BENEFITS:

For Medicare Patients Only

We are participating physicians in Medicare and will bill both Medicare and any co-insurance that you may have. Medicare now requires, however, that you sign the following authorization below authorizing us to release information from your records.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: PENNSYLVANIA PLASTIC SURGERY ASSOCIATES, P.C. (Provider #553335) for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

(Patient's Signature) *(Date)*

FOR ALL OTHER INSURANCE CARRIERS

I authorize payment directly to PENNSYLVANIA PLASTIC SURGERY ASSOCIATES, P.C. for surgical and medical services received by me from its physicians. **I understand that I am ultimately responsible for unpaid balances**.

Date:_____ Patient's Signature: _____

_____

(or signature of Legal Guardian)

RELEASE OF MEDICAL INFORMATION:

Release of Medical Information

I authorize Pennsylvania Plastic Surgery Associates, P.C. to release any information acquired in the course of my treatment or examination to my insurance carrier, to my attorney, and if a workmen's compensation claim, to my employer and their insured.

Date: _____ Patient's Signature: _____

_____

(or Signature of Legal Guardian)

PHOTOGRAPH CONSENT:

Consent for use of Photographs

*I hereby authorize you to take appropriate photographs for purposes of completing my medical records, as illustrations for lectures to medical or non-medical audiences or for publication in medical books or journals.

Date: _____ Patient's Signature: _____

_____

(or Signature of Legal Guardian)

*Specific signed approval will be obtained prior to live use before a lay audience.

HIPPA NOTICE OF PRIVACY PRACTICES
PENNSYLVANIA PLASTIC SURGERY ASSOCIATES, P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students or house staff, licensing, and conducting or managing for other business activities. For example, we may disclose your protected health information to medical school students or residents that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; legal proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity, Military Activity and national Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

The following is a statement of your rights with respect to your protected health information.

Access to Your Protected Health Information:

Generally, you have the right to access, inspect and/or copy protected health information that we maintain about you. All requests for access must be made in writing and signed by you or your representative. If we deny your request, we will give you written reasons for the denial and explain any rights you may have to have the denial reviewed. We may charge you for copying services if the quantity of information to be copied and mailed is high. A determination of any applicable charges will be made after your request has been submitted and you will be advised of any such charges in advance.

Amendments to Your Protected Health Information:

If you believe that there are errors or missing information in your records that are maintained by us, you have the right to request that this protected health information about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. Any denial will state the reasons for the denial, your rights to have the denial reviewed, and your right to attach your objection to our denial to your record. If an amendment or correction you request is made by us, we will also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary.

Accounting for Disclosures of Your Protected Health Information:

You have the right to receive an accounting of certain disclosures made by us of your protected health information. Your request must include the time period for which you are requesting an accounting that may not exceed six years and may not include dates prior to April 24, 2005. This accounting will tell you what protected health information was disclosed, to whom, and for what purpose. You do not have the right to receive an accounting of disclosures made for purposes of treatment, payment and health care operatives for certain other limited purposes. Requests for an accounting must be made in writing and signed by you or your personal representative.

Restrictions on Use and Disclosures of Your Protected Health Information:

You have the right to request restrictions on certain of your permitted uses and disclosures of your protected health information for treatment, payment, or health care operations, though we cannot agree to restrict or limit any use or disclosure that is required by law. We will consider your request, but are not legally required to agree to it. However, we will attempt to accommodate reasonable requests where appropriate and if we agree to accommodate your request, we will abide by it. We retain the right to terminate an agreed-to-restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. Requests for restriction(s) must be made in writing and signed by you or your personal representative.

Confidential Communications:

You have the right to request to receive communications regarding your protected health information from us by alternative means or at alternative locations. You must request such confidential communication in writing. We will attempt to accommodate all reasonable requests.

Paper Copy of Notice:

You retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by email or other electronic means.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

PENNSYLVANIA PLASTIC SURGERY ASSOCIATES, PC

HIPPA Notice of Privacy Practices is available to you for your records.

Please sign below to acknowledge receipt of Pennsylvania Plastic Surgery Associates' Privacy Practices.

_____ _____
Print Name Signature

OR

Please sign below to acknowledge that Pennsylvania Plastic Surgery Associates' Privacy Practices were offered to me, and I declined copies.

_____ _____
Print Name Signature

I, _____, give permission to Pennsylvania Plastic Surgery Associates to provide information concerning my care to the following individuals:

_____	_____	_____
Name	Relationship	Telephone Number
_____	_____	_____
Name	Relationship	Telephone Number
_____	_____	_____
Name	Relationship	Telephone Number

Smoking, Second-Hand Smoke Exposure, Nicotine Products

(Patch, Gum, Nasal Spray)

Patients who are currently smoking, using tobacco products, or nicotine products (patch, gum, or nasal spray) are at a great risk for significant surgical complications of skin dying, delayed healing and additional scarring. Individuals exposed to second-hand smoke are also potentially at risk for similar complications attributed to nicotine exposure. Additionally, smokers may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco have a significantly lower risk of this type of complication. Please indicate your current status regarding the items listed below:

_____ I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

_____ I am a smoker or use tobacco/nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

It is important to refrain from smoking at least 6 weeks prior to your surgery and until your physician states that it is safe to return, if desired.

*I have read and understand the above information provided to me.

_____ _____

Signature Date

PENNSYLVANIA PLASTIC SURGERY ASSOCIATES, PC

Financial Disclaimer

I agree to be financially responsible for the payment of all bills, medical or cosmetic, including all fees not paid by my insurance company.

I acknowledge that I am responsible to know my insurance coverage and benefits, including whether or not Pennsylvania Plastic Surgery Associates, Dr. Howard S. Caplan and Dr. Francine A. Cedrone are **participating providers** of my insurance company.

I understand that if my insurance requires a referral, I must have one at the time of my visit or my appointment will be rescheduled for a later date. PA Plastic Surgery Associates is **not responsible** for contacting your PCP (Primary Care Physician's office) to obtain your referral.

I understand that if I have presented an invalid insurance card, if my insurance coverage has been interrupted or cancelled, if I have pre-existing conditions which would render my coverage invalid or if I fail to present a valid referral at the time of my visit, **I am financially responsible for the payment of all bills.**

_____ _____

Patient Name Date

_____

Patient Signature