Peninsula Plastic Surgery

Account#: **PATIENT INFORMATION**

Last Name **First Name** **Middle**

Address **City** **State** **Zip**

Home Phone: **Cell Phone**: **E-mail**:

Preferred way of contact? ______________________ **Restrictions for contacting you?** ❒No ❒ Yes If yes, List: ______________________

Age: **Birthdate**: **SS#**: ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: ❒ Other: _______ **Referred By:** ______________________________________

PATIENT'S EMPLOYER INFORMATION

Employer: ____ **Occupation**: ____

Work Phone: _________________________ **Ext**: ________ **Is it okay to call you at work?** ❒ Yes ❒ No

Address: ____ **Full Time** ___ **Part Time** ___

Street & Suite# City State Zip

EMERGENCY CONTACT

Name: ____ **Relationship to Patient**: ___________________________________

Home Phone: ___________________________ **Work Phone**: ___________________________ **Other**: __________________________

INSURANCE INFORMATION & AUTHORIZATION

Primary Insurance: **Are You Enrolled In Hospice? Y___ N ___**

Primary Insurance ID Number: Group Number:

Policyholder's Information (if other than the patient)

Name: ____ **Birthdate**: _____/______/__________ **SSN:**__________________________

Employer: ____ **Relationship to Patient**: _______________________________

Does this insurance require a referral? ❒ Yes ❒ No **Copay Amount**: $

Secondary Insurance: Secondary Insurance ID Number:

Group Number:

Policyholder's Information (if other than the patient)

Name: ____ **Birthdate**: _____/______/__________ **SSN:** ______________________

Employer: ____ **Relationship to Patient**: _______________________________

Does this insurance require a referral? ❒ Yes ❒ No **Copay Amount**:

Is this visit due to any type of accident? ❒ No ❒ Yes: **Date of Accident**: ___________________________

Type of Accident ❒ Auto: State? ___________ ❒ Work Related ❒ Other: ____

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practice (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgement. As provided in out Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

CONSENT TO TREATMENT

This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all diagnostic procedures and/or such medical, surgical, lab, or x-ray treatment, which in the judgment of my attending physician or his authorized agent may be considered necessary or advisable.

_________________________________ ____

Date Signature

Confidential Patient History Form

Confidential Record: Information contained herein will not be released unless you have authorized us to do so.

Account: **Name:**

Race: ______________________ **Ethnicity:** _____________________ ❒ I decline to answer

Preferred Language: _______________________ **Reason for Visit:** ____

PAST MEDICAL HISTORY

Have you had any serious illnesses in the last five years? ❒ Yes ❒ No

If yes, please list: ____

Please list all previous surgeries with dates:____

____

If you are a breast cancer patient, please provide the date of diagnoses: ___ ___/ ___ ___/ ___ ___ ___ ___

FAMILY HISTORY

Do you have a family history of? Diabetes: ❒ Yes ❒ No Breast Cancer: ❒ Yes ❒ No

Skin Cancer: ❒ Yes ❒ No Coronary Artery Disease: ❒ Yes ❒ No

Other: ____

____

REVIEW OF SYSTEMS

Have you had or do you have any of the conditions listed below?

- ☐ Abdominal Bleeding
- ☐ Active Infection
- ☐ AFIB
- ☐ Anemia
- ☐ Anxiety
- ☐ Back Problems
- ☐ Blood clots/DVT
- ☐ Breast cancer
- ☐ Breathing Problems
- ☐ Cancer____________
- ☐ Chest Pain/tightness
- ☐ Cholesterol(high/low)
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Defibrillator
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart palpitations/murmur
- ☐ Hepatitis (A, B or C)
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Immunity Problems
- ☐ Irregular Heart Rate
- ☐ Kidney Problems/Stones
- ☐ Mental Illness _____________
- ☐ MRSA
- ☐ Pacemaker (YES or NO)
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ STD _______________
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcer Disease
- ☐ Metals_________________
- ☐ Defibrillator (YES or NO)
- ☐ Implants ________________
- ☐ **No medical history**

Has a doctor advised you of a heart condition? What did he/ she say? _______________________________

Name of Cardiologist: ____

List any medical conditions that your physician should be aware of: __________________________________

Is there anything else that you would like to discuss with the doctor during your visit? ___________________

____

The above information is accurate and complete to the best of my knowledge.

Signature ____ **Date** ______________________________

Keep this form for your records

Peninsula Plastic Surgery's Financial Policy (Front)

Your Plan	What You Do	What We Do
Medicare	Pay your deductible and co-insurance (20% of the allowable.)	We will file Medicare for you.
Medicare secondary insurance	No payment due at time of service.	We will file Medicare and your secondary insurance for you.
Medicaid	Payment due at time of service.	We will file Medicaid for you. You will be reimbursed in the case that Medicaid pays your claim.
CareFirst & Blue Cross Blue Shield	Pay your deductible, co-insurance or co-pay at time of service. Supply a referral if necessary	We will check your eligibility before every visit and will file your Blue Cross insurance for you
United Healthcare	Pay your deductible, co-insurance or co-pay at time of service. Supply a referral if necessary.	We will check your eligibility before every visit and will file your United HealthCare insurance for you.
Informed, Conifer, OneNet, Coresourse, Coventry, Integra	Pay your deductible, co-insurance or co-pay at time of service. Supply a referral if necessary.	We will check your eligibility before every visit and will file your insurance for you.
Aetna & Aetna HMO	Pay your deductible, co-insurance or co-pay at time of service. Supply a referral if necessary.	We will check your eligibility before every visit and we will file your Aetna insurance for you.
Cigna	Payment due in full at time of service.	We will file your insurance for you and assign benefits to you so you will receive payment from your insurance plan.
HealthSmart	Pay your deductible, co-insurance or co-pay at the time of visit or place a credit card on file for the balance when the claim is paid. Supply a referral if necessary.	We will check your eligibility before every visit and will file your HealthSmart insurance for you.
Insurance we are not contracted with	Payment due in full at time of service.	We will file your insurance for you and assign benefits to you so you will receive payment from your insurance plan.
Worker's Compensation	You must have opened a claim with your employer to be seen. No payment due at time of service.	We will file your Worker's Compensation insurance for you. If payment is not received within 120 days, balance is forwarded to the patient.
Automobile Accident	You must have opened a claim with your insurance company to be seen. Full payment due at time of service or supply current medical health insurance.	We will call to find out the terms of and will file your automobile insurance for you. We do not file medical insurance if we know your automobile insurance is responsible.

Peninsula Plastic Surgery's Financial Policy (Back)

Patients Name _________ **Date of Birth** __________

AGREEMENT TO PAYMENT POLICY
I acknowledge that I received a copy of Peninsula Plastic Surgery's financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION
I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to the third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state and local laws. I further authorize any other individual or entity that has provided health care to me to release to Peninsula Plastic Surgery, any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS
I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Peninsula Plastic Surgery for any services provided to me and/ or my dependents. I authorize any holder of medical information about me and/ or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT
I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to Peninsula Plastic Surgery are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to the third party collection agency, I agree to be responsible for a $25.00 collection processing fee and or interest due to amounts in default.

Installment Agreement
In the event you are unable to make payment in full, a payment plan can be set-up. The Set-up and Management fee for this service is $25.00 and must be paid prior to your first payment due date.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES
I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Peninsula Plastic Surgery.

______________________________________ __________________________
Patient's Signature Date

______________________________________ __________________________
Responsible Party Relationship to patient

Medicare Patients Only- Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of my medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits payable for 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 release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees 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:** _________________________

Peninsula PLASTIC SURGERY P.C.
Vincent Perrotta, MD | Christopher Pellegrino, MD
Kerri Holloway, CRNP

Date:
Account #:
Name: **Ht:**_______________ **Wt:**_______________

SOCIAL HISTORY

Do you smoke tobacco? ❐ Yes ❐ No How many packs per day?_________________ How many years? _________

Do you have a history of smoking? ❐ Yes ❐ No If yes, when did you quit? ____________________________________

Do you consume alcoholic beverages? ❐ Yes ❐ No How many drinks/ beers per week? _______________________

Do you use recreational drugs? ❐ Yes ❐ No If yes, please list: ____

FLU VACCINE HISTORY

Did you get a flu vaccine? ❐ No, I did not want it ❐ No, I am allergic ❐ No, I have an egg allergy
❐ Yes, I received one on my own, if yes what pharmacy did you use? ______________________
❐ Yes, I received one at surgery

MEDICATION HISTORY

Are you enrolled in a pain management program? ❐ Yes ❐ No
If yes, please list your current doctor:_________________________________

Are you allergic to any medications or other substances: ❐ Yes ❐ No **If yes, please list:**

Medications you are allergic to	Reaction

Please list any and all medications you are taking by name and dosage

Primary Care Physician:_______________________ **Referring Physician:**___________________

Preferred Pharmacy:____________________________ **City:**_________________________

Medication	Dosage	Frequency	Reason For Taking This Medication

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, , authorize Dr. Perrotta and/or Peninsula Plastic Surgery P.C., and/or their representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please **initial** in the boxes marked Yes or No for each item)

Yes	No	Medium
		in the office **photo album** for prospective patients.
		in office **seminars** for prospective patients.
		on our **website** for prospective patients.
		in print **advertisements**.
		on **television**.
		on **social media**.

I understand that:

Such photographs, slides or videotapes may be published by Dr. Perrotta and/or Peninsula Plastic Surgery P.C. in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Perrotta , for which Dr. Perrotta may be receive direct or indirect remuneration.

I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.

I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to **the Practice Administrator** at 314 West Carroll Street Salisbury, MD 21801. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Perrotta and/or Peninsula Plastic Surgery P.C..

The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Perrotta and/or Peninsula Plastic Surgery P.C. from all liability, including liability for negligence, that in any way arises out of:

any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact the Practice Administrator at **410-546-0464.**

Patient is a minor years of age, and we, the undersigned, are the parents or guardian of the patient and do hereby consent for the patient.

Signature ______________________________ **Date** ____________________

Witness ______________________________

PATIENT HIPAA COMMUNICATION FORM

Disclosure to Self and to Others

Patient Name: Patient ID:

With your approval, we may disclose your personal health information to designated family, friends and others involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval.

By signing this authorization, I allow Peninsula Plastic Surgery, P.C. to discuss with the person(s) named below my personal health information which may include, but is not limited to laboratory, test results, diagnosis, prognosis, treatment plan, and billing status. This may be done in person or by telephone.

By signing this authorization, I understand the following:

This applies to services being rendered to me by the physicians and non-physician providers who practice under the name of Peninsula Plastic Surgery, P.C.

Once this information is released to the designated family member, friend or other person named below, the release information may no longer be protected by the federal privacy regulations.

This authorization is voluntary.

I may withdraw this authorization at any time by notifying the PPS Privacy Officer in writing. If I do withdraw the authorization, it will not have any effect on actions taken by PPS prior to receiving the written request.

I authorize discussion of my personal health information with the following person(s):

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

X______________________________ ______________________ ____________________

Patient or Representative Signature **Relationship to Patient** **Date**