

# Orlando Plastic Surgery Center, LLC

## Patient Information

Name: \_\_\_\_\_  
Last First Middle

Date of first visit \_\_\_\_\_ Account # \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ SS# \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing address \_\_\_\_\_ Home phone ( ) \_\_\_\_\_

Cell phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Driver's License# \_\_\_\_\_ State of Issue \_\_\_\_\_ E-mail address \_\_\_\_\_

Check if you would like to receive promotional information

## Parent or Spouse Information

Name \_\_\_\_\_ Relationship \_\_\_\_\_ SS# \_\_\_\_\_

Mailing Address (if different from patient) \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Driver's License# \_\_\_\_\_ State of Issue \_\_\_\_\_ E-mail address \_\_\_\_\_

## Referral Information

Referred by \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

May we write a letter to them, thanking them for referring you?  Yes  No

Did you hear about us in any of the following media?  Orlando Sentinel  Orlando Magazine  RSVP Cards  SW Orlando Bulletin

Playbill  Internet Search Engine  Yellow Pages  Other \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Have you been treated elsewhere for this problem?  Yes  No If so, by whom? \_\_\_\_\_

Name/Address of Primary Care Physician \_\_\_\_\_

## Medical Records Release

Do you authorize the release of medical records to:

Primary care doctor?  Yes  No Signature \_\_\_\_\_ Date \_\_\_\_\_

Referring care doctor?  Yes  No Signature \_\_\_\_\_ Date \_\_\_\_\_

If your condition is accident-related, please complete the following:

Date of Accident \_\_\_\_\_ Time \_\_\_\_\_ Describe how it happened \_\_\_\_\_

Are there any legal proceedings involved regarding this visit?  Yes  No

Name of insurance carrier: \_\_\_\_\_

How do you plan to pay for this visit?  Cash  Check  Insurance  Credit card

## Emergency Contact

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

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## Medical History

Name \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Exercise? \_\_\_\_\_ Diet? \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Drugs? \_\_\_\_\_

If yes, how much? \_\_\_\_\_

Have you recently gained or lost weight? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Surgical history: \_\_\_\_\_

Other hospitalizations: \_\_\_\_\_

Have you been treated for any medical problems? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

Have you ever seen a psychologist or psychiatrist? \_\_\_\_\_

Are you currently under treatment by a psychologist or psychiatrist? \_\_\_\_\_

Have you ever had any of the following? (If yes, please explain)

- Heart problems \_\_\_\_\_
- Lung problems \_\_\_\_\_
- Kidney problems \_\_\_\_\_
- Coughing up or vomiting blood \_\_\_\_\_
- Blood in urine or stool \_\_\_\_\_
- Seizures or loss of consciousness \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Cancer \_\_\_\_\_
- Hepatitis or yellow jaundice \_\_\_\_\_
- Thyroid disease \_\_\_\_\_
- Other: \_\_\_\_\_

List any other medications you are currently taking, including over-the-counter drugs and herbal supplements: \_\_\_\_\_

Do you have a personal or family history of anesthesia or bleeding problems? \_\_\_\_\_ If so, please explain. \_\_\_\_\_

I hereby affirm that the above information provided is conclusive and true to the best of my knowledge.

\_\_\_\_\_  
Patient or guardian signature Date \_\_\_\_\_

\_\_\_\_\_  
Reviewed by Date \_\_\_\_\_

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## Primary Insurance Information

Insurance company \_\_\_\_\_  
Group or individual \_\_\_\_\_  
Employer \_\_\_\_\_  
Policy number \_\_\_\_\_ Group number \_\_\_\_\_  
Policyholder's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Policyholder's date of birth \_\_\_\_\_  
Policyholder's SS# \_\_\_\_\_ Insurance company phone number \_\_\_\_\_  
Mail claims to: \_\_\_\_\_

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## Secondary Insurance Information

Insurance company \_\_\_\_\_  
Group or individual \_\_\_\_\_  
Employer \_\_\_\_\_  
Policy number \_\_\_\_\_ Group number \_\_\_\_\_  
Policyholder's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Policyholder's date of birth \_\_\_\_\_  
Policyholder's SS# \_\_\_\_\_ Insurance company phone number \_\_\_\_\_  
Mail claims to: \_\_\_\_\_

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## Insurance Related Services

The patient is responsible for all fees, subject to individual insurance requirements. To accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service, it is difficult for us to keep track of all the individual requirements of the plans. Each has different policies on how often services may be rendered and even more important, where services may be performed.

Providing quality medical care for patients is our primary concern. We are more than willing to provide care within your insurance contract guidelines, if you let us know at each time of service exactly what those guidelines are. If you do not inform us of any special requirements in your contract and we subsequently order services not covered (such as lab work or hospitalization), we and the medical facility will have no choice but to bill you directly for those charges. Payment of those charges is then your responsibility, and we accept payment in the form of cash, check or credit card.

When insurance coverage applies, our office will complete the necessary forms (using information that you provide) to expedite insurance payments. Prior authorization of services (especially surgery) and pre-verification of coverage may be necessary. Depending upon insurance coverage, you will be required to pay deductible amounts, co-payments and charges for non-covered services. Dr. Pope uses an assistant during surgical procedures. Insurance companies typically reimburse for these services, but if your insurance provider declares these fees a non-covered service, you will be responsible for them.

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. I hereby authorize Orlando Plastic Surgery Center, LLC to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I have read and understand the policy statement above and agree to accept responsibility as described.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Non-Insurance Related Services

The patient is responsible for all fees for all services provided by our physician.

I agree to pay for all services rendered by my physician per the office policy of Orlando Plastic Surgery Center, LLC.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Cancellation Policy

To provide our patients the best care possible, we require a 24-hour advance notice if you are unable to keep your appointment.

I understand the importance of keeping my scheduled appointment and I agree to notify the office 24 hours in advance if I am unable to keep my appointment. I also understand and agree if I do not give the required notice, I will be charged \$50.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Communication Use & Disclosure Authorization

Please complete the following information for all requests:

Patient name \_\_\_\_\_

Date of birth \_\_\_\_\_ Patient # \_\_\_\_\_

Address \_\_\_\_\_

I hereby request the following regarding the use of my personal health information:

1. You may leave the following information on answering machines or voice mail

- Referral information
- Prescription refill information
- Test results
- Appointment information
- Other:

2. You may discuss information and care with the following family members and/or friends:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. You may contact me regarding my treatment and care at the following numbers:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date \_\_\_\_\_

Signature of Patient or Guardian

\_\_\_\_\_  
Signature & Title of Staff Person

\_\_\_\_\_  
Printed Name & Title of Staff Person

# Orlando Plastic Surgery Center, LLC

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## Notice of Privacy Practices

This notice describes how your health information may be used or disclosed, and how you can access this information. Please review it carefully. At Orlando Plastic Surgery Center, LLC, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow its terms.

- The law permits us to use or disclose your health information to those involved in your treatment. For example, your file might be reviewed by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information to obtain payment for your care. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use the address and telephone number of your preference.
- You have the right to transfer copies of your health information, with a few exceptions. We must receive a written request for the information you would like to see. If you request a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or make changes to your health information. Request in writing to make changes. If you wish to include a statement in your file, please submit that in writing as well. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you at your next appointment after the effective date.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509-F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, for more information or assistance regarding your health information privacy, please contact our office at 407-857-6261.

This notice is effective April 14, 2003.

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## Acknowledgement

I have received a copy of the Orlando Plastic Surgery Center, LLC, Notice of Privacy Practices.

\_\_\_\_\_  
Patient or guardian signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by parent or guardian, please print patient's name