OCALA PLASTIC SURGERY & DERMATOLOGY

Board Certified Plastic Surgeons:
James Rogers DMD, MD · **Navinderdeep Nijher** MD · **Jennel Carreras-Montgomery** MD
Board Certified Dermatologist: **Jessin Blossom** MD, FAAD

Patient Name (Please Print): _____ Date of Birth: _____/_____/_____

Address: _____City, State & Zip _____

Phone (home)_____ (cell) _____

Age: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Reason for appointment: _____ Referred by: _____

Employer: _____Employer phone: _____

EMAIL: _____

** Preferred Pharmacy: _____ Pharmacy Phone: _____

** Primary Care Physician: _____ Phone: _____

INSURANCE INFORMATION

Please provide your insurance card to be scanned into your patient chart

Is this Workman's Compensation? ☐ Yes ☐ No

Type of insurance? ☐ Medicare ☐ Medicaid ☐ Private Insurance ☐ Auto Insurance ☐ Homeowners

Policy Holder name:

Social Security: _____ Date of Birth _____

Work phone: _____

Please remember that insurance is considered a method of reimbursing the patient fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is yourresponsibility to pay any deductible amount, coinsurance, or any other balance not paid by your insurance. To control the cost of billings, we request that charges for your office visits be paid at the conclusion of each visit. If this amount is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

EMERGENCY INFORMATION

In case of an emergency notify: _____

Relationship to patient: _____ Phone: _____

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to Ocala Plastic Surgery & Dermatology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
I hereby authorize said assigned to release all information necessary to secure the payment including the diagnosis and records of any treatment or exam rendered to me during the period of medical and/or surgical care. I understand that I am financially responsible for all charges whether covered by my insurance or not and I authorize Ocala Plastic Surgery & Dermatology to send a letter to the state insurance commissioner if any insurance services rendered is not paid within 45 days.
I hereby authorize the taking of photographs for the purpose of documentation which will be a part of my permanent record, and which may be used for medical education.

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____

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DATE: _____ Referring Doctor.: _____

NAME: _____ Sex: ☐ Male ☐ Female Age: _____

CHIEF COMPLAINT (Why are you here to see the doctor)

Date of Injury / Onset: _____ Hand Dominance (circle one): LEFT RIGHT

MEDICAL HISTORY **LAB** required to use per your insurance (please circle) Ameripath LabCorp Quest

Please indicate whether you have had any of the following illnesses.

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Anemia
- ☐ Kidney Problems
- ☐ Bleeding Problems
- ☐ Chronic Lung Disease
- ☐ Eye Disease
- ☐ Excessive Scarring
- ☐ Stomach Problems
- ☐ Cancer
- ☐ Asthma
- ☐ Other

Explain:

Previous Surgery: _____

MEDICATION	DOSAGE	QTY.	FREQ.	MEDICATION	DOSAGE	QTY.	FREQ.

ALLERGIES/REACTIONS: _____ BLEEDING TENDENCIES: _____

Do you smoke/vape: _____ How many packs a day: _____ Do you drink: _____ How many drinks per week? _____

Have you ever had any psychiatric problems, a nervous breakdown or are under the care of a psychiatrist? Yes No

FAMILY MEDICAL HISTORY: (Please circle all that apply for first degree relative)

Melanoma -	Father	Mother	Sister	Brother	Daughter	Son	Other
Diabetes -	Father	Mother	Sister	Brother	Daughter	Son	Other
Cancer -	Father	Mother	Sister	Brother	Daughter	Son	Other
Heart Disease -	Father	Mother	Sister	Brother	Daughter	Son	Other
Hypertension -	Father	Mother	Sister	Brother	Daughter	Son	Other

If any, please specify/describe _____

GYN HISTORY No. of Pregnancies: _____ No. of Children: _____ Breastfed? _____

Age of 1st Pregnancy _____ Is There Breast, Ovarian or Uterine Cancer in the family? _____

Nipple Discharge _____ Age Periods Started _____ Menses' _____ Age of Menopause _____

PHYSICAL EXAM

HT: _____ WT: _____ BRA SIZE: _____ BP / PULSE: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

This will authorize (facility): to release general medical, as well as psychiatric/psychological, drug/alcohol abuse and HIV testing information from my health record in accordance with the following Florida Statutes: 90.503, 394.459, 395.017, 396.112, 397.053 and 381.609.

A general medical authorization and subpoena duces tecum, without a specific authorization to release psychiatric/ psychological, drug/alcohol and HIV testing information must have this waiver from the patient or his/her empowered representative.

PLEASE PRINT

Patient's Legal Name: _____ Date of Birth: _____

Telephone: _____ Social Security Number: _____

INFORMATION IS TO BE RELEASED TO: _____

INFORMATION TO BE RELEASED (check):

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Progress Notes
- ☐ Other Information (Specify Below): _____
- ☐ Consultation Report
- ☐ Physician Orders
- ☐ Operative Reports

This authorization is for the listed date(s) of treatment:

From: _____ To: _____

RECORD IS TO BE USED FOR: _____

I understand that I have the right to refuse this authorization and that the facility named above as the releasing facility is released from all legal liability that may arise from the release of information requested.

Prohibition on redisclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited.

This authorization will be valid for one year after the date of my signature as it appears below.

Patient Signature: _____ Date: _____

Empowered Representative Signature: _____ Date: _____

(Relationship to patient: _____)

Witness Signature: _____ Date: _____

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OCALA PLASTIC SURGERY & DERMATOLOGY FINANCIAL POLICY

Ocala Plastic Surgery & Dermatology believes that in our commitment to excellence, it is best to establish a patient account policy in order t avoid any misunderstandings. Our Insurance Billing Coordinator will be glad to discuss your account with you at any time. Our primary responsibility is to deliver quality health care services. We wish to spend our time and energy toward that responsibility. To achieve these goals, we need your assistance, and your understanding of our payment policy:

Initial Consultations – Patients are expected to pay for their initial consultation at the time of visit. Exceptions to thiswould be Medicare, Workman's Compensation, and patients having a group policy with which we have a contractual agreement. We accept cash, checks, MasterCard, Visa, Discover Card, American Express, other credit cards and checkcards with the MasterCard or Visa Logo.

Small Office Procedures – You will be contacted prior to your scheduled procedure to let you know your financial responsibility. This is just an estimate based on the information we have prior to surgery, if something changes duringthe procedure, this will change the amount you owe. We will refund or balance bill after your insurance company hasprocessed your claim.

Planned Surgery – There will be a required "pre-payment"/" deposit for surgery" at the time of the patient's pre-op visit (which is usually 1 week before planned surgery). You will be notified of the amount prior to your surgery. All insuranceis verified prior to a patient having surgery. If the insurance company has approved the surgery, then we will, as a courtesy, file the services after surgery is performed. You must realize, however, that:

1) Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2) Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who paya percentage (such as 50% or 80%) of "U.C.R." as defined as usual, customary, and reasonable fees for this region. Thus, most companies consider our fees usual, customary, and reasonable. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Full payment of surgical cost will be required at your pre-op visit, prior to surgery, unless you have a policy with which we have a contractual agreement.

Fees – During your initial consultation, you should receive a detailed breakdown of approximate charges. This breakdown should consist of the following charges that will constitute your billing:

1) Surgeon's fee

If your procedure is performed at Paddock Park Surgery Center, additional charges will apply.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I understand that I am responsible for all expenses incurred, including doctor's fees (and Paddock Park Surgery Center, if applicable). I also understand and agree that if this office receives no payment within sixty days, my signature acknowledges that I will be responsible for the entire unpaid balance regardless of the reason for denial. I also understand that I am responsible for any additional charges incurred if my account is turned over to a collection agency for non- payment.

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We use your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and *administrative proceedings:* We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amended Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to requestthat we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:
Center Director
3320 S.W. 34th Circle
Ocala, Florida 34474
352-629-8154

Effective Date: April 14, 2003

I,_____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgement was not obtained:

_____

Staff Witness seeking acknowledgement:

_____

Date: _____

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Ditzel (In office Minor Procedure)

- If we are non-participating with your insurance company, you will be expected to pay the full amount at the time you schedule your procedure (at least 2 weeks prior to your procedure).
- As a courtesy we will submit your claim to your insurance company for you.
- We do not collect for nor bill anesthesia, pathology, or lab charges. If your procedure is non-cosmetic, you may incur these costs and receive a bill from another provider for these charges.
- Ocala Plastic Surgery & Dermatology uses Ameripath, & KorPath for all specimens sent out to be tested. **If your insurance company requires you to use a specific laboratory, please let us know.**

Surgery (Paddock Park Surgery Center or Hospital)

- Our insurance department will call you prior to your History and Physical (H&P) notifying you how much you will owe for your surgery. If we are non-participating with your insurance company, you will be expected to pay the full amount prior to your procedure.
- The amount given to you by our insurance department will be the amount due at your History & Physical appointment and will be collected in full upon your check-in for that appointment. You have the option of making incremental payments as long as the amount is paid in full by your H&P date.
- As a courtesy we will submit your claim to your insurance company.
- Charges due for Hospital surgery - H&P and surgeon.
- Charges due for PPSC surgery - H&P, surgeon, and facility.
- We do not collect for nor bill anesthesia, pathology, or lab charges. If your procedure in non-cosmetic, you will receive a bill from another provider for these charges.
- Ocala Plastic Surgery & Dermatology uses Ameripath/Quest and KorPath for all specimens being sent for testing. **If your insurance company requires you to use a different laboratory, it is your responsibility to notify us.**

  Our cosmetic patients are sent to **UF Health** Pathology Laboratories for surgical lab/blood work as self-pay patients. **Your insurance company will NOT pay for lab work done for cosmetic procedures.**

Patient Signature:_____ Date: _____

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Please list any family member or any other persons that you authorize to communicate with our staff regarding your medical or financial care or concerns. This includes confirming appointments.

(SPOUSE, CHILD, CHILDREN, CAREGIVER, ETC)

MEDICAL & FINANCIAL RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby authorize Ocala Plastic Surgery & Dermatology to release my medical or financial information if requested by:

Name	Relationship	Daytime Phone Number
Name	Relationship	Daytime Phone Number
Name	Relationship	Daytime Phone Number
Name	Relationship	Daytime Phone Number

_____ _____

Signature of Patient or Legal Guardian of Patient Date

May we leave a detailed message on your answering machine or voicemail?
(circle one) YES _____ (your initials) NO _____ (your initials)

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THANK YOU FOR COMPLETING THIS INFORMATION

Thank you for completing our new patient forms for Ocala Plastic Surgery and the Paddock Park Surgery Center. Please be sure you have completed this paperwork packet in its entirety, print all pages, and bring them with you along with your current driver's license or photo ID and your current insurance card if applicable to your first visit. You can print them by clicking on the print button below.

IMPORTANT: Please remember, these forms contain personal and confidential information and should be protected by you while at home or in transit to our offices.

Print Form