INDIANA PLASTIC SURGERY

PATIENT REGISTRATION FORM

Patient's Name Last_____ **First**_____ **M.I.**____ **Date of Birth**___/___/___**Age**_____

Address_____City_____State_____Zip_____

Home Phone (____) _____**Cell #(____)**_____**Alternate** (___) _____

Social Security #_____ **Sex** F____M____ **Marital Status M____S___D____W____**

Name of Employer _____**Work** (____)_____

Address_____City_____State_____Zip_____

Emergency Contact _____Relationship_____Phone_____

Pharmacy Name_____Telephone **(_____)**_____

How were you referred to our office? Friend_____ Telephone book_____ Newspaper _____ Physician_____

Internet _____ Ins. Company_____Billboard_____Other_____**(please specify)**

Email Address _____

MEDICAL

Purpose of this visit_____

REFERRING PHYSICIAN INFORMATION

Primary Care Physician (PCP)_____Phone#_____

Referring Physician_____Phone#_____

INSURANCE INFORMATION

Primary Insurance_____Phone #_____

Address_____City_____State_____Zip_____

Name of Insured_____**Relationship to Patient**_____

D.O.B.____/____/_____**Group#**_____**ID#**_____**SS#**_____

Secondary Insurance_____ **Phone** #_____

Address_____City_____State_____Zip_____

Name of Insured_____**Relationship to Patient**_____

D.O.B.____/_____/_____Group#_____ID#_____SS#_____

Responsible Party_____**Relationship**_____**Phone #**_____

Responsible Party Address_____**City**_____**State**_____**Zip**_____

Medical Release

I hereby authorize the above physician to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance. I hereby authorized and direct my insurer to issue payment check(s) for benefits due to me for the services rendered by the above name physician to be made directly to him. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered and all reasonable collection and attorney's fee, if applicable. Patients will be assessed a $200.00 charge back processing fee for any CareCredit/ credit card disputes.

Patients will be responsible for a $50.00 charge if they fail to show up for their scheduled appointment or call within 24 hours to cancel.

We do NOT accept personal checks. Payment may be made in the form of cash, cashier's check, money order, VISA, or Mastercard (debit/credit).

All accounts will be assessed a service charge of $10.00 each month of non-payment.

PATIENTS SIGNATURE_____**DATE**_____

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

(If patient is under the age of 18)

To help evaluate your present, past and future health concerns.

PLEASE COMPLETE THE FOLLOWING MEDICAL FORM

Name:_____ **Date**_____

Age: _____ **Height:** _____ **Weight:** _____ **Sex** ☐ **M** ☐ **F**

The purpose of today's visit: _____

How long has the problem been present: _____

Was there any previous treatment? ☐ **No** ☐ **Yes** **When?** _____**Type**_____

Do you have a primary care/family physician? ☐ **No** ☐ **Yes**

Name_____

Phone_____

Past Medical History: Please list _____

_____

Past Surgical History: Please list _____

_____

_____

Please list all medications you are currently taking (prescription, over the counter, supplements, &/or dietary aids)

_____ _____ _____

_____ _____ _____

Do you have any allergies to medicines? ☐ **No** ☐ **Yes** _____

Number of pregnancies _____ **Number of children** _____

Smoker? Yes No If Yes: Packs per day? _____**How long?**_____ **Quit how long ago?**_____

How much alcohol do you drink? _____

Alcohol or Drug problems ☐ **No** ☐ **Yes If yes, describe**_____

Mammogram: Date of last Mammogram_____ **Result:** ☐ **Normal** ☐ **Abnormal**

Have you ever had breast cancer? ☐ **No** ☐ **Yes** _____

Has anyone in your family ever had breast cancer? ☐ **No** ☐ **Yes** _____

Have you ever been treated with chemotherapy or radiation? ☐ **No** ☐ **Yes Please explain**

_____

I certify that the above information is correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to myself or those involved in my care.

Patient Signature_____
(Parent/Guardian if patient is under the age of 18)

Physician Signature_____

Name:_____ Date_____

Please list all medical conditions you currently have or have had in the past (System Review):

SYSTEM REVIEW

SKIN	HEMATOLOGIC/ LYMPTHATIC	CONSTITUTIONAL SYMPTOMS	EYES/EARS/NOSE /THROAT
☐ Normal ☐ Abnormal ☐ Poor healing ☐ Other skin disorders_____ _____	☐ Normal ☐ Anemia ☐ Bleeding problems ☐ Enlarged lymph nodes ☐ Transfusion Other_____	☐ None ☐ Weight loss ☐ Fever ☐Anxiety ☐Depression ☐Cancer ☐Other_____	☐ Normal ☐ Glaucoma ☐ Hearing aid ☐ Other_____ _____ _____

Cardiovascular	Respiratory	Gastrointestinal	Musculoskeletal
☐ Normal ☐Angina ☐ Artificial heart valve ☐ Pace maker ☐ Hypertension ☐Mitral valve prolapse ☐ Heart attack (when?) _____ ☐ Other_____ _____	☐ Normal ☐ Asthma ☐ Emphysema ☐ Other lung problem(s) _____ _____ _____ _____ _____ _____ _____ _____	☐ Normal ☐ Stomach ulcer ☐ Colitis ☐ Liver Disease ☐ Other GI problem(s) _____ _____ _____ _____ _____ _____ _____	☐ Normal ☐ Arthritis ☐ Artificial joint ☐ Other_____ _____ _____ _____ _____ _____ _____ _____

Neurological	Kidney	Endocrine	Infections
☐ Normal ☐ Stroke ☐ Seizures ☐Other_____ _____	☐ Normal ☐ Dialysis ☐ Other kidney problem(s) _____ _____	☐ Normal ☐ Diabetes ☐ Thyroid ☐Other_____ _____	☐ None ☐ Hepatitis ☐ HIV/AIDS ☐ Tuberculosis/T.B. ☐ Transplant ☐ Other

I certify that the above information is correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to myself or those involved in my care.

Patient Signature_____
(Parent/Guardian if patient is under the age of 18)

Physician Signature_____

INDIANA PLASTIC SURGERY
NOTICE OF PRIVACY PRACTICES
EFFECTIVE APRIL 14, 2003

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.

If you have questions, please contact our privacy officer at our Main Phone Number.

INDIANA PLASTIC SURGERY DUTIES

We are required by law to protect your health information. We are also required to provide you with a copy of this notice about our privacy practices. We recognize our legal and ethical obligation to keep your health information secure and confidential.

Use and Disclosure of Health Information

We make disclosures of your health information for treatment, payment and health care operations.

Treatment: The practice may use and disclose your protected health information in the course of providing or managing your health care. For example, the practice may disclose protected health information to other physicians or health care providers for treatment activity of those other providers.

Payment: When needed, the practice may use and disclose your health information to obtain payment for services provided. For example, such disclosures may include disclosures to your health insurer for approval of a recommended treatment, to demonstrate medical necessity of your care or to another provider involved in your care that requires the information to obtain payment.

Operations: We may, when needed, use or disclose your health information in connection with the practice's healthcare operations. Healthcare operations may include quality evaluations, employee review activities and training, certification, licensing or credentialing, reviews and audits or business management.

Federal law allows Indiana Plastic Surgery to make the following disclosures of your protected health information without your consent or authorization.

When Required by Law: The practice will disclose your health information when required by any federal, state or local law.

When Required for Public Health Activities: The practice may disclose your protected health information for public health purposes, including to, as permitted by law:

1. Prevent, control or report disease, injury or disability.
2. Report vital events such as birth or death
3. Conduct public health surveillance, investigations and interventions;
4. Collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements, and conduct post marketing surveillance;
5. Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease; and
6. Report to an employer information about an individual who is a member of the workforce

In Cases of Abuse, Neglect or Domestic Violence: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.

Health Oversight Activities: The practice may disclose your protected health information to a health oversight agency for use in audits, civil administrative, criminal investigations, proceedings or actions, inspections, licensure or disciplinary actions or other necessary oversight activities as permitted by law.

Judicial and Administrative Proceedings: The practice may disclose your protected health information for any judicial or administrative proceedings if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by such order or a signed authorization is provided.

Law Enforcement Purposes: The practice may disclose your protected health information to a law enforcement official for law enforcement purposes when:

1. Required by law to report certain types of physical injuries;
2. Required by court order, court order warrant, subpoena, summons or similar process;
3. Needed to identify or locate a suspect, fugitive, material witness, or missing person;
4. Needed to report a crime in an emergency situation.
5. You are a victim of a crime in specific limited instances; and
6. Your death is suspected by the practice to be the result of criminal conduct.

To Coroners, Funeral Directors and for Organ Donation: The practice may disclose protected health information to a coroner or medical examiner for purpose of identification, determination of cause of death or performance of the coroner or medical examiner's other duties as authorized by law (i.e. cadaveric organ, eye or tissue donation).

For Research Purposes: The practice may use or disclose your protected health information for research if such use or disclosure has been approved by an institutional review board or privacy board that has examined the research proposal and the research protocols which maintain the privacy of your protected health information.

To Avert a Serious Threat to Health or Safety: If in good faith the practice believes that use or disclosure of your protected health information is necessary to prevent or diminish a serious and imminent threat to your health or safety or to the health or safety of the public, the practice may use or disclose your protected health information as permitted under law and consistent with ethical standards or conduct.

OVER

For Specialized Government Functions: Including armed forces personnel, separation or discharge from military service, veterans, foreign military personnel, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions and other law enforcement custodial situations.

Indiana Plastic Surgery may also use your protected health information to:

- ***Provide Appointment reminders or information about treatment alternatives or other heatlh-related benefits and services that may be of interest to our patients.***
- ***Contact you to raise funds for Center for Cosmetic & Reconstructive Surgery, P.C. for the covered entity***

All other disclosures of your protected health information will be made only with your authorization. You have the right to revoke the authorization at any time.

Your Rights

Federal law provides the following rights with respect to your protected health information:

Right to Request Restrictions: You may request that the practice not use or disclose specific sections of your protected health information for the purposes of treatment, payment, or health care operations. Additionally, you may request that the practice not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice. In your request, you must specify the scope of restriction requested as well as the individuals for which you want the restriction to apply. Your request should be directed to the practice's Privacy Officer.

The practice may choose to deny your request for a restriction, in which case the practice will notify you of its decision. Once the practice agrees to the requested restriction, the practice may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The practice may terminate the agreement to a restriction in some instances.

Right to Receive Confidential Communications of your Protected Health Information: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

Right to Inspect and Copy Protected Health Information: Under federal law, however, you may not inspect or copy the following records, psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

Right to Amend Protected Health Information: During the time that the practice holds your protected health information, you may request an amendment of your information in a designated record set. The practice may deny your request in some instances. However, should the practice deny your request for amendment, you have the right to file a statement of disagreement with the practice. In turn, the practice may develop a rebuttal to your statement. If it does so, the practice will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the practice's privacy officer. Your written request must supply a reason to support the requested amendments.

Right to Receive an Accounting of Disclosures of Protected Health Information for Releases Made Under an Authorization: You have the right to request an accounting of the practice's disclosures of your protected health information made for purposes other than treatment, payment or healthcare operations as described in this Notice. The practice is not required to provide an accounting for disclosures that take place prior to April 14, 2003.

Right to Receive a Paper Copy of this Notice: The practice will provide a separate paper copy of this Notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

Complaints

If you believe that your privacy rights have been violated, you have the right to relate complaints to the practice and to the Secretary of the Department of Health and Human Services. You may provide complaints to the practice verbally or in writing. Such complaints should be directed to the practice's Privacy Officer. The practice encourages you to relate any concerns you may have regarding the privacy of your information and you will not be retaliated against in any way for filing a complaint.

Changes to Notice

We reserve the right to make changes to this notice. We also reserve the right to apply changes to the protected health information we have received about you in the past and will receive in the future. Copies of the current notice are available.

Other Uses of Protected Health Information

All other uses of your protected health information not covered by this notice will only be made with your written authorization. If you provide us permission to use this information about you, you make revoke that permission at any time, in writing. If you revoke our permission, we will no longer use your information for the purposes described in the written authorization. Please remember we cannot take back any disclosures that were made under the authorization.

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

In accordance with Indiana law, this notice is to advise you that your physician may have an ownership interest in: Community Surgery Center, LLC.
You have the right to be referred to another entity, other than the entity in which your physician has a financial interest, for the provision of services.

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 for by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practice:

Print Name_____ Signature_____ Date_____