Cape & Islands Plastic Surgery

PATIENT INFORMATION SHEET

Patient Name:_____ **DOB:**_____ **M**____ **F**____

Home Address:_____
Street (or P.O. Box #) Town State Zip

	OK to call	OK to leave message
Home Phone:_____	Y____ N____	Y____ N____
Cell Phone:_____	Y____ N____	Y____ N____

E-mail Address:_____

Is it OK to send mail to your home? Y___ N___ **Is it OK to send you an e-mail via our monthly newsletter? Y___ N ___**

Occupation:_____

Employer:_____ **Address:**_____

Referring MD:_____ **Address:**_____

Primary Care Physician: _____ **Address:**_____

Primary Insurance:_____ **Policy #:**_____

Policy Holder:_____ **Co-Pay Amount:**_____

Secondary Insurance:_____ **Policy #:**_____

How did you hear about us?

☐ Friend/Family _____ ☐ ER ☐ Yellow Pages ☐ Newspaper ☐ Doctor ☐ Internet/Website ☐ Radio

Reason for Visit:_____

Is this a Workmen's Comp.?_____

Person to notify in case of emergency:_____

Relationship:_____ **Phone #**:_____

This certifies that the above information is correct and current as of this date. I also certify that I have received a copy of the Notice of Privacy Practices for Cape and Islands Plastic Surgery.

_____ _____ _____

Patient Signature **Today's Date** **Social Security # (optional)**

Cape & Islands Plastic Surgery

Today's Date:_____

Comprehensive Patient History Form

Patient Name:_____ **DOB:**_____

Describe your main concern:_____

Medical History

	Yes	No		Yes	No		Yes	No
Heart Failure			Asthma			Reflux		
Atrial Fibrillation			Hepatitis			Peptic Ulcer Disease		
Heart Attack			Cancer			Stroke		
Angina			Thyroid			High Cholesterol		
Peripheral Vascular Disease			Seizures			Kidney Disease		
Diabetes			Bleeding Disorders			Anemia		
Drug Allergies			COPD/Emphysema			Rheumatic Fever		
Other Allergies			HIV Infection			Arthritis		
Other			High Blood Pressure					

If yes, explain:_____

List previous hospitalizations/Surgeries/Serious Injuries **(If none, please write none):** **Year?**

_____ _____
_____ _____
_____ _____

List any Medications with dosages that you are currently taking **(If none, please write none):**

_____ _____ _____
_____ _____ _____

Patient Social History:

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Use of Alcohol: □ Never □ Moderate □ Daily

Use of Tobacco: □ Never □ Previously but quit □ Current/packs per day_____

Use of Illegal Drugs: □ Never □ Type/frequency_____

Excessive Exposure at Home/Work to: □ Fumes □ Dust □ Solvents □ Noise □ Chemicals

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____

Cape & Islands Plastic Surgery

Today's Date:_____

Review of Symptoms

	YES	NO	COMMENTS		YES	No	COMMENTS
General				**Cardiac**			
Fever				**Edema**			
Weight Loss				**Heart Murmur**			
Fatigue				**Chest Pain**			
Head & Neck				**High Blood Pressure**			
Head Injury				**Heart Attack**			
Headache				**Shortness of Breath**			
Nose Bleeds				**Rheumatic Fever**			
Hoarseness				**Arrhythmia**			
Sinus Problems				**Gastrointestinal**			
Thyroid Gland				**Reflux**			
EYES				**Nausea/Vomiting**			
Jaundice				**Constipation**			
Pink Conjunctivae				**Diarrhea**			
Breast				**Abdominal Pain**			
Lumps				**Jaundice**			
Discharge				**Hepatitis**			
Pain				**Urinary**			
Respiratory				**Kidney Stones**			
Bloody Sputum				**Frequency**			
Wheezing				**Bloody Urine**			
COPD				**Musculoskeletal**			
Emphysema				**Joint Pain**			
Asbestos Exposure				**Gout**			
Tuberculosis				**Arthritis**			
Endocrine				**Vascular**			
Thyroid Gland				**Leg Pain**			
Diabetes				**Varicose Veins**			
Steroid Use				**Neurological**			
Hematology				**Seizures**			
Anemia				**Strokes**			
Easy Bruising							
Easy Bleeding							
Past Transfusions							

_____

Patient Name (Please Print)

_____ _____

Patient's Signature **Today's Date**

Financial Responsibility Agreement

Insurance Claims: For your convenience, Cape and Islands Plastic Surgery will submit claims to all primary and Secondary insurance carriers and assign benefits payable for physician services to the physician furnishing this service. IF YOUR INSURANCE CARRIER HAS NOT PAID YOUR CLAIM WITHIN 30 DAYS, THE FULL BALANCE MAY BECOME YOUR FULL RESPONSIBILITY AND YOU WILL NEED TO COMMUNICATE WITH YOUR CARRIER TO PROVIDE THEM WITH ANY REQUIRED INFORMATION. Please remember that your insurance coverage is a contract between you and your insurance carrier and Cape and Islands Plastic Surgery is not party to your insurance contract.

Patient's Financial Responsibility: At the time of service, you, the insured, must pay any and all deductibles and/or copays. You may be responsible for payment on any claim that is: (1) denied; (2) unpaid due to deductible; (3) partially paid ; (4) partially paid due to your insurance carrier's arbitrary determination of "usual and customary" rates; and/or (5) Co-insurance. If your claim is involved in litigation and/or is being disputed among insurers, you are still financially responsible. You must pay any balance that your insurance carrier designates as your responsibility.

Uninsured Patients: If you do not have insurance, payment is required prior to the performance of any procedure.

Cosmetic Patients: $150 consultation fee is due at initial consultation **(this does not apply to injectable consultations)**. Payment is required prior to the performance of any procedure. $150 consultation fee will be applied towards balance due.

Delinquent Accounts: In the event that we must take legal action to collect an unpaid account, the patient or the responsible party must pay Cape and Islands Plastic Surgery costs of collection, including attorney fees. After an account is sent to a collection agency/attorney, all further services must be paid in cash, in full, prior to the receipt of the service.

PATIENT AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby authorize payment of health insurance benefits directly to Cape and Islands Plastic Surgery for services furnished me. I authorize the release of any of my medical information necessary to process my claims. I further authorize the release of my medical information to other physicians, hospitals and other health care providers and facilities involved in my treatment. I understand, acknowledge and agree that I am financially responsible for my deductible, co-insurance and any amount exceeding what my insurance company pays except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, pre-authorizations and second opinions.

I have read the above authorization and hereby authorize payment of medical benefits Cape & Islands Plastic Surgery PC. I understand that certain charges may not be covered by my insurance and that I am financially responsible for all charges incurred, including co-payments and deductibles. I also understand that I am responsible for getting referrals from my primary care physician if required by my insurance policy.

Print Name:_____ Date: _____

Signature: _____

(If Legal Representative, provide relationship to Patient)

Consent to Share Confidential Medical Information

To be valid, this form must be filled out COMPLETELY, including the information you are giving us permission to share.

Patient's Legal Name: _____

Birth Date:_____

I HEREBY AUTHORIZE CAPE AND ISLANDS PLASTIC SURGERY TO SHARE:
___† Any of my medical information
___† My lab results
___† My appointment times, dates, and reasons for the visits
___† The medications I am taking
___ The following information (specify): _____

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time (by writing Cape and Islands Plastic Surgery), but that cancelling it will not affect any information that has already been released.
I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider to share my information with individuals listed above.
This authorization expires: † when I cancel it in writing † _____

Printed Name:_____

Signature: _____ Date: _____

Relationship to minor patient (if parent or legal guardian): _____

Cape & Islands Plastic Surgery

"BEFORE AND AFTER" PHOTOGRAPH CONSENT

Please initial each Authorization & Sign this Photograph Consent Form

☐ I hereby grant permission for before and after photographs to be taken, but wish for them to remain with my medical records rather than being shared with outside parties

☐ I hereby grant permission for the use of my pre and post-operative photographs to be used in before and after photo books and presentations to be shown to other patients.

☐ I hereby grant permission for the use of my pre and post-operative photos to be used on the website of Cape & Islands Plastic Surgery, PC, www.capeplasticsurgery.com. Realself.com and other forms of social media, including but not limited to Facebook and Instagram.

_____

Patient's Signature

_____

Witness' Signature

_____

Today's Date

Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Our Pledge

We understand that medical information about your health is personal and we are committed to protecting that privacy. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing

Uses & Disclosures

When you enter our practice we will ask you to sign a consent form. Your consent grants us permission to use your medical information. We typically use or share your health information in the following ways: We can use your health information and share it with other professionals who are treating you. We may also disclose and share your health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities.

There are times when we are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. We can share health information about you for certain situations such as: Help with public health and safety issues • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety Do research • We can use or share your information for health research. Comply with the law • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. Respond to organ and tissue donation requests • We can share health information about you with organ procurement organizations. Work with a medical examiner or funeral director • We can share health information with a coroner, medical examiner, or funeral director when an individual dies. Address workers' compensation, law enforcement, and other government requests • We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services Respond to lawsuits and legal actions • We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You have the right to: Request restrictions on how we use or disclose your information. We do not have to agree with your request. Receive confidential communications at an alternate phone or address. Inspect and copy your medical information, fees will apply. Request amendment of medical information if you feel it is incorrect or incomplete. Receive an "accounting of disclosures" or list of disclosures we have made about you. Obtain a paper copy of this notice. These requests must be sent in writing to the Health Information's Services Department and must include specific information.

If you would like clarification or more information on any part of this Notice, you may contact the Privacy Officer by calling (508) 771-8967 or in writing to 26 Gleason St, Hyannis, MA 02601. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, please call the Privacy Officer at (508) 771-8967. All complaints will be investigated thoroughly and you will not be penalized for filling a complaint. We reserve the right to change this Notice and to make those changes effective for medical information we already have about you and information we receive in the future.