PATIENT INFORMATION

Indiana Plastic Surgery Center, PC

DATE: _____/_____/_____

PHYSICIAN REFERAL: _____

FAMILY/FRIEND REFERAL: _____

PRIMARY CARE PHYSICIAN: _____

LAST NAME _____ FIRST _____ M.I. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME (____)_____-_____ CELL(____)_____-_____ WORK(____)_____-_____ EMAIL_____

MAY WE CONTACT YOU: BY CELL PHONE / TEXTING?: YES OR **NO** **MAY WE CONTACT YOU AT WORK?** : **YES** OR **NO**

CIRCLE: GENDER M / F MARITAL STATUS S M D W FULL TIME STUDENT Y / N SCHOOL _____

DATE OF BIRTH _____/_____/_____ AGE _____ SOCIAL SECURITY NO. _____-_____-_____

EMPLOYER NAME _____ JOB POSITION:_____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE INFORMATION

LAST NAME _____ FIRST _____ M.I. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____/_____/_____ AGE _____ SOCIAL SECURITY NO. _____-_____-_____

EMPLOYER NAME _____ JOB POSITION:_____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENTAL INFORMATION…. ONLY IF PATIENT IS A MINOR:

MOTHER'S LAST NAME _____ FIRST _____ M.I. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____/_____/_____ AGE _____ SOCIAL SECURITY NO. _____-_____-_____

EMPLOYER NAME _____ JOB POSITION:_____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

FATHER'S LAST NAME _____ FIRST _____ M.I. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____/_____/_____ AGE _____ SOCIAL SECURITY NO. _____-_____-_____

EMPLOYER NAME _____ JOB POSITION:_____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

IN CASE OF EMERGENCY, NOTIFY… FRIEND OR RELATIVE *NOT* LIVING WITH YOU:

NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

MEDICAL HISTORY

Indiana Plastic Surgery Center, PC

DATE:_____/_____/_____

NAME: _____

REASONS FOR CONSULTATION: _____

ALLERGIES TO MEDS AND REACTIONS: _____

_____

MEDICATIONS: _____

_____

- **MEDICAL ILLNESSES:**

ILLNESSES	YES	NO	YEARS	NOTES AND CLARIFICATION
ARTHRITIS				
ASTHMA				
BLEEDING DISORDER				
CANCER, BREAST				
CANCER, SKIN				
DEPRESSION				
DRUG/ALCHOHOL ABUSE				
DIABETES				
FIBROMYALGIA				
HEART DISEASE				
HIGH BLOOD PRESSURE				
KIDNEY DISEASE				
LUNG DISEASE				
LUPUS				
PSYCHIATRIC				
STROKE				
OTHER:				
OTHER:				

- **SURGICAL, AND HOSPITALIZATION HISTORY:**

PROCEDURE OR REASON FOR HOSPITALIZATION	YEAR

- **RECENT SYMPTOMS: (**circle)

DIZZINESS	Y OR N
CHEST PAIN	Y OR N
RACING HEART	Y OR N
SEVERE HEADACHES	Y OR N
COLD, FEVER, CHILLS	Y OR N
EXCESSIVE BLEEDING	Y OR N
SHORTNESS OF BREATH	Y OR N
ANXIETY / NERVOUSNESS	Y OR N

- **SMOKING AND SUBSTANCE USE:**

CIGARETTES: PACKS PER DAY____ YEARS____

ALCHOHOL: DRINKS PER WEEK____

MIND ALTERING SUBSTANCES:

_____

_____

- **ADDITIONAL MEDICAL INFORMATION:**

_____

_____

_____

_____

_____

_____

PATIENT CONSENTS

Indiana Plastic Surgery Center, PC

INSTRUCTIONS: <u>IT IS IMPORTANT THAT YOU READ THIS DOCUMENT CAREFULLY AND COMPLETELY</u>. PLEASE PRINT YOUR NAME IN SECTION 1, INITIAL EACH SECTION INDICATING THAT YOU HAVE READ AND UNDERSTAND EACH SECTION. SIGN THE BOTTOM OF THIS FORM INDICATING YOUR UNDERSTANDING AND CONSENT TO ALL SECTIONS.

1. RELEASE OF MEDICAL INFORMATION AND ACKNOWLEDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I ,_____ ACKNOWLEDGE THAT I HAVE REICIEVED A COPY OF INDIANA PLASTIC SURGERY CENTER, PC'S NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW THIS MEDICAL PRACTICE MAY USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION, CERTAIN RESTRICTIONS ON THE USE AND DISCLOSURE OF MY HEALTHCARE INFORMATION, AND RIGHTS I MAY HAVE REGARDING MY PROTECTED HEALTH INFORMATION. I AUTHORIZE INDIANA PLASTIC SURGERY CENTER TO RELEASE MEDICAL INFORMATION IN ACCORDANCE WITH THE NOTICE OF PRIVACY PRACTICES DOCUMENT. I AUTHORIZE THE USE OF US POST, FAX OR EMAIL IN THE TRANSFER OF MY MEDICAL INFORMATION.

INITIALS: _____

2. CLINICAL PHOTOGRAPHS:

I UNDERSTAND THAT MEDICAL PHOTOGRAPHS MAY BE TAKEN BEFORE, DURING OR AFTER A SURGICAL PROCEDURE OR TREATMENT. I AUTHORIZE ROBERT N. SEVERINAC, M.D. AND/OR HIS ASSOCIATES TO TAKE PRE-OPERATIVE, INTRAOPERATIVE AND POST-OPERATIVE PHOTOGRAPHS. I AUTHORIZE THE RELEASE OF MY PHOTOGRAPHS TO MY INSURANCE COMPANY FOR ASSISTANCE IN OBTAINING PRIOR AUTHORIZATION FOR MY SURGERY OR IN ASSISTANCE IN PROCESSING MY CLAIM. FURTHER, I AUTHORIZE THE USE OF THESE IMAGES FOR PROFESSIONAL MEDICAL PURPOSES INCLUDING BUT NOT LIMITED TO SHOWING THESE IMAGES FOR MEDICAL EDUCATION, PATIENT EDUCATION, LAY AND PROFESSIONAL PUBLICATION, DURING LECTURES TO MEDICAL OR LAY GROUPS, ELECTRONIC DIGITAL NETWORKS, OR PUBLIC AND COMMERCIAL TELEVISION, PROVIDED, THAT IT IS UNDERSTOOD THAT IN ANY SUCH PUBLICATION OR USE, I SHALL NOT BE IDENTIFIED BY NAME. I UNDERSTAND THAT WHILE PHOTOGRAPHS MAY BE TAKEN, THEY ARE NOT ALWAYS SAVED AND ENTERED INTO THE PATIENT'S MEDICAL RECORD. I UNDERSTAND THAT I WILL NOT BE ENTITLED TO MONETARY PAYMENT OR ANY OTHER CONSIDERATI0N AS A RESULT OF ANY USE OF THESE IMAGES.

INITIALS: _____

3. AGREEMENT TO PAY:

I AGREE TO PAY INDIANA PLASTIC SURGERY CENTER ALL CHARGES FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY UNCOVERED EXPENSES BY MY INSURANCE COMPANY, INCLUDING DEDUCTIBLES, COINSURANCE, AND ANY CHARGES OVER AND ABOVE MY POLICY'S "REASONABLE AND CUSTOMARY" FEE ALLOWENCES. I UNDERSTAND THAT MY AGREEMENT WITH MY INSURANCE COMPANY IS INDEPENDENT OF MY AGREEMENT WITH MY PHYSICIAN. I FURTHER AGREE THAT IN THE EVENT ANY CHARGES MADE BY MY PHYSICIAN ARE NOT PAID AND THIS MATTER IS REFFERRED TO AN ATTORNEY AND / OR COLLECTION AGENCY, I AGREE TO BE RESPONSIBLE FOR ALL COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY FEES INCURRED TO EFFECT COLLECTION OF THIS ACCOUNT OR FUTURE OUTSTANDING ACCOUNTS.

INITIALS: _____

4. ASSIGNMENT:

I ASSIGN TO INDIANA PLASTIC SURGERY CENTER ALL MEDICAL EXPENSE BENEFITS WHICH ARE DUE FOR MEDICAL SERVICES PROVIDED BY ROBERT N. SEVERINAC, M.D. FROM MY INSURANCE COMPANY AND I AUTHORIZE THE BENEFITS TO BE MADE DIRECTLY TO INDIANA PLASTIC SURGERY CENTER. IN THE EVENT THAT THIS IS OR BECOMES A LIABILITY CASE, I DIRECT MY ATTORNEY TO ISSUE PAYMENT IN FULL DIRECTLY TO INDIANA PLASTIC SURGERY CENTER UPON SETTLEMENT. FURTHER, I REQUEST THAT MY ATTORNEY PROMPTLY ISSUE A LETTER OF PROTECTION TO INDIANA PLASTIC SURGERY CENTER ACKNOWLEDGING THIS CONSIDERATION.

INITIALS: _____

5. **DUPONT HOSPITAL INTEREST**:

I HAVE BEEN NOTIFIED OF DR. ROBERT SEVERINAC'S IS A PART OWNER OF AND HAS FINANCIAL INTEREST IN DUPONT HOSPITAL. I UNDERSTANDAND I MAY BE REFERRED TO DUPONT HOSPITAL FROM TIME TO TIME FOR SERVICES. I UNDERSTAND THAT THE SELECTION OF A SPECIFIC HEALTH CARE ENTITY/FACILITY ALWAYS RESTS WITH THE PATIENT AND I MAY CHOSE AT ANY TIME TO BE REFERRED TO AN ALTERNATE ENTITY/FACILITY OF MY CHOICE.

INITIALS: _____

PATIENT OR GAURDIAN SIGNATURE_____DATE _____

WITNESS SIGNATURE _____DATE _____

NAME OF PATIENT IF MINOR OR DEPENDENT_____

THIS NOTICE DESCRIBES HOW INDIANA PLASTIC SURGERY CENTER P.C CAN USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Indiana Plastic Surgery Center, P.C, is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Indiana Plastic Surgery Center, P.C or received by Indiana Plastic Surgery Center, P.C. from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Indiana Plastic Surgery Center, P.C. will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

Indiana Plastic Surgery Center, P.C. reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Indiana Plastic Surgery Center, P.C. may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies

For example, Indiana Plastic Surgery Center, P.C. may determine that you require the services of a specialist. In referring you to another doctor, Indiana Plastic Surgery Center, P.C. may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Indiana Plastic Surgery Center, P.C. to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, Indiana Plastic Surgery Center, P.C. will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes, evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Indiana Plastic Surgery Center, P.C. may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of you treatment when compared to patients in similar situations.

Indiana Plastic Surgery Center, P.C. may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Indiana Plastic Surgery Center, P.C. is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be the risk of exposure.

This notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R 164.520.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- For workers' compensation.
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Indiana Plastic Surgery Center, P.C. will not make any other use of disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Indiana Plastic Surgery Center, P.C. has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Indiana Plastic Surgery Center, P.C. to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Indiana Plastic Surgery Center, P.C. may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Indiana Plastic Surgery Center, P.C send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Indiana Plastic Surgery Center. P.C. not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you

You have the right to request that Indiana Plastic Surgery Center, P.C. amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Indiana Plastic Surgery Center, P.C. for the six years prior to the date of the request, beginning with disclosures made after April 11, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Indiana Plastic Surgery Center, P.C. and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Indiana Plastic Surgery Center, P.C., please contact the Privacy Officer at the following:

Indiana Plastic Surgery Center, pc
10020 Dupont Circle Court, Suite 100
Fort Wayne, Indiana 46825
260-489-0099

It is the policy of Indiana Plastic Surgery Center, P.C. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.