CPRS
Center for Plastic & Reconstructive Surgery

CHART INFORMATION

Social Security Number _____

Age: _____

Date of first visit: _____

Date Revised: _____

Account Number: _____

Patient's Name: _____ Date of Birth: _____
Last First Middle

Residence Address: _____
Number Street City State Zip Code

Mailing Address: _____
Number Street City State Zip Code

Home Phone: (___) _____ Height: _____ Weight: _____ Sex: M F

Cell Phone: (___) _____ E-mail Address: _____

Occupation: _____ Employer: _____

Work Phone: (___) _____ Business Address: _____

Name of spouse / Parent or Legal Guardian (if patient is a minor): _____

Work Phone: (___) _____ Occupation: _____

Emergency contact other than spouse/phone: _____

Reason for this visit *(Write in your own words)*: _____

_____

Have you ever been treated elsewhere for this problem? _____ By Whom? _____

Have you or any of your family members been treated here before? _____

Who is your primary care physician? _____ Address: _____
Phone Number: _____

Who were you referred by: _____ Address: _____

Who is financially responsible for your bill? _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____

Circle one: Group Policy or Individual Policy

If Group, Name of Employer _____

Policy # _____ Group # _____

Insured Person _____ DOB _____

Insured Soc Sec # _____

SECOND INSURANCE

Insurance Company _____

Circle one: Group Policy or Individual Policy

If Group, Name of Employer _____

Policy # _____ Group # _____

Insured Person _____ DOB _____

Insured Soc Sec # _____

Is your insurance an HMO or PPO? _____ **Does your insurance require pre-admission certification?** _____

Does your insurance require that you go to a specific hospital? _____

IF ACCIDENT RELATED, PLEASE COMPLETE THE FOLLOWING:

Date of Accident: _____ Time: _____ Describe how accident occ urred: _____

Are any legal proceedings involved with respect to your reason for this visit? _____ **Yes** _____ **No**

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.
I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.
WITH MY CONSENT, THE CENTER FOR PLASTIC & RECONSTRUCTIVE SURGERY MAY USE AND DISCLOSE PROTECTED HEALTH INFO RMATION (PHI) ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO); AND MAY MAIL, CALL, OR E -MAIL TO MY HOME OR OTHER DESIGNATED LOCATION ANY ITEMS THAT ASSIST IN CARRYING OUT TPO, SUCH AS APPOINTMENT REMINDERS & PATIENT STATEMENTS. I UNDERSTAND MY RECORDS MAY BE REVIEWED FOR QUALITY ASSURANCE.

DATE: _____ SIGNATURE: _____
(MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN IF APPLICABLE)

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PATIENT PERSONAL HISTORY

Name _____ Date _____

Date of Birth _____ Age _____

Reason for office visit: _____

List any medical conditions/illnesses: _____

_____

_____

List previous surgeries & dates: _____

_____

_____

List previous cosmetic surgeries & dates: _____

_____

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Please list any allergies: _____

Social History

Habits:	☐ Alcohol	☐ Tobacco	☐ Drugs	☐ Exercise	☐ Diet
Frequency: Occasional Moderate Heavy:	_____	_____	_____	_____	_____

Are you: ☐ Married ☐ Single ☐ Divorced Spouse's name: _____

Children: YES/NO Ages: _____

Are you currently employed? _____ What is your occupation? _____

Family History (check all that apply)

Diabetes	☐	Who? _____	What type? _____
Mental Illness	☐	Who? _____	What type? _____
Cancer	☐	Who? _____	What type? _____
High Blood Pressure	☐	Who? _____	
Tuberculosis	☐	Who? _____	
Epilepsy	☐	Who? _____	
Kidney Disease	☐	Who? _____	
Heart Disease	☐	Who? _____	
Stroke	☐	Who? _____	

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Has anyone in your family ever had a problem with anesthesia? ❑ Yes ❑ No

What problem? _____

Mother: Living _____ Deceased _____ Age _____ Cause of Death _____

Father: Living _____ Deceased _____ Age _____ Cause of Death _____

ARE YOU CURRENTLY/RECENTLY EXPERIENCING: (check all that apply)

CONSTITUTIONAL
- Weight Loss ❑
- Fatigue ❑
- Fevers or night sweats ❑

EYES
- Glasses/Contacts ❑
- Double Vision ❑
- Glaucoma ❑
- Cataracts ❑

EAR, NOSE, THROAT
- Difficulty Hearing ❑
- Ringing in Ears ❑
- Vertigo ❑
- Sinus Infection ❑
- Hoarseness ❑

CARDIOVASCULAR
- Murmur ❑
- Chest Pain ❑
- Palpitations ❑
- Dizziness ❑
- Fainting Spells ❑
- Short of Breath ❑
- Difficulty Lying Flat ❑
- Swelling Ankles/Other ❑

HEMATOLOGIC
- Easy Bruising ❑
- Gums Bleed Easily ❑
- Prolonged Bleeding/ ❑
- Clotting Disorder ❑

RESPIRATORY
- Cough ❑
- Coughing Blood ❑
- Wheezing ❑

GASTROINTESTINAL
- Heartburn ❑
- Nausea/Vomiting ❑
- Constipation ❑
- Change in BMs ❑
- Diarrhea ❑
- Difficulty Swallowing ❑
- Jaundice ❑
- Abdomen Pain ❑
- Blood in Stool ❑

GENITOURINARY
- Burning While Urinating ❑
- Frequent Urination ❑
- Blood in Urine ❑
- Abnormal Discharge ❑
- Difficulty Urinating ❑
- History Kidney Stone ❑
- History of Sexually Transmitted Disease ❑

FEMALES ONLY:
- Are Periods Regular? Yes No
- Age at Onset of: _____
- Periods ____
- Menopause ____

SKIN
- Rash/Sores ❑
- Lesions ❑
- Itching/Burning ❑

MUSCULOSKELETAL
- Joint Pain/Swelling ❑
- Stiffness ❑
- Muscle Pain ❑
- Back Pain ❑

NEUROLOGICAL
- Seizures ❑
- Weakness/Paralysis ❑
- Numbness ❑
- Tremors ❑
- Memory Loss ❑

ENDOCRINE
- Loss of Hair ❑
- Heat/Cold Intolerance ❑
- Change in Nails ❑

ALLERGIC/IMMUNOLOGIC
- Hay Fever/Asthma ❑
- Hives/Eczema ❑

PSYCHIATRIC
- Anxiety ❑
- Depression ❑
- Mood Swings ❑
- Difficulty Sleeping ❑

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CURRENT MEDICATIONS
PRESCRIPTION & NON-PRESCRIPTION

Please list below **ALL** over-the-counter and/or prescribed medications you are taking. Include those that can cause bleeding (some examples are (but not limited to): aspirin, ibuprofen, Excedrin, Advil, Motrin, Aleve, Orudis..) ALSO INCLUDE VITAMINS AND HERBAL SUPPLEMENTS.

Name of Medication	DOSE (Amount)	How Often	What do you take this medication for?

		Yes	No
Have you taken (or currently taking):	Accutane (isotretinoin)	☐	☐
	Plavix (clopidogrel)	☐	☐
	Coumadin (warfarin)	☐	☐

Patient Name: _____ Date: _____

Revision Date: _____ _____

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The Center for Plastic and Reconstructive Surgery, P.A. is in the process of implementing in Electronic Health Record (EHR).

Under the American Recovery and Reinvestment Act of 2009, certain demographic and health history information is required in our forms. Therefore, there are several questions that we need from you for our records.

PATIENT: _____

LANGUAGE OF CHOICE: _____

RACE:

_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ White
_____ Other: _____

ETHNICITY:

_____ Hispanic or Latino
_____ Not Hispanic or Latino

SMOKING:

_____ Never smoker
_____ Current every day smoker
_____ Current some days smoker
_____ Former smoker

Start date: _____ Quit date: _____

HEIGHT: _____ WEIGHT: _____

PHARMACY: _____

PHARMACY ADDRESS WITH ZIP CODE: _____

_____

PHARMACY TELEPHONE: _____

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PATIENT'S FINANCIAL AGREEMENT

As a courtesy to our patients, Center for Plastic and Reconstructive Surgery (here and after referred to as "CPRS") will submit charges for medical treatment to your insurance company **where and IF applicable.**

CPRS will attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does not pay.

If the patient participates in an HMO or PPO that requires co-payment, the patient MUST pay the co-payment at the time of the appointment.

We strive to provide an accurate cost **ESTIMATE** for the services to be rendered. Any and all further billing from any other provider needs to be discussed with that particular service provider.

CONTRACTUAL AGREEMENT TO PAY MEDICAL EXPENSES

I understand that I am personally responsible for all medical expenses incurred at CPRS for medical care and treatment. I agree to pay all medical expenses within 30 days of the date that I am billed for those expenses, unless other arrangements have been made with CPRS.

I further understand that the fees and estimates provided are for CPRS **ONLY.** Other providers of services such as the Surgery Center/Hospital, Anesthesia services or Pathology are separate and different from CPRS.

If I do have insurance, I authorize release of my medical information to my insurance company that I authorize payment of all medical benefits by my insurance company to CPRS and authorize CPRS to act as agents on my behalf with my insurance company. I further agree to assist CPRS with the appeal process, should it be necessary.

It may become necessary to release your protected health information to financial parties, credit card entities, and/or financing companies, when requested, to facilitate your payment.

____ Services that are performed and paid with a credit card, debit card or financing company are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow The Center for Plastic & Reconstructive Surgery, P.A. to use and disclose my protected health information to any credit card entity, bank, or financing company when the request such information to process an account and assist with payment.

____ I will not challenge such credit, debit, or financing card payment once services are provided. This practice encourages complete post-op care and follow-up interaction to address any issue that may arise.

____ I agree that this non credit card challenge agreement is irrevocable.

Patient Signature _____ Date _____

Witness _____ Date _____

801 North Orange Avenue
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www.petersplasticsurgery.com

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MEDICAL RECORDS & PHOTOGRAPHIC CONSENT

Center for Plastic & Reconstructive Surgery, P.A. (CPRS) is required to take photographs for purposes of your medical records. Therefore, I authorize CPFS and all designated employees to take pre-operative and post-operative photographs for this purpose. Photographs may also be used for the purpose of research, education and medical publication. I understand that a verbal request will be made by CPRS to grant permission to use these photographs to assist other surgical patients in making their surgical decisions. No form of compensation shall become payable for the use of these photographs. I hereby release CPRS and its agents from any and all claims and demands arising out of or in conjunction with the use of these photographs.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Print Name

I hereby grant permission for the use of any of my medical records including Illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Signature of Witness

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ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

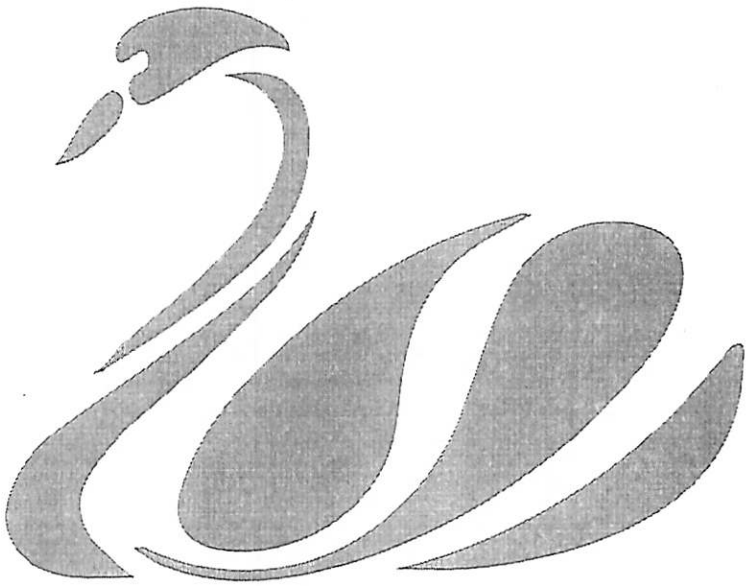
I hearby acknowledge that I have received or been given an opportunity to receive a copy of the Center for Plastic and Reconstructive Surgery, P.A., Kendall K. Peters, M.D. Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practices.

Patient Name (Type or Print)

Patient's Date of Birth

Signature of Patient or Parent/Legal Guardian

Date



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on October 1, 2015 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Pamela Henry. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1.00 for the first page and .25 per page thereafter. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: 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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and receive copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for the first page and .25 each additional page If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: Center for Plastic and Reconstructive Surgery Privacy Officer: Pamela Henry

Telephone: 407.898.1436 Fax: 407.898.6330

Email: Pamela@petersplasticsurgery.com

Address: 801 N. Orange Avenue, Suite 815, Orlando, FL 32801

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I, _____, authorize Center for Plastic & Reconstructive Surgery to speak with any person/s listed below regarding my private health information. I understand this consent will be in effect for the duration of my care with Center for Plastic & Reconstructi ve Surgery. If I choose to end this consent, I will speak with the office manager and will fill out any required forms from your office. I understand private health information means any medical records, financial records, treatment options, and/or any other information that is directly related to me.

Name of Person	Relationship to Patient	Contact Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Patient Signature Date

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