



PATIENT INFORMATION

Please Print

Today's date: _____

Title: Dr Mr Mrs Ms First name: _____ Last name: _____ Middle initial: _____

Address: _____

City: _____ State: _____ Zip: _____

SS# _____ Age: _____ Date of Birth: _____ Gender: M F Marital Status: M S W D

Drivers License number (if a minor, please use guarantor) Issuing State: _____ Number: _____

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Email: _____ Preferred method of contact: Home Work Cell Email

Education: _____ Occupation: _____ Race: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Address: _____

HOW DID YOU HEAR ABOUT US?

- Past Patient
- Physician (please list above)
- Friend
- Another Patient – Who: _____
- Website – DAVinciplasticsurgery.com
- Website – BreastReconstructionDC.com
- Other Website – Which one: _____
- Newspaper
- Seminar
- Magazine – Which one: _____
- Medical Literature
- Hospital – Which one: _____
- Yellow Pages

AUTHORIZATIONS

I authorize DAVinci Plastic Surgery, PC to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in DAVinci Plastic Surgery, PC determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and *if applicable* to process the insurance claim for services rendered at DAVinci Plastic Surgery, PC.

Patient Signature (Guarantor)

Date

GUARANTOR INFORMATION

(The guarantor is the responsible party for insurance payments and charges.)

CHECK HERE, IF SAME AS PATIENT INFORMATION

GUARANTOR NAME	SSN
RELATIONSHIP TO PATIENT	OCCUPATION
HOME ADDRESS	
CITY, STATE, ZIP	
HOME PHONE	BUSINESS PHONE

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME			
POLICY HOLDER'S NAME			
GROUP #		POLICY/ID #	
POLICY HOLDER'S DOB	SSN	RELATIONSHIP TO PATIENT	
CITY, STATE, ZIP			
HOME PHONE		BUSINESS PHONE	

SECONDARY INSURANCE INFORMATION

CHECK HERE, IF NONE

INSURANCE COMPANY NAME			
POLICY HOLDER'S NAME			
GROUP #		POLICY/ID #	
POLICY HOLDER'S DOB	SSN	RELATIONSHIP TO PATIENT	
CITY, STATE, ZIP			
HOME PHONE		BUSINESS PHONE	

Please note we will need to make a copy of your driver's license or state issued photo ID for your record.

AUTHORIZATIONS

Payments: With your signature on this form, you confirm you understand and agree that you are ultimately responsible for the services ever rendered by the Practice Provider. This includes all fees, co-payments and deductibles due at the time of the services as well as charges ever associated with surgeries, hospitalizations, scheduled office visits and/or procedures.

I authorize payment of medical benefits for treatment and/or surgery to DAVinci Plastic Surgery, PC.

If you self paid a surgery, procedure or office visit, regardless if it is for reconstructive or cosmetic services provided, you agree not to bill later your insurance company for The Practice provider's fees.

If my account is turned over to an attorney or collections agent to obtain payment, then I shall be responsible for the attorney's fee, court costs, and any other costs incurred by the collection agency. A copy of my signature shall have the same force and affect as the original.

Patient Signature (Guarantor)

Date



RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

H I P P A

I, _____ have been informed that a copy of our offices Notice of Privacy Practices is posted in the waiting room(s). A copy of this Notice will be furnished to me upon my request.

Patient Signature (Guarantor) _____
Date

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself please complete the following:

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them, in writing, whenever this information changes.

Home telephone	yes___ no___	Voice mail	yes___ no___
Answering machine	yes___ no___	Cell phone/voice mail	yes___ no___
Work phone	yes___ no___	Pager	yes___ no___
May we fax medical records for referrals? yes___ no___			

EMERGENCY CONTACT INFORMATION:

Emergency Contact: _____ Relationship to patient: _____
 Phone (cell): _____ Phone (work) _____ ext. _____ Phone(home): _____
 Preferred method of contact: Home Work Cell Email

Please list names of people we can discuss your medical or skin care with:

Spouse Name _____ yes___ no___
 Parent Name _____ yes___ no___
 Other Name _____ yes___ no___

Please give name and relationship such as boyfriend, sister, etc.

Anytime we receive a call from yourself or those that you have listed as individual(s) that may discuss your medical or skin care records they will have to supply a unique identifier that confirms identity. Please list your unique identifier as either the last four digits of your social security number or your mother's maiden name:

Unique identifier: (select one)

- Last four digits of SS# _____
- Mother's maiden name _____
- Pet _____



FINANCIAL POLICY

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

- I agree to furnish **DAVinci Plastic Surgery, PC** with a copy of my current health insurance card(s). I also agree to provide an explanation of benefits and/or claim form(s) from my insurance company, when applicable.
- I authorize the release of medical information necessary to process my insurance claim and I assign insurance benefits to **DAVinci Plastic Surgery, PC** for services provided to me by Steven P. Davison, MD
- I understand that co-pays are due at the time of service, as required by my insurance company.
- I agree that I will be responsible for balances applied to my account that are not covered by my health insurance plan.
- In the event my account is turned over to an outside collection agency, I agree that I will be responsible for a fee of \$50 by **DAVinci Plastic Surgery, PC** as well as any and all attorney fees, court costs, etc.
- I understand that my account will be charged \$40 when a check I presented for payment is returned and marked "non-sufficient funds" (NSF). Returned checks over \$500 will be assessed a fee of 5% of the amount of the check.
- I understand that **DAVinci Plastic Surgery, PC** will bill my health insurance company and will refund any overpayment on my account to the appropriate party (i.e., insurance company, patient).
- I understand that **DAVinci Plastic Surgery, PC** allows 30 days for the processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim; I will be notified if they do not receive a response.
- I will notify an Insurance Specialist at the practice if I am aware of a payment delay by my insurance company. It is my understanding the Insurance Specialists at the practice will provide me with assistance in resolving the claim.
- Any co-insurance, deductible, out of pocket and co-pay amounts will be my responsibility. Any balance left after your insurance has paid must be remitted within 30 days or each month an interest charge will be applied to your account of \$10 or 10% whichever is greater. In the event I am unable to pay my responsibility in full, I will contact the Insurance Specialist to discuss financial arrangements.
- I have read, understand, and agree to the insurance assignment and financial policies stated above. I also agree that I have had the opportunity to discuss any questions or concerns regarding the above with the Insurance Specialists at the practice.
- If you plan to pay privately for your services, please be advised that it is the policy of DAVinci Plastic Surgery, PC practice to collect payment in full at the time of service. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time.
- Motor Vehicle Accidents (MVA)/Third Party Liability: We will require all claim detail (claim#, contact info, billing address) at the time of your appointment; otherwise we will require payment in full for services rendered for each patient being treated for a MVA/other accident-related injury. We will file claim(s) with the motor vehicle or third party insurance company that you designate, provided we receive all necessary information with which to bill. If the claims are denied, or a protracted lawsuit is involved, the patient is responsible to pay the account balance in full. We will bill your private health for balance left after your personal injury protection (PIP) exhausted.
- Form Fees: Forms and letters requested by our patients will be assessed a fee as listed below. This list is not meant to be all inclusive but is merely representative of the items that may incur a charge. This fee covers our administrative expenses related to physician/staff time, photocopying, mailing, etc.
 - Work Excuses \$15 each
 - Disability forms \$20 each
 - Letters of Medical Necessity \$30 each
 - Family Medical Leave Act Forms \$15 each
 - Medical Records - 1-35 pages = \$0.75 per page; more than 35 pages = \$.20 plus postage

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth for services rendered by DAVinci Plastic Surgery, PC.

Patient Signature (Guarantor)

Date



CONSENT TO PHOTOS

I, _____ (print full name) understand that photographs will be taken periodically throughout my treatments and/or procedures. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give DAVinci Plastic Surgery the right to decline my treatment.

I consent to the taking of photographs by Dr. Steven P. Davison, or his designee of me or parts of my body in connection with the plastic surgery procedures(s) to be performed by Dr. Davison.

Patient Signature

Date

Witness Signature

Date

CONSENT TO USE PHOTOS

I grant Dr. Steven P. Davison the right to use photographs of me, in the following areas: (initial)

- All
- Website for Consumers
- Newsletter to be sent to patients
- Practice brochures
- Public relations material
- Seminars
- Patient before and after photo information sheets

If in the judgment of my physician, medical research, education or science will benefit by their use, the photographs and information relating to my case maybe published and republished in professional journals and medical books, or used for any other purpose which he may deem proper in the interest of medical education, knowledge, or research. I understand that in any such publication or use I shall not be identified by name.

I understand that such photographs may become the property of medical organizations or publications including but not limited to the ASPS, PRS, ASAPS, ASIF, Facial Plastic Surgery, Annals of Plastic Surgery or compatible journals and such organizations.

I understand that I may refuse to authorize the release of any photo documentation and that my refusal to consent to the release of photo documentation will prevent the disclosure of such information, but will *not* affect the health care services is presently received, or will receive.

I understand that by signing below DAVinci Plastic Surgery need not approach me again for authorization on these photos.

Patient Signature

Date

Witness Signature

Date

MEDICAL HISTORY

NAME	DOB	DATE
CHIEF COMPLAINT (Reason you came to the doctor)		
BRIEF HISTORY OF PRESENT ILLNESS/CONDITION		
LIST WHEN AND HOW YOUR CONDITION STARTED		
PAIN LEVEL 0 1 2 3 4 5 6 7 8 9 10	SEVERITY OF PAIN <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE	GRADE OF PAIN <input type="checkbox"/> CONSTANT <input type="checkbox"/> INTERMITTENT
DURATION OF COMPLAINT	WHAT HELPS THE PROBLEM	WHAT EXASERBATES THE PROBLEM
ASSOCIATED SYMPTOMS		

SOCIAL HISTORY

OCCUPATION	MARITAL STATUS
SMOKING <input type="checkbox"/> NO <input type="checkbox"/> YES Pack per Day _____ How Long _____ Quit Date _____	
ALCOHOL USE: <input type="checkbox"/> NONE <input type="checkbox"/> RARE <input type="checkbox"/> OCCASIONALLY <input type="checkbox"/> FREQUENT	HISTORY of ALCOHOL ABUSE: <input type="checkbox"/> YES <input type="checkbox"/> NO
RECREATIONAL DRUG USE <input type="checkbox"/> DENIED <input type="checkbox"/> MARIJUANA <input type="checkbox"/> COCAINE <input type="checkbox"/> HEROIN <input type="checkbox"/> PAIN MEDS <input type="checkbox"/> METH	

SURGICAL HISTORY (Past Surgeries with Dates)

BREAST:	ABDOMEN:	FACIAL:
COSMETIC:		OTHER:
ANESTHESIA PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	Explain: _____	

PAST MEDICAL HISTORY

NONE	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEART MURMUR	<input type="checkbox"/> YES <input type="checkbox"/> NO	LUNG DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
BREAST CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	MENTAL ILLNESS	<input type="checkbox"/> YES <input type="checkbox"/> NO
BLEEDING TENDANCY	<input type="checkbox"/> YES <input type="checkbox"/> NO	HISTORY DVT/PE	<input type="checkbox"/> YES <input type="checkbox"/> NO	NEUROLOGIC DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIV/ AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO
EYE PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	KIDNEY	<input type="checkbox"/> YES <input type="checkbox"/> NO	SKIN CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART DISEASE/MI	<input type="checkbox"/> YES <input type="checkbox"/> NO	LIVER DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	THYROID DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO

FAMILY HISTORY (indicate which Blood Relative)

SKIN CANCER	DIABETES	STROKE
BREAST CANCER	HEART DISEASE	ABNORMAL BLEEDING
OTHER CANCER	MALIGNANT HYPOTHERMIA	OTHER

CURRENT MEDICATIONS

<input type="checkbox"/> See List (Please list dosage and schedule)		<input type="checkbox"/> None	
1.	4.		
2.	5.		
3.	6.		
NON-PRESCRIPTION DRUGS			
ASPIRIN: <input type="checkbox"/> YES <input type="checkbox"/> NO IBUPROFEN: <input type="checkbox"/> YES <input type="checkbox"/> NO HOMEOPATHIC: <input type="checkbox"/> YES <input type="checkbox"/> NO SBE PROPHYLAXIS: <input type="checkbox"/> YES <input type="checkbox"/> NO			

Steroids in the last 12 months: Yes No
 Do you take a Blood Thinner? Yes No Name: _____

ALLERGIES TO MEDICATIONS/MEDICAL SUPPLIES
 Penicillin Licocaine Latex Tape Other: _____

Have you had recent weight gain? Yes Recent weight loss _____ lbs loss _____ lbs gain
 Height: _____ Current Weight: _____

REVIEW OF SYSTEMS

Fever / Chills: <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Ulcer: <input type="checkbox"/> Yes <input type="checkbox"/> No Night Sweats: <input type="checkbox"/> Yes <input type="checkbox"/> No Reflux: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision Loss: <input type="checkbox"/> Yes <input type="checkbox"/> No Back/Neck Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Double Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No Nerve Pain/Paralysis: <input type="checkbox"/> Yes <input type="checkbox"/> No Dry Eye: <input type="checkbox"/> Yes <input type="checkbox"/> No Facial Weakness: <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Obstruction: <input type="checkbox"/> Yes <input type="checkbox"/> No Depression/Anxiety: <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Urinating: <input type="checkbox"/> Yes <input type="checkbox"/> No Drug or Alcohol Dependency: <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Tendency: <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Swallowing: <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No Speech Changes: <input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged Thyroid/Goiter: <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure: <input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged Gland/Node: <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain or Tightness: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Sunburns: <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma/Breathing Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No Scarring/ Keloids: <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath: <input type="checkbox"/> Yes <input type="checkbox"/> No Renal Failure/Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Mass/Lump: <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis/Jaundice: <input type="checkbox"/> Yes <input type="checkbox"/> No
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FEMALE PATIENTS

Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you take birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you Planning Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently breast-feeding? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In the past Have you had a c-section? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? _____ <input type="checkbox"/> 1 year <input type="checkbox"/> 5 year
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When was your last mammogram? _____

Patient / Parent's Guardian Signature _____ **Date:** _____

Reviewed with Patient By: _____ **Date:** _____

Addendum's: _____ **Date:** _____

Updated with Patient By: _____ **Date:** _____