Orlando Cosmetic Surgery, LLC

PATIENT INFORMATION

Patient Name ____
LAST **FIRST** **MIDDLE**

Date of First Visit ____________________ Account # ____________________

Date of Birth __________ Age _________ Sex _________ Race ____ SS# ______________

Street Address ______________________City__________State _____ Zip____________

Mailing Address ______________________City__________State_____Zip____________

Home Phone (__)______________Cell Phone (__)______________Work Phone (__)________

Employer ___________________________ Address ______________________________

Driver's License # ____________ State of Issue ____ E-mail address ________________

PARENT OR SPOUSE INFORMATION

Name _____________________Relationship _____________ SS#____________

Mailing Address (if different from Patient) __________________________________

Home Phone (__)_____________________Work Phone (__)_________________

Employer ___________________________ Address ______________________

Driver's License # ____________ State of Issue ____ E-mail address ________________

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Referred by ________________ Address _______________ Phone________
May we write a letter to your referral source, thanking them for referring you?____Yes____No
Reason for Visit ____
Have you been treated elsewhere for this problem? _________ If so, by whom? _____
Name/Address of Primary Care Physician ______________________________

Do you authorize the release of medical records to:
Your Primary Care Doctor? ____Yes ____No ______________________________
Signature Date
Your referring Doctor? ____Yes ____No ______________________________
Signature Date

IF ACCIDENT RELATED, PLEASE COMPLETE THE FOLLOWING

Date of Accident _____ Time ______ Describe how accident happened: __________
____

Any legal proceedings involved regarding this visit _____Yes _____No
NAME OF INSURANCE CARRIER:______________________________
How do you plan to pay for this visit? ___Cash ___Check ___Insurance ___Credit Card

EMERGENCY CONTACT PERSON

Emergency contact person (or friend) other than a relative, who does not reside with you:
Name ____________________ Address ______________Phone ________

PRIMARY INSURANCE INFORMATION

Insurance Company ______________________________

Group or Individual ______________________________
If Group, Name of Employer ______________________________
Policy # ______________ Group# ______________ Insured's Date of Birth ______________
Insured's Name ______________________ Relation to Patient ______________
Insured's SS# ______________________ Ins. Co. Phone # ______________
Mail Claims To: ______________________________

SECONDARY OR WORKER'S COMPENSATION INSURANCE INFORMATION

Insurance Company ______________________________

Group or Individual ______________________________
If Group, Name of Employer ______________________________
Policy # ______________ Group# ______________ Insured's Date of Birth ______________
Insured's Name ______________________ Relation to Patient ______________
Insured's SS# ______________________ Ins. Co. Phone # ______________
Mail Claims To: ______________________________

INSURANCE RELATED SERVICES

The patient is responsible for all fees, subject to individual insurance requirements. We accept payment in the form of cash, check, or credit card. When insurance coverage applies, our office ill complete the necessary forms (using information that you provide) to expedite insurance payments. Prior authorization of services (especially surgery) and pre-verification of coverage may be necessary. Depending upon insurance coverage, you will be asked to pay deductible amounts, co-payments and charges for no-covered services.

I authorize release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. I hereby authorize Orlando Cosmetic Surgery, LLC to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents.

DATE: ______________ SIGNATURE: ______________________________

NON- INSURANCE RELATED SERVICES

The patient is responsible for all fees for any and all services provided by our physicians. I agree to pay for all services rendered by my physician per the office policy of Orlando Cosmetic Surgery, LLC

DATE: ______________ SIGNATURE: ______________________________

MEDICAL HISTORY

Height ____________ Weight _________ Exercise? _________ Diet? ___________

Do you use Tobacco? _______ Alcohol? __________ Drugs? __________
If yes, how much? ____

Have you had a recent weight loss or gain? _______ If yes, please explain.
____

Please list any allergies. ____

Surgical History: ____
____
____

Other Hospitalizations: ____
____
____

Have you been treated for any medical problems? __________ If yes, please explain: __________
____

Have you ever seen a psychologist or psychiatrist? ___________________________
Are you currently under treatment by a psychologist or psychiatrist? _______________________

______ Heart Problems: ____
______ Lung Problems: ____
______ Kidney Problems: ____
______ Coughing up or Vomiting Blood: ____
______ Blood in urine or stool: ____
______ Seizures or loss of consciousness: ____________________________________
______ High Blood Pressure: ____
______ Diabetes: ____
______ Cancer: ____
______ Hepatitis or yellow jaundice: ____
______ Thyroid Disease: ____
______ Other: ____

List any other medications you are currently taking, including over-the-counter drugs and herbal supplements: ____
____

Personal or family history of anesthesia or bleeding problems? If so, please explain:
____
____

Form for E-Prescribing Prescription Electronically

Dear Patients,

As we are transferring to electronic medical recording, we would like to help accommodate you by transmitting your prescriptions electronically. Please provide us with the following information for E-Prescribing:

Patient name: ______________________________

Name of your Pharmacy: ______________________________

Pharmacy Phone Number: ______________________________

Pharmacy Location: ______________________________
(Full address)

____

____

** If you should change your pharmacy in the future, please notify us so we can update our records.

Thank you,

Orlando Cosmetic Surgery, LLC

CONSENT TO RELEASE INFORMATION

Name:______________________________ Date of Birth: __________________

I, the undersigned, hereby authorize Orlando Cosmetic Surgery, LLC to release medical information concerning the above named patient to:

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship: ________________

You **may/may not** call me at home   You **may/may not** call me at work

_____ I give permission to leave a message on **home/work** recorder.

I understand that I may revoke this consent at any time by sending a written notice to the office.

I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

I do not want information released regarding: ______________________________

____

Signature of patient or legal guardian: ______________________ Date: __________

____

Street address   City   State   Zip code

____

Relationship (if not parent)   Witness

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:______________________ Signature: ______________________ Date: _________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and or patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

REORDER # 0403102

Orlando Cosmetic Surgery, LLC
Notice of Privacy Practices

- This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
- At Orlando Cosmetic Surgery, LLC, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- Our Electronic medical records database is protected by encrypted software using 250byte encryption for your protection.
- Our website and patient portal is protected using a certificate by third party (Comodo) that allows a secure connection from user to our office using secured socket layer (SSL).
- Even though our computer database is well protected, should your PHI ever be compromised you would receive a notice of breach.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may be required by your insurance company to send a report of your progress, history and physical, photos and/or surgical report for their review to determine payment benefits.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may use or disclose your medical information with one of our business associates, such as a billing or transcription service. We have an updated written contract with each business associate that requires them to protect your privacy. This contract is in compliance with the new HIPAA final rule released January 17, 2013, effective March 26, 2013.
- We may use your information to contact you. For example, we may send newsletters or other information to you. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- We may use or disclose your demographic information and the dates that you received treatment from our physician, as necessary, in order to contact you for fundraising activities supported by our office. All fundraising communications will include information about how you may opt out of future fundraising communications. If you do not want to receive further fundraising communications, please contact our Privacy Officer and request that these fundraising materials not be sent to you. We will then make reasonable efforts to ensure that no further fundraising communications be sent to you.
- In an emergency, we may disclose your health information to a family member or another person responsible for you care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond that above normal uses.

- As we will need to contact you from time to time, we will use whatever address or telephone number we have on file for you.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you need. If you also want a copy of your records, we may charge you a reasonable fee for the copies based on Florida law.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the change at your next appointment after the effective date of the change.
- We reserve the right to have your medical records and files reviewed by our corporation's attorney (currently, Law Offices of Dominick Salfi, Jr.) as part of our medical quality assurance.
- If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. Any complaints should be in writing, state the nature of the complaint, and how to contact you. Our privacy officer will be happy to try to resolve any adverse event with you or write to: Secretary of Health and Human Services; The U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint and your complaint will not affect your diagnosis or any treatment we are providing you.
- However, before filing a complaint, for more information, or assistance regarding your health information privacy, please contact our office at 407-681-3223. We would be most happy to try to honor your request.

This notice goes into effect as of September 23, 2013.

Acknowledgement

I have received a copy of the Orlando Cosmetic Surgery, LLC; Notice of Privacy Practices.

Signed ______________________________ Print Name____________________ Date_________

If signing as a parent or guardian, please note the name of the patient ______________________

Orlando Cosmetic Surgery, LLC

Cosmetic and Reconstructive Plastic Surgery

Orlando J Cicilioni, Jr. M.D. F.A.C.S.
Certified – American Board of Plastic Surgery
Chairman, Florida Hospital Plastic Surgery Department

Phone # (407) 681-3223
Fax # (407) 681-0976

Patient Payment Policy

Thank you for choosing Orlando Cosmetic Surgery, LLC as your service provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy to explain things more clearly. Please read it, ask any questions you may have, and sign in the space provided. A copy may be provided to you upon request.

1. **Insurance**
   We participate in most insurance plans, including Medicare. If you are not insured by a place we do business with, payment in full is expected at each visit and prior to surgery. If you are insured by a plan we do business with, but do no have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments, Co-Insurance, & Deductibles**
   - Co-payment: This is the payment your insurance policy requires you to pay directly to the doctor each time you have a visit, or when medical services are rendered. Copayments are usually required, even after your insurance deductible has been met.
   - Co-insurance: This is generally defined as the percentage of the payment you are required to pay for your service after the deductible has been met, up to a certain limit as defined by your insurance plan. This must be paid before any policy benefit is payable by an insurance company.
   - Deductible: This is the portion of your bill that you must pay out of pocket, before your insurance policy is required to pay any benefits.

All co-payments, co-insurance, and deductibles must be paid at the time of service and prior to surgery. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payment, co-insurance, and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit and prior to your surgery.

3. **Non-Covered Services**
   Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other private insurers. You must pay for these services in full at the time of each visit.

4. **Proof of Insurance**
   All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance care to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner you may be responsible for the balance of the claim.

5. **Claim Submission**
   We will submit your claim and assist you in any way we reasonably can to help your claims get paid. We utilize a billing agency called M.D. Everywhere for the purposes of submitting our claims and performing our billing through insurance carriers. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. **Coverage Changes**

If your insurance changes, please notify us before your next visit and prior to your surgery so we can make appropriate changes to help you receive your maximum benefits. **If your insurance company does not pay your claim within 180 days, the balance will be automatically billed to you.**

7. **Non-payment**
   It is our office policy to give your insurance carrier 120 days from the date of service of your surgery to make good on payment for the claim. During this time if your insurance carrier denies payment for the service we will make every attempt possible to re-bill and work this claim diligently. At the end of 120 days if the claim is still not paid by your insurance company we will inform you in writing of the situation and advise you that your insurance carrier has not paid on your claim and that your account is now delinquent, then you will be given 60 days to make restitution and payment in full. Please be aware that if a balance remains unpaid for 60 days we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period our physician will only be available to treat you on an emergency basis.

8. **Missed appointments**
   Our policy is to charge for missed appointments not cancelled by you with at least 24 hours advance notice. These charges will be your responsibility and billed to you directly. Your insurance carrier is not responsible for coverage for your missed appointments. Please help us serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by the guidelines.

______________________________ ______________

Signature of patient or responsible party **Date**

____

Printed name of patient or responsible party

Payment Policy for patients receiving treatment who do not have insurance coverage

Orlando Cosmetic Surgery, LLC and the physicians who work for this practice are considered to be "private practice plastic and reconstructive surgeons." This office does not receive subsidy or funding from the State of Florida for taking care of patients who are uninsured. We will certainly render treatment to your in any life-threatening situation of if we are on call for the emergency room whether or not you have insurance and provide the same high quality level of care irrespective of insurance status.

However, we do reserve the right to bill your for our services. If you do not have health insurance coverage for your condition it remains your responsibility to make payment arrangements for your treatment. Please consult with our office manager with regards to what the expected costs will be for your treatment and/or surgery. We are willing to work with your and negotiate payment arrangements on a term that is manageable for your situation. Please understand that it is not possible for us to extend charity care to all patients who walk through our door. It is very expensive to run a medical practice and payment will be expected for the services you receive.

I have read the payment policy and I understand and agree to abide by the guidelines.

______________________________ ______________

Signature of patient or responsible party **Date**

____

Printed name of patient or responsible party