ORLANDO COSMETIC SURGERY, LLC dba

Altiora

Plastic Surgery & Med Spa

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 _____

****

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 INSUREANCE 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 will 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, dba Altiora Plastic Surgery and Med Spa 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, dba Altiora Plastic Surgery and Med Spa

DATE: _____ SIGNATURE:_____

MEDICAL HISTORY

Height _____ Weight _____ Diet? _____

Exercise? Yes No
If yes, how often?_____

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

Do you use Tobacco? _____ Alcohol? _____ Drugs? _____
If yes, how much? _____

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:
_____
_____

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ELECTRONIC PRESCRIPTIONS

Dear Patients,

As we are transferring to electronic medial recording we would like to help accommodate you by transmitting your prescriotions 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, dba
Altiora Plastic Surgery and Med Spa

Orlando Cosmetic Surgery, LLC, dba

Altiora Plastic Surgery and Med Spa

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, dba Altiora Plastic Surgery and Med Spa, 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 through our software company, Macpractice 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 941.388.1110. We would be most happy to try to honor your request.

This notice goes into effect as of February 22, 2017.

Acknowledgement

I have received a copy of the Orlando Cosmetic Surgery, LLC, dba Altiora Plastic Surgery and Med Spa; 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, dba

Altiora Plastic Surgery and Med Spa

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: _____

You **may/may not** call me at <u>home</u> You **may/may not** call me at <u>work</u>

_____ 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

Orlando Cosmetic Surgery, LLC dba
Altiora Plastic Surgery and Med Spa
PATIENT PAYMENT POLICY

Thank you for choosing Orlando Cosmetic Surgery, LLC dba Altiora Plastic Surgery and Med Spa 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 plan 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 not 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, COINSURANCE, & DEDUCTIBLES**.

   Deductable: This is the portion of your bill that you must pay out of pocket, before your insurance policy is required to pay any benefits.

   Copayment: 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 deductable has been met.

   Coinsurance: This is generally defined as the percentage of the payment you are required to pay for your service after the deductable 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.

   Copayments usually do not contribute to any policy out-of-pocket maximums, whereas coinsurance payments usually do.

   All co-payments, deductibles and co-insurance 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, deductibles and co-insurance 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 card 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 a 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. **NONPAYMENT**. 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. However, 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, that your account is now delinquent, and you will be given 60 days time to make restitution and payment in full. Please be aware that if a balance remains unpaid after 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 to 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 guidelines:

_____ _____

Signature of patient or responsible party Date

PAYMENT POLICY FOR PATIENTS RECEIVING TREATMENT WHO DO NOT HAVE INSURANCE COVERAGE

Orlando Cosmetic Surgery, LLC dba Altiora Plastic Surgery and Med Spa 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 you in any life-threatening situation or 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 you for our services. If you have no 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 your surgery. We are willing to work with you 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 in our door. It is very expensive to run a medical practice and some form of payment will be expected for the services you receive.

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

_____ _____

Signature of patient or responsible party Date