Peninsula Plastic Surgery

Account#: **PATIENT INFORMATION**

Last Name **First Name** **Middle**

Address

City **State** **Zip**

Home Phone: **Cell Phone** **E-mail:**

Preferred way of contact? _____ **Restrictions for contacting you?** ☐No ☐ Yes If yes, List: _____

Age: **Birthdate:** **SS#:** ☐ Female ☐ Male ☐ Unspecified

Marital Status ☐ Single ☐ Married to: ☐ Other: _____ **Referred By:** _____

PATIENT'S EMPLOYER INFORMATION

Employer: _____ **Occupation:** _____

Work Phone: _____ **Ext:** _____ **Is it okay to call you at work?** ☐ Yes ☐ No

Address: _____ **Full Time** ___ **Part Time** ___

Street & Suite# City State Zip

EMERGENCY CONTACT

Name: _____ **Relationship to Patient:** _____

Home Phone: _____ **Work Phone:** _____ **Other:** _____

INSURANCE INFORMATION & AUTHORIZATION

Primary Insurance: **Are You Enrolled In Hospice? Y___ N ___**

Primary Insurance ID Number: **Group Number:**

Policyholder's Information (if other than the patient)

Name: _____ **Birthdate:** ____/____/_____ **SSN:** _____

Employer: _____ **Relationship to Patient:** _____

Does this insurance require a referral? ☐ Yes ☐ No **Copay Amount:** $

Secondary Insurance: Secondary Insurance ID Number:

Group Number:

Policyholder's Information (if other than the patient)

Name: _____ **Birthdate:** ____/____/_____ **SSN:** _____

Employer: _____ **Relationship to Patient:** _____

Does this insurance require a referral? ☐ Yes ☐ No **Copay Amount:**

Is this visit due to any type of accident? ☐ No ☐ Yes: **Date of Accident:** _____

Type of Accident ☐ Auto: State? _____ ☐ Work Related ☐ Other: _____

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practice (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgement. As provided in out Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

CONSENT TO TREATMENT

This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all diagnostic procedures and/or such medical, surgical, lab, or x-ray treatment, which in the judgment of my attending physician or his authorized agent may be considered necessary or advisable.

_____ _____

Date Signature

Peninsula | PLASTIC SURGERY P.C.

Vincent Perrotta, MD
Kerri Holloway, CRNP | Jayme Isett, PA-C | Paige Torpey, CRNP

Confidential Patient History Form

Confidential Record: Information contained herein will not be released unless you have authorized us to do so.

Account: **Name:** _____

Race: _____ **Ethnicity:** _____ ❒ I decline to answer

Preferred Language: _____ **Reason for Visit:** _____

PAST MEDICAL HISTORY

Have you had any serious illnesses in the last five years? ❒ Yes ❒ No

If yes, please list: _____

Please list all previous surgeries with dates: _____

_____

If you are a breast cancer patient, please provide the date of diagnoses: ___ ___/ ___ ___/ ___ ___ ___ ___

_____

FAMILY HISTORY

Do you have a family history of? Diabetes: ❒ Yes ❒ No Breast Cancer: ❒ Yes ❒ No

Skin Cancer: ❒ Yes ❒ No Coronary Artery Disease: ❒ Yes ❒ No

Other: _____

REVIEW OF SYSTEMS

Have you had or do you have any of the conditions listed below?

- ☐ Abdominal Bleeding
- ☐ Active Infection
- ☐ AFIB
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood clots/DVT
- ☐ Breast cancer
- ☐ Breathing Problems
- ☐ Cancer_____
- ☐ Chest Pain/tightness
- ☐ Cholesterol(high/low)
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Defibrillator (YES or NO)
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Palpitations/Murmur
- ☐ Hepatitis (A,B or C)
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Immunity Problems
- ☐ Implants _____
- ☐ Kidney Problems/Stones
- ☐ Liver Disease
- ☐ Mental Illness _____
- ☐ Metals _____
- ☐ MRSA
- ☐ Pacemaker (YES or NO)
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ STD _____
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcer Disease
- ☐ **No Medical History**

Has a doctor advised you of a heart condition? What did he/ she say? _____

Name of Cardiologist: _____

List any medical conditions that your physician should be aware of: _____

List the date and location of your last mammogram _____

Is there anything else that you would like to discuss with the doctor during your visit? _____

_____

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____

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Date:
Account #:
Name: **Ht:**_____ **Wt:**_____

SOCIAL HISTORY

Do you smoke tobacco? ❒ Yes ❒ No How many packs per day?_____ How many years? _____

Do you have a history of smoking? ❒ Yes ❒ No If yes, when did you quit? _____

Do you consume alcoholic beverages? ❒ Yes ❒ No How many drinks/ beers per week? _____

Do you use recreational drugs? ❒ Yes ❒ No If yes, please list: _____

FLU VACCINE HISTORY

Did you get a flu vaccine? ❒ No, I did not want it ❒ No, I am allergic ❒ No, I have an egg allergy

❒ Yes, I received one on my own, if yes what pharmacy did you use? _____

❒ Yes, I received one at surgery

MEDICATION HISTORY

Are you enrolled in a Pain management program or Methadone clinic? ❒ Yes ❒ No

If yes, please list your current doctor:_____

Are you allergic to any medications or other substances: ❒ Yes ❒ No **If yes, please list:**

Medications you are allergic to	Reaction

Primary Care Physician:_____ **Referring Physician:**_____

Preferred Pharmacy: _____ **City:**_____

Please list any and all medications you are taking by name and dosage

Medication	Dosage	Frequency	Reason For Taking This Medication

Keep this form for your records

Peninsula Plastic Surgery's Financial Policy (Front)

Your Plan	What You Do	What We Do
Medicare	Pay your deductible and co-insurance (20% of the allowable.)	We will file Medicare for you.
Medicare secondary insurance	No payment due at time of service.	We will file Medicare and your secondary insurance for you.
Medicaid	Payment due at time of service.	We will file Medicaid for you. You will be reimbursed in the case that Medicaid pays your claim.
CareFirst & Blue Cross Blue Shield	Pay your deductible, co-insurance or co-pay at time of service. Supply a referral if necessary	We will check your eligibility before every visit and will file your Blue Cross insurance for you
United Healthcare	Pay your deductible, co-insurance or co-pay at time of service. Supply a referral if necessary.	We will check your eligibility before every visit and will file your United HealthCare insurance for you.
Informed, Conifer, OneNet, Coresourse, Coventry, Integra	Pay your deductible, co-insurance or co-pay at time of service. Supply a referral if necessary.	We will check your eligibility before every visit and will file your insurance for you.
Aetna & Aetna HMO	Pay your deductible, co-insurance or co-pay at time of service. Supply a referral if necessary.	We will check your eligibility before every visit and we will file your Aetna insurance for you.
Cigna	Payment due in full at time of service.	We will file your insurance for you and assign benefits to you so you will receive payment from your insurance plan.
HealthSmart	Pay your deductible, co-insurance or co-pay at the time of visit or place a credit card on file for the balance when the claim is paid. Supply a referral if necessary.	We will check your eligibility before every visit and will file your HealthSmart insurance for you.
Insurance we are not contracted with	Payment due in full at time of service.	We will file your insurance for you and assign benefits to you so you will receive payment from your insurance plan.
Worker's Compensation	You must have opened a claim with your employer to be seen. No payment due at time of service.	We will file your Worker's Compensation insurance for you. If payment is not received within 120 days, balance is forwarded to the patient.
Automobile Accident	You must have opened a claim with your insurance company to be seen. Full payment due at time of service or supply current medical health insurance.	We will call to find out the terms of and will file your automobile insurance for you. We do not file medical insurance if we know your automobile insurance is responsible.

Peninsula Plastic Surgery's Financial Policy (Back)

Patients Name _____ **Date of Birth**

AGREEMENT TO PAYMENT POLICY
I acknowledge that I received a copy of Peninsula Plastic Surgery's financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION
I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to the third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state and local laws. I further authorize any other individual or entity that has provided health care to me to release to Peninsula Plastic Surgery, any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS
I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Peninsula Plastic Surgery for any services provided to me and/ or my dependents. I authorize any holder of medical information about me and/ or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT
I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to Peninsula Plastic Surgery are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to the third party collection agency, I agree to be responsible for a $25.00 collection processing fee and or interest due to amounts in default.

REFUNDS
In the event a patient payment results in an overpayment or "credit balance" on your account, the overpayment will be refunded to the patient as soon as all payments posted to the account have been verified and any unpaid dates of service have been resolved.

Installment Agreement
In the event you are unable to make payment in full, a payment plan can be set-up. The Set-up and Management fee for this service is $25.00 and must be paid prior to your first payment due date.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES
I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Peninsula Plastic Surgery.

_____ _____
Patient's Signature Date

_____ _____
Responsible Party Relationship to patient

Medicare Patients Only- Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of my medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature: _____ **Date:** _____

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PATIENT HIPAA COMMUNICATION FORM

Disclosure to Self and to Others

Patient Name:_____ Patient ID:

With your approval, we may disclose your personal health information to designated family, friends and others involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval.

By signing this authorization, I allow Peninsula Plastic Surgery, P.C. to discuss with the person(s) named below my personal health information which may include, but is not limited to laboratory, test results, diagnosis, prognosis, treatment plan, and billing status. This may be done in person or by telephone.

By signing this authorization, I understand the following:

This applies to services being rendered to me by the physicians and non-physician providers who practice under the name of Peninsula Plastic Surgery, P.C.

Once this information is released to the designated family member, friend or other person named below, the release information may no longer be protected by the federal privacy regulations.

This authorization is voluntary.

I may withdraw this authorization at any time by notifying the PPS Privacy Officer in writing. If I do withdraw the authorization, it will not have any effect on actions taken by PPS prior to receiving the written request.

I authorize discussion of my personal health information with the following person(s):

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

X_____ _____ _____

Patient or Representative Signature **Relationship to Patient** **Date**

Patient: Procedure Date:

SOCIAL MEDIA & ADVERTISING CONSENT FORM

Authorization: I, _____, authorize the use of my photographic/video images, interview, questionnaire, and/or patient testimonial for marketing and educational purposes (as selected below) by Dr. Perrotta and/or Peninsula Plastic Surgery P.C.. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA and state law patient privacy regulations.

Purpose: The photographic/video images, interview, questionnaire, and/or testimonial may be used for the following purpose(s) (**initial next to each approved media**):

_____ Social media option #1 (e.g. Facebook, Instagram, Youtube, Snapchat, etc.)

_____ Social media option #2 (images **MAY** be used but will block patient identifiers e.g. eyes, tattoos and piercings)

_____ Print Advertising (e.g. magazines, newspapers, postcards)

_____ Digital Ads (e.g. Web ads, social ads)

_____ Patient Education/Information (e.g. photo album, seminars, website)

_____ None

Use of Name (initial one):

_____ My full name may be associated with my photographic/video images, interview, questionnaire, and/or testimonial

_____ Only my first name may be associated with my photographic/video images, interview, questionnaire, and/or testimonial

_____ My name may **NOT** be associated with my photographic/video images, interview, questionnaire, and/or testimonial

Reprint/Redistribution: I acknowledge that my photographic/video images, interview, questionnaire, and/or testimonial may be reprinted or redistributed across all approved media. **Patient Initials** _____

Revocability: I understand that I may revoke this authorization at any time, provided I give notice to the practice in writing via registered or certified U.S. mail. Revocation is not retroactive and will not affect the prior use of my photographic/video images, interview, questionnaire, and/or testimonial. This authorization expires 10 years from the date signed. **Patient Initials** _____

No treatment conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization. I am free to refuse to sign this form for any reason, without affecting my treatment in any way. **Patient Initials** _____

Copy: I have been provided a copy of this Social Media & Advertising Consent Form. **Patient Initials** _____

☐ Patient is a minor, and we, the undersigned, are the parents or guardian of the patient and hereby consent for the patient.

Signature _____ **Date** _____

Witness _____

Vincent Perrotta, MD
Kerri Holloway, CRNP | Jayme Isett, PA-C | Paige Torpey, CRNP

SCHEDULING AND CANCELLATION POLICY FOR PENINSULA PLASTIC SURGERY, PC and RENAISSANCE MED SPA

At Peninsula Plastic Surgery, PC and Renaissance Med Spa, we pride ourselves in offering the best care for our patients. Please make yourself aware of our practice policies and procedures described below. Our policies have been designed to ensure you enjoy a truly peaceful and relaxing visit with us.

CONSULTATION – Peninsula Plastic Surgery, PC and Renaissance Med Spa are dedicated to helping you achieve your aesthetic goals. We offer consultations to better understand each individual's needs. Based on a private skin and/or body analysis and conversation, we partner with you to design a treatment plan that will best meet your expectations.

SCHEDULING – Peninsula Plastic Surgery, PC and Renaissance Med Spa are always busy, so appointments are necessary. For your convenience, we recommend scheduling your next treatment before leaving our facility. Due to the nature of many of our treatments, appointments can sometimes exceed their scheduled time. Please be patient and know that you will also receive the same exceptional service and personal attention.

DEPOSIT & CANCELLATION POLICY – A scheduled appointment at Peninsula Plastic Surgery, PC and Renaissance Med Spa reserves the time of our professionals. Out of respect for the providers time, we do require a 50% deposit towards laser and all other self-pay procedures. A $100 deposit is required to schedule a consult with one of our providers and this will go towards the treatment. Cancellations are accepted up to 24 hours prior to your appointment without incurring a charge. Cancellations with less than 24 hours or no-shows require a $50 service fee. Thank you for your consideration.

PAYMENT – Payment is expected at the time of service. If payment is not rendered, Peninsula Plastic Surgery and Renaissance Med Spa reserve the right to charge your credit card on file for the full amount due.

We apologize in advance for any inconvenience our new policy may cause you. Unfortunately, it is needed so we can continue to provide you with the highest quality of service and care that you expect from Peninsula Plastic Surgery, PC and Renaissance Med Spa.

_____ _____

Signature Date