Mid Atlantic Plastic Surgery | Adam M. Mecinski, M.D.

NEW PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Birthdate (mm/dd/yyyy): _____ Last 4 digits of SS: _____ Sex: (circle) Male Female

Address: Street_____ City_____ State_____ Zip_____

Cell Phone: _____ Home Phone: _____

Email address:_____

Primary Care Provider: _____ Cardiologist: _____

Pharmacy Name/Address: _____

Marital Status: (circle) MARRIED SINGLE SEPARATED DIVORCED WIDOWED

Emergency Contact: Name_____ Phone _____ Relationship_____

PRIMARY INSURANCE

Insurance Company:_____ Employer:_____

Policy Holder Name:_____ Birthdate (mm/dd/yyyy): _____

Policy # or ID#: _____ Group #:_____

Policy Holder Address (if different than patient):_____

Patient Relationship to Policy Holder (circle): SELF SPOUSE CHILD OTHER: _____

SECONDARY INSURANCE

Insurance Company:_____ Employer:_____

Policy Holder Name:_____ Birthdate (mm/dd/yyyy): _____

Policy # or ID#: _____ Group #:_____

Policy Holder Address (if different than patient):_____

Patient Relationship to Policy Holder (circle): SELF SPOUSE CHILD OTHER: _____

WORKER'S COMPENSATION CLAIM INFORMATION

Date of injury:_____ State occurred in: _____ Insurance Carrier: _____

Claim #: _____Adjuster Name: _____ Phone #: _____

I certify that I have read and understand this packet. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____

NEW PATIENT REGISTRATION

HEALTH HISTORY

Last Name: _____ First Name: _____ MI: _____

Age: _____ Height: _____ Weight: _____ Occupation: _____

Reason for your visit today: _____

List your significant medical problems:

_____

_____

_____

_____

List your previous operations (with approximate dates):

_____

_____

_____

_____

Allergies (Including iodine, tape, etc):_____

_____

List all medications that you are currently taking, amount and how often:

_____

_____

_____

_____

Do you currently smoke? YES NO If yes, how much per day? _____

Do you drink alcohol? YES NO If yes, circle one: FREQUENTLY OCCASIONALLY RARELY

Have you been on steroids (Cortisone/Prednisone) in the last year? YES NO

HEALTH HISTORY (continued)

HAVE YOU HAD OR DO YOU CURRENTLY HAVE… (check one below)

	YES	NO		YES	NO
Rheumatic Fever?			Epilepsy or convulsions?		
Damaged heart valves/MVP?			Stroke?		
Heart Murmur?			Thyroid trouble?		
Do you pre-medicate when you go to the dentist?			Diabetes?		
High blood pressure?			On dialysis?		
Low blood pressure?			Stomach ulcers?		
Chest pain, Angina?			Fever blisters of the lips?		
Heart Attack(s)?			AIDS or HIV infection?		
Irregular Heartbeat?			Problems of the immune system?		
Cardiac Pacemaker?			Mental health problems?		
Asthma?			Dry eye symptoms?		
Tuberculosis (TB)? *(if yes, circle one: active inactive)*			Contact lenses?		
Emphysema?			Eye Disease / Glaucoma?		
Shortness of breath when walking?			Radiation or Chemo treatment?		
Blood Disorder such as anemia?			Blood transfusion?		
Excessive bleeding tendency?			Family history of malignant hyperthermia?		
Hepatitis? *(if yes, circle one: A B C)*			Do you form large scars or keloids?		
Jaundice or liver disease?			Pain in your calves with walking?		
Pulmonary Edema, Embolus, or DVT?			Epilepsy or convulsions?		

Form 1: General Notice to Patients

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, MID ATLANTIC PLASTIC SURGERY ("Provider"), to disclose the information in your medical records to the extent needed for the following purposes:

- For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other health care providers who are treating you or consulting in your care.
- For the purpose of arranging payment for your care. This would include, for example, your insurer or other third-party payor who is responsible for paying all or part of the cost of your care.
- For the purpose of Provider's "health care operations." This would include such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and the provision of legal and auditing services.

B. A Specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing disclosure and will contain any limitations on the authority to disclose your records.

C. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.

D. Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Dept of Health and Human Services.

I acknowledge that I was provided with a copy of the General Notice of my rights regarding release of my medical records.

Signature: _____

Print Name: _____

Date:_____

Form 2: Release of Medical Information

E. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

F. You have the following rights with respect to your medical records/information:

- You have the right to request restrictions on the use and disclosure of your medical records/information; however, the Provider is not required to agree to restrictions guaranteed by law. You will be informed if the Provider will not agree to a requested restriction.
- You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
- You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
- You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
- You have a right to receive an accounting (list) of disclosures of your medical records/information made by Provider. (Except for those disclosures that fall within the scope of Provider's "health care operations" or disclosures made for payment or treatment purposes.)
- You have the right to receive a paper copy of this notice, at your request.

G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate.

H. If a patient believes that his or her privacy rights have been violated, the patient may complain to the Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to the Provider, please write or call us with the details. Providers will not retaliate in any way against a patient for making a complaint.

I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office.

J. Provider reserves the right to change its privacy practices and to make its new policies effective for all protected health information that provider maintains. If such changes are made, Provider will issue an updated "Notice to Patients" to all of Provider's patients.

I acknowledge that I was provided with a copy of the General Authorization for Release of Medical Records, and that these policies may be changed by the provider and I will be given an update notice if this occurs.

Signature: _____

Print Name: _____

Date:_____

DISCLOSURE OF INFORMATION TO FAMILY/FRIENDS

_____ I do not want Mid Atlantic Plastic Surgery ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

_____ _____

_____ _____

The authorizations provided for above are subject to the following limitations or restrictions:

_____

_____

DISCLOSURE OF INFORMATION TO MEDICAL PRACTICES

Please list the following providers that you give permission to share copies of any Office Notes, Pathology Reports and Surgical Reports if requested by their offices:

Provider name :_____ Phone: _____

Provider name :_____ Phone: _____

Provider name :_____ Phone: _____

Provider name :_____ Phone: _____

Signature: _____

Print Name: _____

Date:_____

FINANCIAL POLICY

Basic Policy: Payment for service is due in full at the time service is rendered unless insurance information has been provided to the office.

Facility Policy: The professional fee will be billed by Dr. Adam Mecinski/Mid Atlantic Plastic Surgery. You will receive a separate bill for the use of the surgery center or hospital and their services, as they are separate entities. You may also receive a separate bill for anesthesia or pathology if utilized. These are not included in our fee.

Insurance Billing: We bill most insurance carriers for you if you have provided the proper information to us. Referrals (if required) must be obtained and brought to our office for initial consultation and follow up visits. Co-Payments and deductibles are due at the time of service. Since your agreement with your insurance is specific to your own policy, we will work with you if there is an insurance problem, but our agreement is with you and may not be with your insurance. Any payment denied by your insurance will be your responsibility.

Non-Covered Services: Any service designated as non-covered by your insurance will require payment at the time services are provided or upon notice of insurance denial for “non-covered service.” Any payment denied by your insurance will be your responsibility.

Assignment of Insurance Benefits: For services rendered by Adam M. Mecinski, M.D. / Mid Atlantic Plastic Surgery, I hereby assign any and all medical and or surgical benefits to which I am entitled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my medical insurance, workers compensation or other insurance plans. I hereby authorize Adam M. Mecinski, M.D. and/or Mid Atlantic Plastic Surgery to release all information necessary to secure reimbursement (including photographs). I have read, understood and agreed to the above financial policy for payment of professional fees.

Signature: _____

Print Name: _____

Date:_____