Posh Plastic Surgery

PATIENT REGISTRATION

Date:_____

Last Name:_____ **First Name**:_____ **MI**:__

Date of Birth:____/____/____ Age:____ **Gender**: Male Female **SSN**_____/_____/____

Weight:_____ **Height:**_____ **Name Suffix**: Jr. Sr.

Marital Status: Married Single Other

Employment Status: Employed FT student PT student

Health Insurance--Primary: _____

Sponsor ID/Insurance plan Number_____

Health Insurance--Secondary: _____

Sponsor ID/Insurance plan Number_____

Address:_____

City:_____ **State**:_____ **Zip**:_____

Home phone: (_____)_____**Work phone:** (_____)_____**Preferred contact:** home work cell Do Not Call email

Cell phone: (_____)_____ **Fax :** (_____)_____

Email: _____

EMPLOYMENT INFORMATION:

Employer Name: _____ **Employer phone:** (_____)_____

Employer Address: _____

_____

EMERGENCY CONTACT:

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

Address:_____

Home phone: (_____)_____ **Cell phone**: (_____)_____

How did you hear about us? Google Search Real self Money Pages Friend Referral Other:_____

Friends name:_____

9066 Cypress Green Drive
Jacksonville, FL 32256
office (904) 260-2001
fax (904) 260-2010
www.PoshPlasticSurgery.com

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Primary Care Physician:_____
Address:_____
Phone: (_____)_____ **Fax:** (_____)_____

Name:_____ **Age:**_____ **Date:**_____

Reason for visit today:_____
_____

PAST HEALTH HISTORY

Medical History
My present state of health is: FAIR GOOD EXCELLENT

Do you have:	High blood pressure	Y / N	Diabetes	Y / N	
	History of heart attacks	Y / N	Skin Cancer	Y / N	
	Heart conditions	Y / N	Take Aspirin	Y / N	
	Mitral valve prolapse	Y / N	Cancer	Y / N	type_____
	Take Blood Thinners?	Y / N	Anemia	Y / N	

Please list any medical problems or conditions that you have:_____
_____
_____
Exercise: Type and frequency:_____

Surgical History:
Prior surgeries: Y / N
Please list all prior surgeries and dates:_____
Problems with anesthesia (general or local):_____

Gynecological History:
Pregnancies_____ Live Births_____ Age of your Children_____
Birth control method_____ Last period_____ Could you be pregnant? _____
Did you ever Breastfeed? Y N How long?_____ When did you stop?_____
For reduction consults: Upper Back pain Y/N Neck pain Y/N Shoulder strap grooves Y/N Skin irritation Y/N

Family history:
Diseases that run in your family_____
Family history of breast cancer? Y / N if yes, who?_____
Last mammogram date and results _____

Social History:
I drink alcohol: NEVER SOCIALLY DAILY
Recreational drug use: NEVER SOCIALLY DAILY
Smoking: Current every day smoker **Frequency:** 1-5/day quit date:_____
Current some day smoker 6-10/day
Former smoker ½ pack/day
Never smoked 1pack/day More

Allergies: (drug, food, or seasonal) Y / N _____

Medications: please list all medications you take including vitamins and diet pills:_____
_____
I attest the above information is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescribed course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Dr. Kirk or any member of her staff

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Patient Signature _____ Printed name:_____ Date:_____

COSMETIC SURGERY TREATMENT PLAN AND FINANCIAL POLICY

The cost of the surgery will include price of Anesthesia, Surgical Facility, any implants or devices used, an initial garment, and the surgeon's fee.

It does **NOT** include, and you may need to obtain the following: Medications, Clearance for surgery by your General Practitioner/Internal Medicine Physician, EKG, and Mammogram (before breast surgery), additional compression garment/binder, Lab work, Hospital overnight /Overnight Care, pathology, and revisionary procedures.

A DEPOSIT IS REQUIRED TO SCHEDULE YOUR SURGERY:

In office: local anesthesia surgical procedures $1300.00
General anesthesia procedures (Surgery Center) $2000.00
Minor in office procedures (less than $1300): ½ of the cost of the procedure

- **Quoted prices are good for 90 days. If surgery is scheduled more than 90 days after deposit, any price increases will apply. After 90 days, a repeat consultation is mandatory.**
- **Surgery must be performed within 6 months of placing a deposit or loss of deposit will result.**
- **Deposit is NON-REFUNDABLE. If there is a medical reason for cancellation, the deposit will be returned minus a 250.00 fee, with sufficient evidence from the patient's physician. If you think you have a medical condition that would make your surgery not possible, please have it evaluated BEFORE you place a deposit**
- Rescheduling surgery less than 2 weeks prior to scheduled surgery date will result in $250.00 fee
- **Cancellation of surgery** less than 2 weeks prior to scheduled surgery **will result in loss of the deposit**
- **Cancellation of surgery** less than 1 weeks prior to scheduled surgery **will result in loss of the entire surgical fee.**
- For in office minor procedures- If you fail to show for your appointment or do not give 24 HOUR notice, your deposit will NOT be refunded, and you will owe the full price of the procedure to reschedule.
- There will be a $30 fee for any returned checks
- **There are NO REFUNDS for any procedures, treatments or products**
- Minimum in-office revision fee regardless of problem is $250.00 and covers the cost of supplies and staff.

The balance of the fee for surgery must be paid on the day of your pre-op appointment which is usually 7-10 days prior to your procedure. We accept cash, cashier's check, money order, Visa, Discover, MasterCard, AMEX or though patient financing with Care Credit. Personal checks will be accepted ONLY if paid two weeks in advance

If you have a pre-paid package, and cancel or reschedule an appointment without 24 hours notice you will forfeit that treatment and it will be deducted from the number of treatments you have left.

If you are a smoker and have not complied with the doctor's instructions, your surgery will be cancelled and fees will not be refunded. Nicotine testing will be performed if indicated. There is NO refund for cancelled surgeries.

REVISIONS: Surgical Fees for revisions are at the discretion of the surgeon based on the nature of the problem, and whether you have attended all postoperative visits and were compliant with the post op care.
In the event of a revision, the patient is responsible for anesthesia and facility fees, and cost of supplies.

I have read and understand the above financial policy and agree to its terms.

Patient Signature_____ **Date**_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *October 1, 2005* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $*1* for each page and the staff time charged will be $*25* per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

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QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Sofia K. Kirk, M.D.

Privacy Officer: Simon Newton

Telephone: (904) 260-2001 Fax: N/A

E-Mail: simon@poshplasticsurgery.com

Address: 13241 Bartram Park Blvd, Suite 1017, Jacksonville, FL 32258

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____ _____

Print name **Signature** **Date**

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

_____ _____

Employee signature Date