
# SOMA PLASTIC SURGERY
# GEORGE PAPANICOLAOU MD, PA

## PATIENT INFORMATION

Patient Name: _____
Last First MI

Address: _____
Street Apt. # City State Zip

Home Phone: _____ Cell: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

SSN#: _____ Email Address: _____

Preferred Language: _____ Ethnicity: _____

Pharmacy Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

## GUARANTOR INFORMATION (if other than patient)

Responsible Party' Name (If Patient Minor/Under 18): _____

Responsible Party Contact #s: Home # _____ Cell# _____

Responsible Party: Date of Birth: _____ SSN#: _____

## EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

REFERRED BY: Dr. LAST Name _____ 1st Name _____ Phone# _____

## PRIMARY INSURANCE INFORMATION

Company: _____ Policy ID#: _____ Group#: _____

Insured Party Name; _____ Group Name: _____ DOB: _____

SSN#: _____ Relationship: _____ Employer: _____

## SECONDARY INSURANCE INFORMATION

Company: _____ Policy ID#: _____ Group#: _____

Insured Party Name; _____ Group Name: _____ DOB: _____

SSN#: _____ Relationship: _____ Employer: _____

SOMA PLASTIC SURGERY

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# GEORGE PAPANICOLAOU, MD, PA

## PATIENT LIABILITY FORM

**I.Financial Agreement**

Our office will file your insurance according to your individual plan(s); however, you are responsible for deductibles, co-pays or co-insurances at the time of service.

**Outside Facility Fees**

Procedures performed incurring fees in outside facilities (i.e., surgery centers, radiology testing &/or reading fees, labs, etc.) are separately billed to you by that entity and will NOT include fees for our physician's services rendered in that facility. These are due and payable separately.

**Referrals, Authorizations, Insurance Coverages**

Referral numbers and authorizations by insurance plans are required prior to time of service; otherwise fees associated with services become your liability. If you do not have the required authorizations/referrals at the time of visit, you understand it may be necessary to reschedule the appointment.

**I acknowledge it is my responsibility**:

- To understand my insurance plan's coverages, limitations, requirements.
- To obtain all necessary authorization(s) &/or referral(s) from any other physicians or facilities as required for treatment and payment by my insurance company to Dr. Papanicolaou.
- To verify and understand my specific plan coverages regarding In/Out-of-Network providers.
- To remit full payment of my account balance as requested up front &/or after services rendered, if my insurance plan denies payment for any of the above listed reasons.
- **I am responsible for the whole account balance amount due if I have no insurance. PATIENT INITIALS _____**

**II.Assignment of Insurance Benefits**

I authorize direct payment of medical benefits to George Papanicolaou MD for services rendered. I understand I am financially responsible for any balance not covered by my insurance company. **I understand and agree if I receive direct payment from my insurance company, I am personally responsible for disbursement of payment directly to the physician. A photocopy of these assignments shall be valid as the original.

**III.Health Information Release**

I hereby authorize treatment of myself by George Papanicolaou MD, and authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/ AIDS, confidential information necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities, unless specified otherwise by me below.

**In case of any dispute regarding our services with any entity, company or institution, I waive the right to privacy under the Health Insurance Portability and Accountability Act of 1996. PATIENT INITIALS _____**

_____

Patient Name (please print)

_____

If patient is a minor, Guarantor Name (please print)

_____

Signature of Patient or Guarantor Date

**SOMA PLASTIC SURGERY**
**GEORGE PAPANICOLAOU, MD, PA**

# Return Check Policy

**George Papanicolaou, MD, PA** will charge a fee for any check that is returned to our office regardless of the reason. The following is a list of fees that will be applied to your account based on the amount of the return check.

$21.00 fee if the face value docs not exceed $30.00
$30.00 fee if the face value exceeds $30.00 but does not exceed $300.00
$40.00 fee if the face value exceeds $300.00 or amount of up to 5% of the face amount of the check.

Florida law states you have 7 days from receipt of notice to tender payment of the full amount of such check plus fees. Unless this amount is paid in full within the time specified **George Papanicolaou MD, PA** may turn over the dishonored check and all other available information relating to this incident to the State Attorney Office for criminal prosecution. You may be additionally liable for attorney fees and court cost.

# "No Show Policy"

Due to the increased number of "NO SHOW" patients this practice charges a "NO SHOW" fee of $30.00.

Please call at least 24 hours prior to your appointment time if you need to cancel or reschedule an appointment in order to avoid the $30 fee on your account!

Dr. George Papanicolaou is working diligently to ensure that the best possible care, service, and appointment availability is provided to all of our patients.

I, the patient &/or guarantor, understand the above policies.

_____

PRINT: Patients Last Name, First Name

_____

PRINT: Guarantor's Last Name, First Name (If patient is a minor)

_____

SIGN: Patient or Guarantor's Signature

SOMA PLASTIC SURGERY
Cosmetic & Reconstructive

**SOMA PLASTIC SURGERY**
**GEORGE PAPANICOLAOU MD, PA**

# HIPAA Notice of Patient 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 Dr. George D. Papanicolaou MD, PA 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 terns of this notice.
• 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 you care.
• We may use of disclose your health information for payment of your services with your authorization. For example, we may send a report of your progress to your insurance company.
•We may use of disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
• We may share your medical information with your business associates, such as a billing service. We have a written contract with each business associate that request them to protect your privacy.
• We may use your information to contact you. For example, we may send newsletters or other information or other information. We may also want to call and remind you about your appointments. If you arc not home, we may leave this information on your answering machine or with the person who answers the telephone.
• In an emergency, we may disclose your health information to a family member or another person responsible for your care.
• We may release some or all of your health information when required by law.
• If (his 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 used 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 you prefer.
• You have the right to transfer copies of your health information to another practice. Wc will mail your files for you.
• You have the right to see and receive a copy of your health information. With a few exception. Give us a written request regarding the information you want to see. if you also want a copy of your records we may charge you a reasonable fee for the copies.
• 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 as part of our medical quality assurance.
• You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509-F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
• However, before filing a complaint, or for more Information, or assistance regarding your health information privacy, please contact our office at 407-478-31SI
This notice goes into effect as of April 14,2003
Acknowledgment
I have received a copy of the **Dr. George D. Papanicolaou MD, PA**; Notice of Privacy Practices.

Signed._____Print Name _____ Date_____

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

# SOMA PLASTIC SURGERY
# GEORGE PAPANICOLAOU MD, PA

## AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by **George Papanicolaou MD, PA DBA Soma Plastic Surgery** (the"Practice") in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:_____

_____

I agree that the Practice may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below):

_____ HIV/AIDS Information
_____ Mental Health Information
_____ Substance Abuse Information
_____ Sexually Transmitted Disease Information
_____ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manner(s) (please initial the appropriate spaces below):

_____ Via e-mail to the Patient's designated e-mail address which is: (I am responsible for notifying the practice of any changes to my e-mail address.) _____
_____ Via regular mail with any envelopes being marked personal and confidential and addressed to me.
_____ Via telephone, if I contact the Practice and provide the appropriate information (including my name, social security number and unique personal identifier).
_____ Via fax to my designated fax number which is: _____

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

**The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form.** If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Please list two individuals authorized for communication. These contacts will be able to call to receive calls from our office on your behalf, and they will have permission to discuss your personal information.

1. _____ _____
Name Phone Number

2. _____ _____
Name Phone Number

_____ _____
Signature of Patient or authorized representative Print Name

Date: _____ Time: _____ AM/PM

SOMA PLASTIC SURGERY
Creative & Reconstructive

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## MEDICAL HISTORY FORM

Name: _____ DOB: _____ Age:_____ Sex:_____ Date: _____

Reason for Visit Today: _____ Referring Dr: _____

**Personal Medical History:**

Height: _____ ft/in Weight:_____ lbs. BMI: _____

**Please indicate whether you have had, or currently have any of the following medical problems:**

- ▫ No Medical Problems
- ▫ High Cholesterol
- ▫ High Blood Pressure
- ▫ Heart Disease
- ▫ Diabetes
- ▫ Asthma/Lung Disease
- ▫ Skin Lesions/Cancer (specify)_____
- ▫ Other: _____
- ▫ Anemia
- ▫ Depression/Anxiety Disorder
- ▫ Kidney Disease
- ▫ Thyroid Problems
- ▫ Arthritis/Joint Problems
- ▫ Weakness/Paralysis
- ▫ Hepatitis/Liver Disease
- ▫ Sleep Apnea
- ▫ Reflux Disease (GERD)/Heartburn
- ▫ Bleeding/Blood Clot/Clotting Disorder
- ▫ Breast Lump/Discharge/Problems
- ▫ HIV/AIDS
- ▫ Problems with Anesthesia (specify)_____
- ▫ Cancer (specify) _____

**Medications:** Please list any medications you are taking, including herbal supplements and over the counter medications with dosages:

| Medication Name: | Dosage: | Medication Name: | Dosage: |
|---|---|---|---|
| 1._____ | _____ | 6._____ | _____ |
| 2._____ | _____ | 7._____ | _____ |
| 3._____ | _____ | 8._____ | _____ |
| 4._____ | _____ | 9._____ | _____ |
| 5._____ | _____ | 10._____ | _____ |

If more than (10) current medications, please attach a list for our records **

**ARE YOU ALLERGIC TO ANY MEDICATIONS? YES or NO**

**IF YES, please list what medication and the reaction:** _____

_____

**DO YOU HAVE ANY OTHER ALLERGIES? SEASONAL_____, LATEX_____, OTHER_____**

**Family History:**

**Please indicate the family members (parents, siblings, grandparents, aunt or uncle) with any of the serious conditions: (Heart Disease, Cancer, etc.)**

_____

_____

**List all surgical procedures and approximate dates:**

_____

_____

_____

_____

**Social History: Strictly Confidential**

**Daily Alcohol Consumption:** _____ **Daily Tobacco Consumption:** _____

**Specify Any Recreational or Mind-Altering Drugs? How Often?** _____

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## MEDICAL PHOTO CONSENT

In connection with the medical services that I am receiving from Dr. George Papanicolaou, I do hereby consent for Dr. George Papanicolaou M.D., or a qualified person approved by Dr. Papanicolaou, to take photographs of me that will be used in my medical record for purposes of medical treatment and/or procedures. Such Photographs shall remain the property of Dr. George Papanicolaou. I understand that the use of my photographs is for treatment purposes as well as medical and patient education and that they will become a part of my permanent medical records.

HEREBY FULLY AND EXPRESSLY RELEASE, INDEMNIFY AND HOLD HARMLESS Dr. George Papanicolaou, ANY PARENT AND OR ENTITY THEREOF, THEIR DIRECTORS, OFFICERS, EMPLOYEES, AGENTS, REPRESENTATIVES, SUCCESSORS, ASSIGNS AND SUBCONTRACTORS FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION THAT I MAY HAVE, OF ANY NATURE WHATSOEVER, WHICH MAY IN ANY MANNER RESULT FROM THE USE OF THE PHOTOS.

I HAVE FULLY READ THE FOREGOING "CONSENT FORM." I FULLY UNDERSTAND ITS CONTENTS AND ACCEPT AND AGREE TO THE ABOVE IN ITS ENTIRETY. I AM SIGNING THIS CONSENT VOLUNTARILY AND ON MY OWN FREE WILL.

Printed Name of Patient / Guardian _____ Date of Birth _____

Signature of Patient / Guardian _____ Today's Date _____

Photo Release Form

By signing this release, I authorize Dr. Papanicolaou to use any photograph/video taken by him or his designee, for Marketing, Advertising or Public Relations use deemed necessary without releasing my identity.

I authorize photographs to be taken of the area of my body or face of concern to be sent via Text or Email for medical evaluation.

Refusing to sign will not affect your treatment, payment, enrollment or eligibility.

Printed Name of Patient / Guardian _____ Date of Birth _____

Signature of Patient / Guardian _____ Today's Date _____

Signature of Witness _____ Today's Date _____