2201 Murphy Avenue, Suite 407 ● Nashville, TN 37203
Phone 615.401.9454 ● Fax 615.873-1934

Patient Information Date________________

Patient's Full Name____

Last First M.I.

Preferred Name (if different than above) ____

Patient's Address____

City_______________________________________ State__________________ Zip Code____________________

Home # (___)__________________ Work # (___)___________________ Mobile # (___)_____________________

E-mail Address____May we contact you by e-mail? YES or NO

Sex M or F Date of Birth______________________ Age_______ Social Security #______________________

Place of Employment_______________________________________ Occupation__________________________

Marital Status_________________ Spouse's Name (if applicable)_______________________________________

How did you hear about our practice?____

What are you interested in discussing at your consultation? ____

Are you interested in Botox, injectables or skin care?____

If so, how do you prefer to be contacted?____

INSURANCE INFORMATION

Primary Insurance ___________________________________ ID # _________________________________

Subscriber's Name ____________________________________ Subscriber's Social Security #__________________

Subscriber's relationship to patient (Self Spouse Child Other) Sex M or F Date of Birth_____________________

Secondary Insurance (if applicable) _____________________ ID # _________________________________

Subscriber's Name_____________________________________ Subscriber's Social Security # __________________

Subscriber's relationship to patient (Self Spouse Child Other) Sex M or F Date of Birth______________________

Medical History

Primary Care Physician ____ Phone Number_____________________

Medication allergies____

Other allergies____

List all current medications: (include Aspirin, Advil, Ibuprofen, Motrin, Vitamins, and any other non-prescription medications.)

Medication____________________________________ Dose_________________________________

Medication____________________________________ Dose_________________________________

Medication____________________________________ Dose _________________________________

Medication ____________________________________ Dose_________________________________

Medication ____________________________________ Dose_________________________________

Are you currently taking or have you in the last 6 months taken any diet pills? YES NO
If you answered yes, please list____

Have you had a cortisone injection in the past year? YES NO
If you answered yes, location and date of injection____

List previous surgeries:

Date_________ ____

Date ________ ____

Date ________ ____

Date ________ ____

Height ________ Weight ___________

Do you exercise daily? YES NO Do you smoke? YES NO If so, how much? ___________________________
Do you drink alcohol? YES NO If so, frequency?________________________

Do you currently have or have you ever had any of the following?

Vision Problems	YES	NO	Migraines	YES	NO	Fever Blister	YES	NO
Hypothyroidism	YES	NO	Cancer	YES	NO	Emphysema	YES	NO
Heart Attack	YES	NO	Heart Murmur	YES	NO	Chest Pain	YES	NO
Hypertension	YES	NO	Diabetes	YES	NO	Stroke	YES	NO
Staph/MRSA	YES	NO	Blood Clot	YES	NO	Fibromyalgia	YES	NO
Asthma	YES	NO	Sleep Apnea	YES	NO	Snoring	YES	NO
Arthritis	YES	NO	Pneumonia	YES	NO	Anemia	YES	NO
Hepatitis B	YES	NO	Hepatitis C	YES	NO	HIV/AIDS	YES	NO
Healing Problems	YES	NO	Bleeding Disorder	YES	NO	Autoimmune Disorder	YES	NO

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under Federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing, and insurance information.

How we use your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations. This includes administrative purposes and evaluation of the quality of care that you receive. In some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians or other members of your treatment team will record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations. This includes proper administration of records, evaluation of the quality of treatment and assessment of the care of outcomes of your case and others like it.

Special Uses: We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- Required by Law: We may be required by law to report gunshot wounds, if we suspect abuse or neglect, or similar injuries and events.
- Public Health Activities: As required by law, we may disclose to public health authorities vital statistics, diseases, information related to recalls of dangerous products and similar information.
- Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.
- Judicial and administrative proceedings: We may disclose information in response to an appropriate court order.
- Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
- Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.
- Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- Research: We may use or disclose information for approved medical research.
- Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

If any other situation arises, we will ask for your written permission before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future disclosures.

Individual Rights

You have the following rights with regard to your health information:

- Request Restrictions: You may request restrictions on certain uses and disclosures. We are not required to agree to such restrictions; but if we do agree, we must abide by those restrictions.
- Confidential Communication: You may ask us to communicate with you confidentially. For example, we may send notices to a special address or not send postcards to remind you of your appointment.
- Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a charge for copies.
- Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
- Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of this Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. We will post the new Notice in the waiting area. You can also request a copy at any time.

Complaints

If you are concerned that we have violated your privacy rights or if you disagree with a decision we made about your records, you may contact the number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

The number listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact:

Robbins Plastic Surgery
2201 Murphy Avenue, Suite 307
Nashville, TN 37203
(615) 401-9454

Effective Date: 10/15/12

Acknowledgment of Receipt of Privacy Practices

I , _____________________________, hereby acknowledge receipt of this Notice of Privacy Practices given to me by Robbins Plastic Surgery.

Signed ____ Date ___________________

Printed Name ____

Patient Agreement

Limitation of Practice: Patient understands that Robbins Plastic Surgery practice is limited to Plastic and Reconstructive Surgery.

Patient Consent: Patient hereby gives my consent, if needed, for drawing blood samples for diagnosis or in case of accidental puncture or exposure to medical personnel during my course of treatment either in the offices or in the hospital. These tests may include AIDS testing.

Collection Policy

Insurance Claims Filing

In all cases, the patient is responsible for payment of their account. As a courtesy, Robbins Plastic Surgery will file a claim to the patient's insurance company.

Assignment and Release: Patient hereby authorizes and assigns applicable insurance benefits to be paid directly to the physician. Patient is financially responsible for non-covered services. Patient authorizes release of information necessary to process insurance claims. Patient authorizes photographs to be restricted for medical, educational or insurance purposes and information released to other practitioners in good faith effort for my medical care.

Medicare: Patient requests that payment of authorized Medicare benefits be made either to the patient or on the patient's behalf to Robbins Plastic Surgery and their associates for any services furnished to the patient by the physician. Patient authorizes any holder of medical information about the patient to release to the Health Care Financing Administration (Medicare) or its agents any information needed to determine these benefits payable for related services. This form is not to be used by the patient for Medicare reimbursement.

Managed Care Plans and Referrals

Managed care plans (e.g. HMOs) require specialists and sub-specialists to obtain a referral number before a patient can be seen by the physician. The patient is responsible for obtaining a referral number, not this office. Failure to have a referral number prior to service will result in reduced benefits by the managed care plan. Therefore, the patient is responsible for any balance not paid by the coverage plan.

Co-Payments

In all cases, the patient is responsible for making co-payments at the time of the patient visit in the form of cash or check or credit card. If a co-payment is not made at the time of the patients visit, Robbins Plastic Surgery reserves the right to require co-payment to be made prior to all future patient visits.

Patient Agreement

Maximum 30 Day Period for Unpaid Balances

Patient balances are due 30 days after insurance coverage payment has been made. In the alternative, the patient must make acceptable payment arrangements by contacting the Administrator at Robbins Plastic Surgery. Balances may be paid using cash, check, Visa, MasterCard, American Express, or Discover.

Unpaid Balances

If for any reason the patient cannot make scheduled payments, the patient must immediately contact our billing office to make acceptable arrangements. Robbins Plastic Surgery reserves the right to refer all unpaid accounts to collection agencies. Any fees associated with the collection, including collection agency contingency fees and court costs, will be added to the patient's account balance. After accounts are placed with collection agencies, all patient visits and procedures will be on a cash only basis.

Responsible Party Signature ____ Date ___________________

Printed Name ____

If Responsible Party is different than the patient, or the insured, please complete:

Name ____

Address ____

City _____________________________ State _____________ Zip Code _________

Date of Birth______________________ Social Security # _____________________

Home Phone ____________Cell Phone ______________Work Phone____________

Pharmacy Information

Patient Name ____

Pharmacy Name ____

Pharmacy Location ____

Pharmacy Phone Number ____________________________________

Patient Disclosures

Date_______________

Patient Name___________________________________ ___(please print)

Signature ____ (Patient/Guardian)

Please initial to acknowledge receipt of HIPAA Privacy Practices _______________

May we leave a detailed message on your answering machine? YES NO

May we discuss/disclose your account of medical information with members of your family? If so, you must list their name(s). We will only discuss information with those listed. YES NO

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In case of emergency, please contact:

Name____________________________________ Relationship ___________________________

Phone Number ____________________________

May we contact you or leave a message for you at your employment? YES NO

Do you have an Advanced Directive? (Living Will/ Power of Attorney) YES NO

If you do not have one, are you interested in an Advanced Directive? YES NO

Organ Donation- I want you to know about my decision to become an organ, eye and tissue donor. Upon my death, if I am a candidate for donation, I ask that you honor my wishes. YES NO

I wish to donate the following:

- □ Any needed organs and tissue
- □ only the following organs and tissue ____

*In the immediate post-op phase, all measures will be taken for resuscitation if needed. Your request for DNR would not be followed while under the affects of anesthesia.