



ROBBINS PLASTIC SURGERY

503 Spruce Street • 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 Birth Sex: M or F Gender Identity: 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? _____

Internet Realfself Healthgrades Our Website Instagram Youtube Facebook Events Other _____

Friend _____ Physician _____

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? Text Email Both

Are you on any Social Media? Instagram Facebook Twitter

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 _____

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 _____

Height _____ Weight _____

Do you exercise daily? YES NO Do you drink alcohol? YES NO If so, frequency? _____

Do you smoke/use any tobacco products (vape, cigars, etc.)? YES NO If so, how much and what type of tobacco product? _____

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

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 _____

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 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 YES NO

with members of your family? If so, you must list their name(s).

We will only discuss information with those listed.

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 YES NO

organ, eye and tissue donor. Upon my death, if I am a candidate for donation, I ask that you honor my wishes.

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.

Notice of Privacy Practices

- **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.

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.

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.