Plastic Surgery of Palm Beach, P.A.

Alan B. Pillersdorf, M.D., Dov I. Eidelman, M.D., Ernesto Hayn, M.D., Alberto Navarro, M.D.

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name : Last, First, M		☐ **M** ☐ **F**	**Date of Birth :**	**Age:**
Marital status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Social Security :**		
Address:				
City:			**State/Zip:**	
Home Tel #		**Preferred Contact #**	☐ Home ☐ Cell ☐ Work	
Cell Phone #		**Work Tel #**		
Email:		**Newsletter/Eblasts**	☐ Check box if you would like to be on email list	
Occupation:		**Employer & Address:**		

Nearest relative not living with you: **Telephone #**

Emergency Contact & Relationship: **Telephone #**

Reason for today's visit :

Referred by:

Primary Care Physician: **Telephone #**

Cardiologist Name: **Telephone #**

Dermatologist : **Telephone #**

Other Specialist : **Telephone #**

Pharmacy Name: **Telephone #**

Primary language: ☐ **English** ☐ **Spanish** ☐ **French** ☐ **Creole** ☐ **Other**

Do You Have a Power of Attorney? ☐ **Y** ☐ **N** **Do you have Advanced Directives?** ☐ **Y** ☐ **N** **If yes please provide a copy**

Do You Live in an Assisted Living Facility/Extended Care Facility? ☐ **Y** ☐ **N**

Are you here for a : ☐**Work Injury** ☐**Auto Injury** ☐**Other Injury** **Date of injury:**

INSURANCE INFORMATION: **Insurance Company Name:** **Secondary Ins Name:**

Policy Holder's Name: **Policy Holder's DOB:** **Policy Holder's SS# :**

STATISTICAL DATA

This information is required by The Agency for Healthcare Administration as part of Chapter 59B9.023 of the State of Florida Statistics

Patient Race:1. ☐ American Indian or Alaska Native 2.☐ Asian 3.☐ Black or African American 4.☐ Native Hawaiian or Other Pacific Islander 5.☐ White 6.☐ Other 7.☐ Unknown

Patient Ethnicity: 1. ☐ Hispanic or Latino 2. ☐ Non-Hispanic or Latino 3. ☐ Unknown

By signing this form , I hereby absolutely and unconditionally guarantee payment of any and all charges related to the treatment of the Patient by Plastic Surgery of Palm Beach, P.A., its physicians, Alan Pillersdorf, M.D., Dov Eidelman, M.D., Ernesto Hayn, M.D., and J. Alberto Navarro, M.D (hereinafter "Physicians"). This guaranty is deemed primary. I hereby further acknowledge that Plastic Surgery of Palm Beach P.A. and its Physicians have agreed to submit their bill for services to my insurance company or other third party insurance company and have agreed to do so solely as a courtesy to me, but without limiting or otherwise affecting my liability as guarantor hereunder. I understand and agree that Plastic Surgery of Palm Beach, P.A. , its Physicians have the right to demand immediate payment in full from me at any time prior to receipt of payment from any insurance carrier, unless otherwise provided by contract. I hereby further acknowledge that I have been told, prior to receiving treatment, that I will be billed by Plastic Surgery of Palm Beach, P.A. and/or its Physicians. I further agree that if I am more than thirty (30) days late in the payment of any bill connected with services rendered by Plastic Surgery of Palm Beach, P.A. or its Physicians, .a finance charge of 1.5% per month will accrue on the unpaid balance. I further agree that if my account becomes delinquent and is referred to a collection agency and/or an attorney, I agree to pay reasonable attorneys fees and/or collection agency fees incurred by Plastic Surgery of Palm Beach, P.A. or its Physicians in collecting my account. I further understand and agree that I am liable for any and all services rendered by Plastic Surgery of Palm Beach, P.A. and its Physicians whether or not any insurance company refuses to pay for any reason. I further understand and agree that I am liable for all health insurance deductibles and co-insurance payments. I acknowledge that I have read this Agreement and I fully understand its terms. I further acknowledge that any questions that I have concerning the terms of this Agreement have been answered by a representative of Plastic Surgery of Palm Beach, P.A. to my satisfaction.

DATE: _____ SIGNATURE: _____

AUTHORIZATION FOR TREATMENT AND CONSENT FOR PHOTOPGRAPHS, SLIDES, VIDEOTAPES AND DIGITAL IMAGES:

I hereby give permission to Plastic Surgery of Palm Beach, Drs. Pillersdorf, Eidelman, Hayn and Navarro to furnish information to insurance carrier concerning your illness and treatment. I hereby assign all payments for medical service rendered to my descendants or myself. I understand that I am responsible for any amount not covered by my insurance. If it becomes necessary to effect collection of this amount, the undersigned agrees to pay all costs and expenses therefore, including any reasonable attorney's fees. I also hereby authorize Drs. Pillersdorf, Eidelman, Hayn, Navarro or his associates or licensees to take preoperative, intraoperative and postoperative photographs, slides, digital images and videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks for purposes of medical education, patient education, lay publication or during lectures to medical or lay groups. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/such interview.

DATE: _____ SIGNATURE: _____

Have you ever had, or been diagnosed with: Check all that apply		
☐ Acne	☐ Depression	☐ Kidney Disease
☐ Alzheimer's Disease or Dementia	☐ Diabetes	☐ Lupus
☐ Anemia	☐ Dizziness/Vertigo	☐ Malignant Hyperthermia
☐ Anxiety	☐ Epilepsy/Seizures	☐ Mitral Valve Prolapse
☐ Arrhythmia or Palpitations	☐ Filler Injections	☐ Pacemaker/Defibrillator
☐ Asthma	☐ Glaucoma	☐ Pneumonia
☐ Bleeding Disorder	☐ Heart Attack / Heart Disease	☐ Rheumatoid Arthritis
☐ Blood Clot/ DVT	☐ High Cholesterol	☐ Rheumatic Fever
☐ Botox	☐ Heart Murmur	☐ Shingles/ Herpes Zoster
☐ Breast Cancer	☐ Hepatitis ABC/Liver Disease (Type_____)	☐ Sickle Cell Anemia or Trait
☐ Breast Disease (Type_____)	☐ Herpes Simplex (Type 1 or 2)	☐ Skin Cancer
☐ Bronchitis	☐ High Blood Pressure	☐ Sleep Apnea
☐ Cancer (Type_____)	☐ HIV/AIDS	☐ Stroke
☐ Cataracts	☐ Implants	☐ Thyroid Disease
☐ COPD	☐ Keloid Scars/ Poor Scarring	☐ Vasculitis

List any significant family history of any of the above:

List any other medical conditions:

List all past surgeries and hospitalizations (including cosmetic surgeries) :

Year	Type	Year	Type

List all prescription and over the counter medications you take (include herbals and vitamins):

Name of medication	Dose/Frequency	Name of medication	Dose/Frequency

List any allergies : (Include medications, over the counter products, and foods)

Name of product	Reaction	Name of product	Reaction

Please list height and weight:	Ht	Wt	lbs
Do you have a latex allergy or sensitivity?		☐ Yes	☐ No
Do you have an allergy to tape or adhesives?		☐ Yes	☐ No
Do you take prophylactic antibiotics before surgery or dental work?		☐ Yes	☐ No
Do you take Aspirin or Aspirin products?		☐ Yes	☐ No
Do you take any blood thinners (such as Coumadin, Plavix, or Lovenox)?		☐ Yes	☐ No
Do you take steroids (Prednisone, Corticosteroids)?		☐ Yes	☐ No
Any problems with bleeding or bruising?		☐ Yes	☐ No
Any personal or family history of trouble with anesthesia?		☐ Yes	☐ No
Do you smoke? If yes, how many packs/day _____? For how many years_____?		☐ Yes	☐ No
Do you drink alcohol? If yes, how much _____? How often? _____?		☐ Yes	☐ No
Do you use recreational drugs? If yes, describe_____		☐ Yes	☐ No

The above information is accurate and complete and to the best of my knowledge.

Signature_____Date_____

Plastic Surgery of Palm Beach, P.A.

OUTPATIENT PLASTIC SURGERY CENTER, INC.

Licensed by the State of Florida

I. Acknowledgement of Practice's *HIPAA Privacy Notice*:

By subscribing my name below, I _____ acknowledge that **Plastic Surgery of Palm Beach PA /Outpatient Plastic Surgery Center Inc.** has provided a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if I so chose) and understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

_____ _____ _____

Name of Patient **Signature of Patient/Parent/Guardian** **Date**

II. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communication to me by the alternative means that I have listed below.

Home / Cell Telephone Number: _____
Written Communication Address: _____

_____OK to leave message with detailed information _____OK to mail to address listed above
_____Leave message with call back numbers only _____E-mail me at: _____

Work Telephone Number: _____Fax Communication: _____

_____OK to leave message with detailed information _____OK to Fax to the number listed above
_____Leave message with call back numbers only

III. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I, _____, agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____ Last four digits of his/her SSN or password (required):_____

Print Name: _____Last four digits of his/her SSN or password (required):_____

Print Name: _____Last four digits of his/her SSN or password (required):_____

_____ _____ _____

Name of Patient (Print) **Patient Signature** **Date**

Witness: _____ **Date**: _____

I, _____, acting on behalf of my minor son/daughter, _____,
Parent/Guardian (print)
as legal Personal Representative in all matters. If representative is a court appointed legal guardian, a copy of court documents must be provided and kept in medical records

_____ _____ _____

Name of Patient (Print) **Signature Parent/Guardian** **Date**

PATIENT NOTIFICATION –OUTPATIENT PLASTIC SURGERY INC.

DISCLOSURE OF OWNERSHIP
Physicians with financial interest in this facility:
Alan B. Pillersdorf, M.D.
Dov I Eidelman, M.D.

Physicians without financial interest in this facility:
Ernesto Hayn, M.D.
J. Alberto Navarro, M.D.

PATIENT RIGHTS:

- The patient has the right to be informed of his/her rights in advance of, receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, cultural, economic, education, religious background, physical handicap, or the source of payment for care.
- Considerate, respectful and dignified care, provided in a safe environment, with protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these accessed on the patient's
- Appropriate assessment and management of pain.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to request a change in providers if other qualified providers are available.
- Be advised if the physician has a financial interest in the surgery center.
- Be advised as to the absence of malpractice coverage if applicable.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Be informed of the facility's policy and state regulations regarding advance directives and be provided advance directive forms if requested.
- Receive a copy of a clear and understandable itemized bill and receive and explanation of his/her bill regardless of source of payment.
- Receive upon request, full information and necessary counseling on the availability of known financial resource for his/her care, including information regarding facilities discount and charity policies.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his/her health care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her written permission will be obtained before medical records can be made available to anyone not directly concerned with their care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record within a reasonable time frame.
- Be advised of the facility's grievance process, should he/she wish to communicate a concern regarding the quality of the care they received. Notification of the grievance process includes: whom to contact to file a grievance, and that he/she will be provided with a written notice of the grievance determination that concerns the name of the facility's contact person, the steps taken on his/her behalf to investigate the grievance, the results of the grievance and grievance completion date.
- Be advised of contact information for the state agency to which complaints can be reported, as well as contact information for the office of the Medicare Beneficiary Ombudsman.
- Be advised if the facility/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's rights to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided it subjects will be contained in the medial record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate of thereof of the continuing healthcare requirement following their discharge from the facility.
- Be informed if Medicare eligible, upon request and in advance of treatment, whether the health care provider or healthcare facility accepts the Medicare assignment rate.
- Receive upon request, prior to treatment, a reasonable estimate of charges for medical care.

PATIENT RESPONSIBILITIES:

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary supplements), allergies and sensitivities and other matters relating to his/her health.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

PATIENT NOTIFICATION –OUTPATIENT PLASTIC SURGERY INC.

- The patient is responsible for following the treatment plan established by his/her professionals as they carry out the physician's orders.
- The patient is responsible for reporting to the health care provider any unexpected changes in his/her condition.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hrs unless exempted from that requirement by the attending physician.
- In the case of pediatric patients, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.
- The patient is responsible for his/her actions should you refuse treatment or not follow your physician's orders.
- The patient is responsible for assuring that the financial obligations o his/her care are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible to inform the facility about the advance directives.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.
- To provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.

ADVANCE DIRECTIVE NOTIFICATION:

In the state of Florida, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. The Outpatient Plastic Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, the Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after surgery.

Therefore, it is our policy, regardless of the contents of an Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse even occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measure already begun will be ordered in accordance with your wishes, Advance Directive, or Healthcare Power of Attorney.

Patient Name: _____

Patient Signature:_____

If you wish to complete an Advance Directive, copies of the official forms are available at

http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/index.shtml

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

If a patient is adjudged incompetent under the states laws, the rights of the patient are exercised by the person appointed and/or legal representative designated by the patient under Florida law to act on the patient's behalf. The center will accept a Court Appointed Guardian, Dual Power of Attorney, or a Health Care Surrogate.

PATIENT COMPLAINT OR GRIEVANCE

- If you have a problem or complaint, please speak to the Nurse Manager, Nancy Borroto RN. We will address your concern(s) promptly.
- If necessary, your problem or complaint will be advanced to the Administrator and/or Quality Assurance coordinator for resolution. You will receive a letter or phone call to inform you of the actions take to address your complaint.
- If you are not satisfied with the response of the Surgery Center, you may contact:

Patient complaints or grievances may be filed through the state of Florida Consumer Services Unit at 1-888-419-3456 (press 2) or write to the address below:

Complaints against an ambulatory surgical center may be filed with the state of Florida by calling the Consumer Assistance Unit a 1-888-419-3456 or write to:

Agency for Health Care Administration
Consumer Assistance Unit
2727 Mahan Drive/BLDG. 1
Tallahassee, Florida 32308

If you have a complaint against a health care professional and want to receive a complaint form, call Consumer Services Unit at 1-888-419-3456(press 2) or write to the address below:

Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399

You may also Contact AAAHC by mail at:

Accreditation Association for
Ambulatory Health Care, INC.
5250 Old Orchard Road, Suite 200
Skokie, Illinois 60077

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman.
Visit the Ombudsman's webpage on the web at:

www.cms.hhs.gov/center/ombudsman.asp

Date:_____