BEVERLY FISCHER, MD
THE ADVANCED CENTER FOR PLASTIC SURGERY
(410) 308-4700

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____

Date of Birth: _____

Gender (circle): Transgender / Female / Male / Non-Binary

Height: _____ Weight: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Marital Status (circle): Single / Married / Other

Patient's Employer/School: _____ Occupation: _____

Work Phone: _____

Is it okay to call you at work (circle)? Yes / No

How did you hear about us? _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Emergency Contact Address: _____

Cell Phone: _____ Other Phone: _____

_____

Signature/Guardian Date

BEVERLY FISCHER, MD
THE ADVANCED CENTER FOR PLASTIC SURGERY
(410) 308-4700

Health Information

Check all that apply.

Heart Attack	Yes ❑ No ❑	Gallstone or Gallbladder Trouble	Yes ❑ No ❑
Heart Murmur	Yes ❑ No ❑	Jaundice	Yes ❑ No ❑
Hypertension	Yes ❑ No ❑	Alcoholism	Yes ❑ No ❑
Abnormal EKG	Yes ❑ No ❑	Esophageal Varices	Yes ❑ No ❑
Heart Palpitations	Yes ❑ No ❑	Frequent Indigestion	Yes ❑ No ❑
Stroke	Yes ❑ No ❑	Ulcers	Yes ❑ No ❑
Chest Pain	Yes ❑ No ❑	Gastritis	Yes ❑ No ❑
Family History of Heart Trouble	Yes ❑ No ❑	Colitis	Yes ❑ No ❑
Shortness of Breath	Yes ❑ No ❑	Constipation	Yes ❑ No ❑
Asthma	Yes ❑ No ❑	Hemorrhoids	Yes ❑ No ❑
Bronchitis/Pneumonia	Yes ❑ No ❑	Diabetes	Yes ❑ No ❑
Tuberculosis	Yes ❑ No ❑	Bleeding Tendency or Disorder	Yes ❑ No ❑
Emphysema	Yes ❑ No ❑	Family History of Bleeding Disorders	Yes ❑ No ❑
Anxiety/Depression	Yes ❑ No ❑	Blood Transfusion	Yes ❑ No ❑
Insomnia	Yes ❑ No ❑	Skin Disorders	Yes ❑ No ❑
Self-Destructive Tendencies	Yes ❑ No ❑	Arthritis	Yes ❑ No ❑
Psychiatric Care / Hospitalization	Yes ❑ No ❑	Fracture of Neck/Spine	Yes ❑ No ❑
Drug Abuse / Dependency	Yes ❑ No ❑	Nasal Airway Obstruction	Yes ❑ No ❑
Thyroid Problems	Yes ❑ No ❑	Breast Cysts / Tumors / Abscesses	Yes ❑ No ❑
Kidney or Renal Disease	Yes ❑ No ❑	Nipple Discharge	Yes ❑ No ❑
Cancer	Yes ❑ No ❑	Seizures / Convulsions / Fainting	Yes ❑ No ❑
Family History of Cancer	Yes ❑ No ❑	Dentures, Bridges, Crowns, Caps	Yes ❑ No ❑
Hepatitis / HIV / AIDS	Yes ❑ No ❑	Loose or Chipped Teeth	Yes ❑ No ❑
Cirrhosis of the Liver	Yes ❑ No ❑	Eye Problems	Yes ❑ No ❑

Surgical History

Name Date

Medications: (current and that have been used in the last 6 months; including birth control)

Name / Dosage / Frequency Purpose

BEVERLY FISCHER, MD
THE ADVANCED CENTER FOR PLASTIC SURGERY
(410) 308-4700

Allergies (please include reaction):

Medication / Allergen Reaction

_____

_____

_____

_____

Please answer the following questions (circle and/or explain):

- Do you smoke? Currently / Previous / Never
  - How much tobacco are/were you using? _____ For how long? _____ When did you quit? _____
- Do you drink alcohol regularly? Yes / No
  - If yes, how much? _____
- Have you ever been diagnosed with a Latex allergy? Yes / No
- Are you currently being treated for chronic pain? Yes / No
- Have you or a blood relative ever had any difficulties with anesthesia? (i.e. muscle weakness, jaundice, breathing problems, unexpected fever) Yes / No
- What is the name of your primary care doctor? _____
- Are you pregnant or breastfeeding? Yes / No

AREAS OF INTEREST (circle all that apply)

Face	Breast	Body	Non-Surgical
Blepharoplasty: Eyelid Surgery	Breast Augmentation	Abdominoplasty	Botox / Dysport
Brow Lift	Breast Implant Exchange	Body Lift	Hormone Balance for Men and Women
CO2 Laser Resurfacing	Breast Implant Removal	Brachioplasty: Arm Lift	Filler: Juvaderm / Restalyne / Sculptra
Facelift	Breast Lift	Cellulaze / Precision TX	Hydrafacial
Fat Transfers	Breast Reduction	Labiaplasty	Halo Laser
Otoplasty: Ear Surgery	FTM Top Surgery	Panniculectomy	BBL Laser
Necklift	Gynecomastia	Scar Revision	Microneedling
Threading	MTF Top Surgery	Thigh Lift	VI Peel
Other:	Nipple Reconstruction	Liposuction	ZO Medical Skincare

NOTICE to PATIENTS

BEVERLY FISCHER, MD
THE ADVANCED CENTER FOR PLASTIC SURGERY
(410) 308-4700

We are required by law to protect the privacy of your protected health information. This describes how your medical information may be used and disclosed, and explains how to gain access to your medical information.

The general consent for release of medical records that you sign authorizes Advanced Center for Plastic Surgery to disclose the information in your medical record for treatment, payment and health care operations:

- For the purpose of providing treatment to you, your information may be shared with employees, contractors of the provider, or with other healthcare providers involved in your care.
- For the purpose of arranging payment for your care, your information may be shared with your insurer or third-party payer who is responsible for paying all or part of the cost for your care.
- For the purpose of health care operations, we may use and disclose information that is necessary for our operations (internal quality assessments, contacting other providers about treatment alternatives).
  - We may disclose information to doctors, nurses, technicians or other practice personnel who are involved in your medical care and treatment. Different areas of the practice may also share your medical information in order to coordinate things you need, such as prescriptions and lab work.
  - We may disclose your medical information to anyone involved in your care after you leave our office, such as family members or others we may rely upon or ask to assist us in caring for you.
  - We may use your information to provide appointment reminders such as voicemails or text messages.

You may be asked to sign a specific authorization for release of medical records, which will authorize us to make a specific disclosure that is not covered above. The specific information, the entity to whom it will be disclosed, and the purpose for which it will be used will be documented for your review before signing.

You may revoke any consent or authorization provided to us by giving a written notice of revocation.

We may be required by law to disclose your records that you have not authorized. For example, if we receive a subpoena for the records. We will keep all disclosure of your medical records to the minimum necessary.

Your rights regarding health information about you:

- You have the right to inspect and request a copy your health information, as well as the right to find out how it is used and to whom it is disclosed. You may request an accounting of your medical records disclosures made by us except for disclosures made for treatment, payment and health care operations.
- If you feel the information we have is incomplete or inaccurate, you have the right to request changes.
- You have the right to receive a paper copy of this notice.

We are required by law to maintain the privacy of your protected health information. If you believe your rights have been violated, you may complain to the Secretary of The U.S. Department of Health and Human Services or to our office. Please ask to speak to our Office Manager who is our Privacy Contact person.

If you have an advanced directive, please provide us a copy. Visit www.Medicare.gov. for more information.

If necessary, these policies will be modified to ensure compliance with State and Federal operations privacy regulations.

PATIENT SIGNATURE DATE

PATIENT RIGHTS and RESPONSIBILITIES

BEVERLY FISCHER, MD
THE ADVANCED CENTER FOR PLASTIC SURGERY
(410) 308-4700

At Advanced Center for Plastic Surgery, we believe that our patients have the following rights:

- Patients may expect to be treated courteously and with respect, dignity and compassion by all who provide care, free from all forms of abuse or harassment.
- Patients may expect privacy and safe physical surroundings while in the surgical suite.
- Patients may expect that all information, communication and records related to their care will be treated confidentially and may approve or refuse the release of their health information except when required by law.
- Patients will be informed of their diagnosis, options for treatment and the likely outcomes of those options.
- Patients may expect to receive instructions related to their care upon discharge.
- Patients may expect that all personnel providing care will be current in their knowledge and skills and be licensed or certified as required.
- Patients may review a copy of their bill regardless of who pays for the services.
- Patients will not be discriminated against on the basis of race, religion, nationality, sex, age, handicap, marital status, or source of payment.
- Patients have the right to refuse to participate in experimental research should such research be conducted.
- Patients have the right to decide who provides their care and may review their medical credentials. In the event the patient wishes to change providers, our center will facilitate the transfer of all medical records to such provider.
- Patients have the right to report any grievances to the facility or state and federal agencies. To file a complaint to the State: Maryland Office of Health Care Quality call 1-800-492-6005 or visit https://health.maryland.gov/ohcq/Pages/ home.aspx. Click on file a complaint or download a complaint form or write the program manager of Ambulatory Care, Office of Health Care Quality, 7120 Samuel Morse Drive, Columbia, MD 21046.
- Patients are responsible to provide to the best of his/her knowledge, accurate and complete current and past health history to healthcare provider. Patient are also responsible for reporting unexpected changes in his/her condition to the healthcare provider.
- Patients are responsible for acknowledging understanding of treatment plan, following the treatment plan, and remaining compliant throughout the course of treatment. They are responsible for his/her actions if he/she refuses treatment for any reason or refuses to follow given instructions regarding their treatment.
- Patients are responsible for keeping appointments, and if unable to do so, to notify the facility in a timely manner.
- Patients are responsible for fulfilling financial obligations for his/her healthcare as agreed by the healthcare provider/ facility.
- Patients are responsible for conducting themselves appropriately while in the facility. Patients are responsible for providing an adult to transport you home after receiving general anesthesia, sedation or major anesthetic block.

PATIENT SIGNATURE DATE

ADVANCE DIRECTIVES and INSURANCE

Information on Advance Directives

Notice of Policy regarding advance directives:

- There are many types of advance directives, with the two most common forms being living wills and a durable power of attorney designation.
- The surgery center will honor your advance directives, however, if a life-threatening situation occurs, the surgery center will perform resuscitative and stabilization efforts until the patient is transferred to a higher level of care. Your executed advanced directive will be sent with you to the higher level of care.

For additional information regarding advance directives, please visit https://www.oag.state.md.us

Information on Insurance

- We do not accept ANY insurance.
- All payments are paid out of pocket by our patients in the form of cash, check, and/or credit card. If you would need to finance, we have a partnership with Care Credit.
- You will need to become your own advocate. Here are the proper steps for you to follow to submit to insurance.
  - Contact your insurance company and find out if your specific surgery is a covered benefit under your policy. Be reminded that Dr. Fischer is out of network with EVERY insurance company.
  - If it is a covered benefit, you will need to obtain a copy of the medical policy listing the criteria that is required. Get a call reference number and document the person you spoke with, the date and time. This is to protect yourself when finding out what your insurance covers and collecting reimbursement from them.
- We cannot call insurance companies or fill out paperwork for prior authorization. We can give you CPT and diagnosis codes in preparation for when you call your insurance company. When calling your insurance company please be aware that we are an outpatient surgical center and we are an out of network provider with all insurance companies.
- We guarantee NO reimbursements from your insurance company to you. Again you need to be your own advocate in submitting the claim to your insurance company.

PATIENT SIGNATURE DATE

FINANCIAL POLICY

Please take a moment to review our financial policy, as a clear understanding of the policy is important to our professional relationship. Changes to the financial policy may take place without advanced notification.

A non-refundable depsoitt is required to schedule surgery.

Payment for consultation is due at the time of service ($100). This fee includes a secondary consultation within 60 days, if needed.

A surgical quote will be provided as part of the consultation. The surgical quote does not factor potentional costs for physical examinations, blood work, prescriptions, or other testing that may need to be completed.

We schedule surgeries on a first request, first deposit basis. A nonrefundable deposit of 10% of your surgical quote is required to reserve your surgical date. This deposit will be used toward the total amount of your surgery. The remaining balance is due 3 weeks prior to your surgical date. The deposit and surgery will be forfeited if the full payment is not received by our office at the this time.

If you must cancel your surgery after the balance has been paid, you may reschedule the same surgical procedure within one year. No desposit or balance will be refunded.

If a revision is neccesary, Dr. Fischer reserves the right to determine the additional costs associated with that new procedure, which would be covered by the patient.

In the event of you not being medically cleared to have surgery, the 10% despoit will not be refunded. We will need a written note from your physician that clearly states that you are not medically cleared. Only then will a refund for the balance of your surgery be given. By signing this, you understand the above statements. You also acknowledge that refunds may take up to 45 days to process.

PATIENT SIGNATURE DATE

HIPPA PATIENT FORM

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) PRIVACY RULE

PURPOSE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We are required by the HIPPA privacy rule under federal and state law to protect the privacy of our patient medical information.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. These records may be created in a physical form (i.e. paper), electronic form (i.e. computer) or other form. These records may include photos or videos.

The medical record helps us provide you with quality care and assists us in complying with certain medical and legal requirements. The health and billing records we maintain are the physical proptery of the Advanced Center for Plastic Surgery and Dr. Beverly Fischer. However, you may inspect and obtain a copy. This notice will tell explain the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following section describes different ways that we use and disclose medical information. For each kind of use or disclosure, we will explain what we mean and give examples. Not every disclosure or use will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. However, you may not revoke this authorization once signed.

FOR TREATMENT

We may use medical information about you to provide you medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, therapists, pyschiatrists or other people who are taking care of you.

FOR PAYMENT USING CREDIT/DEBIT CARDS, ELECTRONIC PAYMENTS, AND FINANCING

It may become necessary to release your information to financial parties, credit card entities, banks, and financing companies when requested to facilitate your payment. Services that are performed that are paid with a credit card, electronic payment, debit card or financing third parties are not eligible for payment challenges after services are provided. The patient irrevocably consents to allow our practice to use and disclose protected health information to a credit card entity, bank or financing company when they request such information to process an account and assist with payment.

PATIENT SIGNATURE DATE