

**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

**PATIENT REGISTRATION FORM**

**Health Information**

Check all that apply.

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

**Surgical History**

Name	Date
_____	_____
_____	_____
_____	_____
_____	_____

**Medications:** (current or that have been used in the last 6 months; including birth control, Accutane, & HRT)

Name	/	Dosage	/	Frequency	Purpose
_____	/	_____	/	_____	_____
_____	/	_____	/	_____	_____
_____	/	_____	/	_____	_____
_____	/	_____	/	_____	_____

**PATIENT REGISTRATION FORM**

**Allergies (please include reaction):**

Medication / Allergen Reaction

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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	GLP-1 Therapy
Facelift	Breast Lift	Cellulaze / Precision TX	Hydrafacial
Fat Transfers	Breast Reduction	Labiaplasty	Halo Laser BBL Laser
Otoplasty: Ear Surgery	FTM Top Surgery	Panniculectomy	Filler: Juvaderm / Restalyne / Sculptra
Necklift	Gynecomastia	Scar Revision	Microneedling
Threading	MTF Top Surgery	Thigh Lift	VI Peel
Other:	Nipple Reconstruction	Liposuction	ZO Medical Skincare

## NOTICE to PATIENTS



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](http://www.Medicare.gov). for more information.

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

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PATIENT/GUARDIAN SIGNATURE

DATE

**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.

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PATIENT/GUARDIAN 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>

### Insurance & Prior Authorization Policy

- Our practice is a *fully self-pay, non-participating provider office*. We do not participate with any insurance carriers and do not submit claims, obtain prior authorizations, complete predeterminations, communicate directly with insurance companies, participate in appeals, submit medication authorizations, complete insurer forms, participate in peer-to-peer reviews, or engage in any insurance-related administrative processes on a patient's behalf.
- Patients seeking possible reimbursement from their insurance carrier are solely responsible for communicating with their insurer regarding coverage requirements, prior authorization requirements, eligibility, reimbursement policies, medication coverage requirements, appeals, and submission procedures.
- Patients understand that many insurance carriers require prior authorization, insurer-directed documentation, or provider participation before considering reimbursement or medication coverage. Because our practice does not participate in insurance administrative processes, failure to obtain prior authorization or otherwise satisfy insurer requirements may result in partial reimbursement, denial of reimbursement, or denial of medication coverage by the insurance carrier.
- If a patient's insurance carrier requires provider participation, prior authorization submission, insurer communication, or completion of insurance administrative processes as a condition of reimbursement or medication approval, patients may wish to seek care from a provider or facility that participates directly with their insurance plan and its administrative requirements.
- As a courtesy, following surgery and upon request, our office may provide available documentation such as operative reports, procedure descriptions, diagnosis codes (ICD-10), procedure codes (CPT), receipts, or itemized billing statements for patient self-submission. The provision of documentation does not constitute participation with insurance and does not guarantee reimbursement or coverage.
- By signing below, the patient acknowledges and accepts full financial responsibility for all services rendered regardless of insurance reimbursement outcome.

**I understand that this practice does not participate with insurance companies and will not obtain prior authorizations, submit claims, communicate with insurers, participate in insurance appeals, or complete insurance-related administrative processes on my behalf.**

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PATIENT/GUARDIAN SIGNATURE

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## 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 despoitt 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 potential 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 neccessary, 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.

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PATIENT/GUARDIAN SIGNATURE

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## 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 property 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, psychiatrists 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.

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PATIENT/GUARDIAN SIGNATURE

DATE