SOMA PLASTIC SURGERY
GEORGE PAPANICOLAOU MD, PA

PATIENT INFORMATION

Patient Name: ____
Last First MI

Address:____
Street Apt. # City State Zip

Home Phone:______________ Cell: ______________ Work Phone: ______________

Date of Birth: ______________ Age:________ Sex:________ Marital Status: ______________

SSN#: ______________________ Email Address: ______________________

Preferred Language:________________ Ethnicity: ______________________

Pharmacy Name: ______________________ Phone: ______________________

Address: ______________________ City:__________ State:_____ Zip:______________

GUARANTOR INFORMATION (If other than patient)

Responsible Party' Name (If Patient Minor/Under 18): ______________________

Responsible Party Contact #s: Home # ______________ Cell#______________

Responsible Party: Date of Birth: ______________ SSN#:______________

EMERGENCY CONTACT

Name:______________ Relationship: ______________Phone: ______________

REFERRED BY: Dr. LAST Name__________1st Name__________Phone#____________

PRIMARY INSURANCE INFORMATION

Company: ______________ Policy ID#:______________ Group#: ______________

Insured Party Name; ______________ Group Name: __________ DOB:______________

SSN#: ____________ Relationship: ____________ Employer: ______________________

SECONDARY INSURANCE INFORMATION

Company: ______________ Policy ID#:______________ Group#: ______________

Insured Party Name; ______________ Group Name: __________ DOB: ______________

SSN#: ____________ Relationship: ____________ Employer: ______________________

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HIPAA Notice of Patient Privacy Practices

• This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
• At Dr. George D. Papanicolaou MD, PA wE have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terns of this notice.
• The law permits us to use or disclose your health information to those involved in your treatment For example, a review of your file by a specialist doctor whom we may involve In you care.
• We may use of disclose your health information for payment of your services with your authorization. For example, we may send a report of your progress to your insurance company.
•We may use of disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
• We may share your medical information with your business associates, such as a billing service. We have a written contract with each business associate that request them to protect your privacy.
• We may use your information to contact you. For example, we may send newsletters or other information or other information. We may also want to call and remind you about your appointments. If you arc not home, we may leave this information on your answering machine or with the person who answers the telephone.
• In an emergency, we may disclose your health information to a family member or another person responsible for your care.
• We may release some or all of your health information when required by law.
• If (his practice is sold, your information will become the property of the new owner.
• Except as described above, this practice will not use or disclose your health information without your prior written authorization.
• You may request in writing that we not use or disclose your health Information as described above. We will let you know if we can fulfill your request.
• You have the right to know of any used or disclosures we make with your health information beyond that above normal uses.
• As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
• You have the right to transfer copies of your health information to another practice. Wc will mail your files for you.
• You have the right to see and receive a copy of your health information. With a few exception. Give us a written request regarding the information you want to see. if you also want a copy of your records we may charge you a reasonable fee for the copies.
• You have the right to request an amendment or change to your health information, give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
• You have the right to receive a copy of this notice.
• if we change any of the details of this notice, we will notify you of the change at your next appointment after the effective date of the change.
• We reserve the right to have your medical records and files reviewed by our corporation's attorney as part of our medical quality assurance.
• You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509-F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
• However, before filing a complaint, or for more Information, or assistance regarding your health information privacy, please contact our office at 407-478-31SI
This notice goes into effect as of April 14,2003
Acknowledgment
I have received a copy of the **Dr. George D. Papanicolaou MD, PA**; Notice of Privacy Practices.

Signed.____________________ Print Name ____________________ Date_______________

If signing as a parent or guardian, please note the name of the patient ____________________

SOMA PLASTIC SURGERY
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PATIENT LIABILITY FORM

I.Financial Agreement

Our office will file your insurance according to your individual plan(s); however, you are responsible for deductibles, co-pays or co-insurances at the time of service.

Outside Facility Fees

Procedures performed incurring fees in outside facilities (i.e., surgery centers, radiology testing &/or reading fees, labs, etc.) are separately billed to you by that entity and will NOT include fees for our physician's services rendered in that facility. These are due and payable separately.

Referrals, Authorizations, Insurance Coverages

Referral numbers and authorizations by insurance plans are required prior to time of service; otherwise fees associated with services become your liability. If you do not have the required authorizations/referrals at the time of visit, you understand it may be necessary to reschedule the appointment.

I acknowledge it is my responsibility:

- To understand my insurance plan's coverages, limitations, requirements.
- To obtain all necessary authorization(s) &/or referral(s) from any other physicians or facilities as required for treatment and payment by my insurance company to Dr. Papanicolaou.
- To verify and understand my specific plan coverages regarding In/Out-of-Network providers.
- To remit full payment of my account balance as requested up front &/or after services rendered, if my insurance plan denies payment for any of the above listed reasons.

II.Assignment of Insurance Benefits

I authorize direct payment of medical benefits to George Papanicolaou MD for services rendered. I understand I am financially responsible for any balance not covered by my insurance company. **/ understand and agree if I receive direct payment from my insurance company, I am personally responsible for disbursement of payment directly to the physician. A photocopy of these assignments shall be valid as the original.

III.Health Information Release

I hereby authorize treatment of myself by George Papanicolaou MD, and authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/ AIDS, confidential information necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities, unless specified otherwise by me below.

____

Patient Name (please print)

____

If patient is a minor, Guarantor Name (please print)

____

Signature of Patient or Guarantor   Date

SOMA PLASTIC SURGERY
GEORGE PAPANICOLAOU, MD, PA

Return Check Policy

George Papanicolaou, MD, PA will charge a fee for any check that is returned to our office regardless of the reason. The following is a list of fees that will be applied to your account based on the amount of the return check.

$21.00 fee if the face value docs not exceed $30.00
$30.00 fee if the face value exceeds $30.00 but does not exceed $300.00
$40.00 fee if the face value exceeds $300.00 or amount of up to 5% of the face amount of the check.

Florida law states you have 7 days from receipt of notice to tender payment of the full amount of such check plus fees. Unless this amount is paid in full within the time specified **George Papanicolaou MD, PA** may turn over the dishonored check and all other available information relating to this incident to the State Attorney Office for criminal prosecution. You may be additionally liable for attorney fees and court cost.

"No Show Policy"

Due to the increased number of "NO SHOW" patients this practice charges a "NO SHOW" fee of $30.00.

Please call at least 24 hours prior to your appointment time if you need to cancel or reschedule an appointment in order to avoid the $30 fee on your account!

Dr. George Papanicolaou is working diligently to ensure that the best possible care, service, and appointment availability is provided to all of our patients.

I, the patient &/or guarantor, understand the above policies.

____
PRINT: Patients Last Name, First Name

____
PRINT: Guarantor's Last Name, First Name (If patient is a minor)

____
SIGN: Patient or Guarantor's Signature

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MEDICAL HISTORY FORM

Name: ______________________ DOB: ________ Age: ________ Sex: ______ Date: _________

Reason for Visit Today: ______________________________ Referring Dr: __________________

Personal Medical History:

Height: _______ ft/in Weight: ______ lbs. BMI: ______

Please indicate whether you have had, or currently have any of the following medical problems:

- ▫ No Medical Problems
- ▫ High Cholesterol
- ▫ High Blood Pressure
- ▫ Heart Disease
- ▫ Diabetes
- ▫ Asthma/Lung Disease
- ▫ Skin Lesions/Cancer (specify)__________________
- ▫ Other: ________________________
- ▫ Anemia
- ▫ Depression/Anxiety Disorder
- ▫ Kidney Disease
- ▫ Thyroid Problems
- ▫ Arthritis/Joint Problems
- ▫ Weakness/Paralysis
- ▫ Hepatitis/Liver Disease
- ▫ Sleep Apnea
- ▫ Reflux Disease (GERD)/Heartburn
- ▫ Bleeding/Blood Clot/Clotting Disorder
- ▫ Breast Lump/Discharge/Problems
- ▫ HIV/AIDS
- ▫ Problems with Anesthesia (specify)_____
- ▫ Cancer (specify) __________________

Medications: Please list any medications you are taking, including herbal supplements and over the counter medications with dosages:

Medication Name:	Dosage:	Medication Name:	Dosage:
1.__________________	____________	6. __________________	____________
2.__________________	____________	7. __________________	____________
3.__________________	____________	8. __________________	____________
4.__________________	____________	9. __________________	____________
5.__________________	____________	10. __________________	____________

If more than (10) current medications, please attach a list for our records **

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES or NO

IF YES, please list what medication and the reaction: ________________________________

____

DO YOU HAVE ANY OTHER ALLERGIES? SEASONAL______, LATEX_______, OTHER________

Family History:

Please indicate the family members (parents, siblings, grandparents, aunt or uncle) with any of the serious conditions: (Heart Disease, Cancer, etc.)

____

____

List all surgical procedures and approximate dates:

____

____

____

____

Social History: Strictly Confidential

Daily Alcohol Consumption: ________________ **Daily Tobacco Consumption:** ________________

Specify Any Recreational or Mind-Altering Drugs? How Often? __________________________

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MEDICAL PHOTO CONSENT

In connection with the medical services that I am receiving from Dr. George Papanicolaou, I do hereby consent for Dr. George Papanicolaou M.D., or a qualified person approved by Dr. Papanicolaou, to take photographs of me that will be used in my medical record for purposes of medical treatment and/or procedures. Such Photographs shall remain the property of Dr. George Papanicolaou. I understand that the use of my photographs is for treatment purposes as well as medical and patient education and that they will become a part of my permanent medical records.

HEREBY FULLY AND EXPRESSLY RELEASE, INDEMNIFY AND HOLD HARMLESS Dr. George Papanicolaou, ANY PARENT AND OR ENTITY THEREOF, THEIR DIRECTORS, OFFICERS, EMPLOYEES, AGENTS, REPRESENTATIVES, SUCCESSORS, ASSIGNS AND SUBCONTRACTORS FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION THAT I MAY HAVE, OF ANY NATURE WHATSOEVER, WHICH MAY IN ANY MANNER RESULT FROM THE USE OF THE PHOTOS.

I HAVE FULLY READ THE FOREGOING "CONSENT FORM." I FULLY UNDERSTAND ITS CONTENTS AND ACCEPT AND AGREE TO THE ABOVE IN ITS ENTIRETY. I AM SIGNING THIS CONSENT VOLUNTARILY AND ON MY OWN FREE WILL.

______________________________ ______________________________

Printed Name of Patient / Guardian — Date of Birth

______________________________ ______________________________

Signature of Patient / Guardian — Today's Date

<u>Photo Release Form</u>

By signing this release, I authorize Dr. Papanicolaou to use any photograph/video taken by him or his designee, for Marketing, Advertising or Public Relations use deemed necessary without releasing my identity.

I authorize photographs to be taken of the area of my body or face of concern to be sent via Text or Email for medical evaluation.

Refusing to sign will not affect your treatment, payment, enrollment or eligibility.

______________________________ ______________________________

Printed Name of Patient / Guardian — Date of Birth

______________________________ ______________________________

Signature of Patient / Guardian — Today's Date

______________________________ ______________________________

Signature of Witness — Today's Date