Patient Information

Name_____ Age_____ Date of Birth_____/____/_____

Address_____

City_____ State_____ Zip Code_____

Home Phone (_____)_____ Cell Phone (_____)_____

Email Address _____ SS# _____

Employed By _____ Position _____ Work Phone_____

Marital Status (Circle One) Single / Married / Divorced / Widow Sex Male/ Female

Emergency Contact: _____ Relation_____ Number (____)_____

Specific reason for seeing doctor _____

Who referred you to our office: Website Google Search Social Media Doctor

Friend Real Self Other: _____

Personal Physician

Physician Name _____ Physician Phone (___)_____

Pharmacy Information

Pharmacy Name _____ Phone (___) _____

Location / Address _____

Insurance Information

Insurance Name _____ ID # _____

Group # _____ Secondary / Other Insurance _____

Medical Information

Medications: Please print clearly and include herbal supplements, eye-drops, and ointments

Medication	***Dosage***	***Frequency***	***Method***

Drug Allergies / Sensitivities: ☐ None ☐ Penicillin ☐ Sulfa Drugs ☐ Other Drugs _____
_____

Family History: ☐ None ☐ Melanoma ☐ Breast Cancer ☐ Heart Problems

Have you received the Flu Vaccine in the past year? ☐ No ☐ Yes **Date:** _____

Medical History

Check all that apply

Breathing Problems: ☐ Emphysema ☐ Asthma ☐ COPD ☐ Bronchitis

Gastrointestinal: ☐ Ulcers/ Reflux ☐ Colitis ☐ Gall Bladder ☐ Hernia ☐ Kidney Disease
☐ Liver Disease / Hepatitis

Heart Disorder: ☐ Arrhythmia ☐ Anemia ☐ Heart Valve ☐ Heart Attack- Date_____
☐ High Blood Pressure ☐ Low Blood Pressure ☐ Coronary Artery Disease

Blood Vessels: ☐ Peripheral Vascular Disease ☐ Stroke / TIA

Cancer: ☐ Skin ☐ Colon ☐ Lung ☐ Breast ☐ Prostate ☐ Other_____

Eye Problems: ☐ Vision Problems ☐ Glaucoma ☐ Dry Eyes ☐ Cataracts

Other: ☐ Bleeding Disorder ☐ Neurologic Disorder ☐ Headaches / Migraines
☐ Cold Sores / Fever Blisters ☐ Arthritis ☐ Diabetes ☐ Thyroid Disorder

Other Medical History: _____

Surgery History

Check all that apply

Cosmetic Surgery: ☐ Face ☐ Eyes ☐ Neck ☐ Breast ☐ Abdomen

Heart / Lung: ☐ Bypass graft ☐ Valve replacement ☐ Angioplasty / Stents ☐ Lung Surgery

Blood Vessels: ☐ Leg Bypass ☐ Carotid ☐ Vein Stripping

Abdomen: ☐ Hernia ☐ Gall Bladder ☐ Colon ☐ Stomach ☐ Other _____

GYN / GU: ☐ Hysterectomy ☐ Bladder ☐ Breast Surgery ☐ Prostate

Orthopedic: ☐ Hip ☐ Knee ☐ Shoulder ☐ Back

Eyes: ☐ Eye Surgery ☐ Cataracts

Other: ☐ Other Surgery _____

☐ Yes ☐ No Do you drink alcoholic beverages?

☐ Yes ☐ No Do you smoke?

☐ Yes ☐ No Do you vape?

☐ Yes ☐ No Have you ever used street drugs?

☐ Yes ☐ No Have you or any family member have a history of Malignant Hyperthermia, a muscle or neuromuscular disorder, High temperature following exercise, personal history of muscle spasm, dark urine, or unanticipated fever immediately following anesthesia or serious exercise?

☐ Yes ☐ No Have you ever been treated for MRSA or staph infection?

☐ Yes ☐ No Have you ever had a history of bleeding after surgery?

Height _____ **Weight** _____ **Most recent Blood Pressure measurement** _____

I HAVE READ THE ABOVE MEDICAL INFORMATION LISTING AND I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Patient Signature _____ **Date** _____

Consent to use the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

Photographs: Pre and postoperative photographs are essential in Plastic Surgery both for panning and for analysis of postoperative results. It is the policy of the office that all patients coming in for surgery have photographs taken. These photographs are intended solely for the use in the office. They cannot be shown to any prospective patients, nor can they be used in any talks or demonstrations without expressed permission by you, the patient. I have read the above and fully understand the implications. I hereby give my consent to allow Scott T. Farber, M.D. to take pre-intra operative and / or postoperative photographs of me.

Patient Signature _____ Date_____

Release of Information / Medical Records and Assignment of Benefits: I hereby authorize Scott T. Farber, M.D. to release any information acquired in the course of my examination or treatment to my attorneys, physicians, and / or insurance companies or for quality assurance and peer review. I hereby authorize payment directly to Scott T. Farber, M.D. for surgical benefits and / or major medical benefits under the terms of my insurance. I understand I am financially responsible for all charges whether or not paid by my insurance and also the charges incurred to collect these fees. I also understand that a finance charge of 1.5% may accrue on all unpaid balances. I also understand there is no relationship between Scott T. Farber, M.D. and any other entity and that I may be billed separate by the provider of the service. I hereby authorize photocopies of this form to be valid and original. This statement will remain in effect until revoked in writing.

Patient Signature _____ Date_____

FINANCIAL RESPONSIBILITY

By signing this notice, I am aware that Farber Plastic Surgery and Dr. Scott Farber is a participating provider with Medicare, and several specific United Health Care, Cigna, Aetna, and Bluecross/Blueshield PPO plans. However he **is OUT-OF-NETWORK with LocalPlus, SELECT or LIMITED NETWORK Plans** within United Health Care, Cigna, Aetna, and Bluecross/Blueshield PPO plans. Please be aware that all other private insurance will not be accepted.

It is the responsibility of the patient to determine the network status of Dr. Farber with their insurance provider.

The patient or financially responsible representative is responsible for any copays, deductibles, or out-of-network fees that may occur. Please check with your plan prior to seeing the doctor to determine the network status of Dr. Farber and your financial responsibility.

Medicare patients will be financially responsible for the difference between Medicare allowed amount and the amount paid to the provider. As a courtesy, we will submit to your supplemental insurance. If the secondary does not cover the balance, you will be financially responsible.

Patient Signature_____ Date_____

Witness Signature_____ Date_____

HIPAA PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within the organization for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of the organization receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime, or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by the organization or remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You may be contacted by the organization for the purposes of raising funds to support the organization's operations.
- You have the right to restrict the use of your confidential healthcare information. However, the organization may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The organization is required by law to protect the privacy of its patients. It will keep any and all patient healthcare information confidential and will provide patients with a list of duties or practices that protect confidential healthcare information.

- The organization will abide by the terms of this notice. The organization reserves the right to make changes to this notice and will continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.

- You have the right to complain to the organization if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the organization:

  ATTN: FARBER PLASTIC SURGERY
  7700 W. Camino Real, Suite 403
  Boca Raton, FL, 33433

- All complains will be investigated. No personal issue will be raised for filing a complaint with the organization.

- For further information about this Privacy Notice, please contact: **Administrator: Leslie Farber (561) 503-2700**

- This notice is effective as of April 16th, 2013. This date must not be earlier than the date of which the notice is printed or published.

Patient Signature _____ **Date** _____

Witness Signature _____ **Date** _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's HIPAA Privacy Notice:

By subscribing my name below, I acknowledge that Farber Plastic Surgery has provided a copy of the HIPAA Privacy Notice, and that I have read (or have had the opportunity to read if I so choose) 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. 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 a 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: _____

Print Name: _____

Print Name: _____

I, _____, acting on behalf of my minor son/daughter _____

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

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.