DONEN DAVIS PLASTIC SURGERY, LLC

Donen Davis, J.D, M.D.

PATIENT INFORMATION

Patient Name: ____ Date of Birth: _________________ Age: __________
(Last) (First) (Middle)

Home Address: ____ Home Phone: (_____)________________________

____ Work Phone: (_____)________________________

City/State/Zip ____ Cell/Pager: (_____)________________________

E-mail address:____ (if you would like to receive information from us)

SS#: _________________________ Gender: Male / Female Marital Status: (circle one) Single Married Divorced Widowed

Spouse Name: ____________________________ Parent's Name (if patient is a minor): _________________________________

Person to notify in an emergency: __________________________/______________________ Phone: (_____)_____________
Name Relationship

Patient's Employer: ______________________________________ Occupation: ________________________________

Referring Physician: _____________________________________ Primary Care Physician: __________________________

How did you hear about us? ________________________________

INSURANCE INFORMATION - Provide a copy of your insurance cards to the receptionist

Primary Insurance Company: ___________________________________ Insured's Name: _______________________________

ID# or Policy #: ___________________________ Group #:__________________ Group Name/Employer: __________________

Insured's Date of Birth: ____________________________ Insured's Social Security Number: ____________________________

Secondary Insurance Company: __________________________________ Insured's Name: _______________________________

ID# or Policy #: ___________________________ Group #: _________________ Group Name/Employer: _________________

Insured's Date of Birth: ___________________________ Insured's Social Security Number: ______________________________

AUTHORIZATION TO RELEASE INFORMATION / ASSIGNMENT

I hereby authorize Donen Davis Plastic Surgery, LLC to furnish information to my Insurance carriers concerning my treatment, and I hereby assign to Dr. Donen Davis all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance. I authorize a photocopy of this assignment in lieu of the original when necessary.

____ ________________________

Patient / Responsible Party Signature Date

MEDICAL HISTORY

Reason for Visit Today: ____

Symptoms and for how long: ____

Have you been diagnosed and/or treated for: (Please answer each one)

Condition			Condition		
Alcoholism	☐ Yes	☐ No	Hepatitis A,B,C	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	HIV+	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Keloids or scarring	☐ Yes	☐ No
Anxiety Disorder	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Blood Disorder	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bowel Disorder	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Prolonged Bleeding	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Skin cancer	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No

If you answered yes to any of the above, please explain:

____

Other current or previous medical conditions not listed above:

____

List previous operations with approximate dates:

____

Family history:

____

Please list all medications & supplements including dosages:

____

List any drug & food allergies: ____

Do you use tobacco products? ☐ **Yes** ☐ **No** If so, what type ____________________ and how often________________

Alcohol Use (circle one): ☐ **Socially**/☐ **Rarely**/☐ **Daily**/☐ **Never** Do you use cocaine? ☐ **Yes** ☐ **No** Marijuana? ☐ **Yes** ☐ **No**

Patient's Height _________ Weight _________ Bra Size _________ Date of last mammogram: ______________

OFFICE USE ONLY

Positive Findings: ____

Impression: ____

Donen Davis, J.D., M.D.: ____________________________________ *Date:* ______________

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Donen Davis Plastic Surgery, LLC to obtain any and all medical records concerning my care from any physicians, hospital or other health care professional that has provided medical care to me in the past.

I also authorize Donen Davis Plastic Surgery, LLC to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize Donen Davis Plastic Surgery, LLC to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third party administrator or managed care company and for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

Patient Signature _______________ Date _______________

Printed Name _______________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Health Insurance Portability & Accountability Act of 1996 (HIPPA), in order for your physician or staff of Donen Davis Plastic Surgery, LLC to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

Please choose one:

☐ Initials — I **DO NOT** authorize Donen Davis Plastic Surgery, LLC to release any or all information concerning my medical care to any individual.

☐ Initials — I **DO** authorize Donen Davis Plastic Surgery, LLC to release any or all information concerning my medical care to the below listed individual(s).

Name _______________ Relationship to Patient _______________

Name _______________ Relationship to Patient _______________

Patient Signature _______________ Date _______________

Witness _______________

Photographic Consent

In planning your surgery, clinical pre-operative and post-operative photographs are necessary and may be used during an operative setting. These photographs will be used exclusively by your surgeon and remain part of your permanent medical record. Photographs may be taken before, during and/or after a surgical procedure or treatment. Photographs serve a variety of purposes including:

- Patients medical record documentation
- Documentation to provide to insurance company.
- Patient education (before and after pictures).
- Clinical education and medical presentations.

When the surgical procedure does not involve the head, neck, or face, photographs do not show the patient's face. When photographs are used for educational purposes, the patient's name is excluded.

☐ Initials — I hereby authorize Dr. Davis to take pre-operative, operative and post-operative photographs and permit submission of these photographs to my insurance company if necessary.

☐ Initials — I hereby authorize Dr. Davis to use said photographs for medical purposes and/or education. Including but not limited to medical publications, lectures and patient education.

Waiver:

☐ Initials — I hereby authorize Dr. Davis to take pre-operative, operative and post-operative photos but **DO NOT** consent to these photographs being used for educational purposes.

____ ________________

Patient Signature or Personal Representative Date

____

Witness

FINANCIAL AND INSURANCE POLICIES

If you have medical insurance, we will help you receive the maximum allowable benefits. In order to achieve this, we need your assistance and understanding of our financial and insurance policies.

FINANCIAL POLICY

Your co-pay is due at the time of your office visit. If we participate with your insurance company, we will file your insurance claim for you. You will also be responsible for any portion that your insurance company does not pay and deems your responsibility.

Surgery pre-payment: Any amount not covered by your insurance company is due no less than 5 days prior to your surgery. Once your procedure is pre-authorized and scheduled, you will receive notification from our office stating the amount you are responsible for prior to your surgery. If we do not receive your payment, your surgery will be cancelled and/or rescheduled.

Please be aware that pre-authorization from your insurance company does not guarantee payment. If you have any questions, you should contact your insurance company prior to having any procedures.

☐ Initials

I hereby assign all medical benefits to which I am entitled to make direct payment to Donen Davis Plastic Surgery, LLC. I understand that I am responsible for payment of all co-pays, deductibles, or non-covered services at the conclusion of each visit. I understand that my insurance company may not cover certain services and that I may be responsible for payment of those services upon being billed.

REFERRAL AUTHORIZATION

If your insurance requires a referral authorization from your primary care physician, YOU ARE RESPONSIBLE FOR OBTAINING THIS PRIOR TO YOUR VISIT. If you have not done so, you have the option of rescheduling or making payment in full for the amount of the service rendered.

ELECTIVE COSMETIC SURGERY FINANCIAL POLICY

Our staff will provide you with a surgical estimate of the cost of your procedure. **All cosmetic procedures must be paid in full two (2) weeks prior to the date of your surgery.** We accept cash, check, Visa, MasterCard, Discover and American Express. If we have not received your payment, the surgery will be cancelled.

FINANCIAL ASSISTANCE

Donen Davis Plastic Surgery does offer payment plans for patients. We will be happy to schedule a payment plan with you to allow for monthly payments over either a three (3) or six (6) month period. In order to make monthly payments, we will need a credit card or debit card number to charge your monthly payment. Our staff will provide you with an authorization form stating each payment amount and the date for each payment. Additionally, there will be a one time service charge of $25.00 for the payment plan. Any balance remaining after six months will be forwarded to our collection agency regardless of previous payments.

I have read and understand the above policies of Donen Davis Plastic Surgery, LLC and agree to fulfill all obligations as outlined above.

_______________________________________ ____________________

Patient / Responsible Party Signature Date