HIGHPOINT

High Point Plastic Surgery, LLC

Patient's Name: _____ Sex: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____

Email Address: _____ Social Security Number: _____

Marital Status (circle): Minor Single Married Divorced Separated Widow(er)

If a minor, give parents and / or legal guardian's names: _____

Minor resides with: _____ **

**Note: Custodial Parent / Guardian receives all correspondence and billing information from this office.

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Patient's (or custodial parent / guardian's) Employer: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Work Phone: _____ Spouse's Cell Phone: _____

Person to Contact in Case of Emergency: _____ Phone: _____

Reason for Office Visit: _____

Family Doctor: _____ Phone: _____ Referred By: _____ Phone (if doctor): _____

Dermatologist: _____

How did you hear about us? (circle one) Patient Google Marketing event Internet Site: _____

Other: _____

Is this a work related injury? Yes No Is this an auto related injury? Yes No

HEALTH INSURANCE INFORMATION

(Reconstructive Patients Only)

Primary Health Insurance: _____

Identification Number: _____ Group Number: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Secondary Health Insurance: _____

Identification Number: _____ Group Number: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's Employer: _____

ASSIGNMENT AND RELEASE: I understand that I am financially responsible for all services. I hereby authorize release of any information concerning my (or my child's) health care, advice and treatment provided, for the purpose of evaluating and administrating claims for insurance benefits as well as that needed for treatment by other physicians. I also hereby authorize payment of insurance benefits directly to High Point Plastic Surgery, LLC and/or Jason S. Cooper MD.
Insurance co-payments are due at the time of service. I understand that this account is my responsibility. Should the account be referred to an attorney or collection agency, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at the legal rate.

Signed: _____ Date: _____

Signature of Patient or Parent / Guardian if Minor

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Returning Patient Update

Please take a moment to fill out this form so we can update your medical records.

Reason for today's visit:_____

Since your last visit have you been diagnosed with any new medical conditions?
_____

Since your last visit, have you had surgery or been hospitalized?
_____

Are you taking any new medications or supplements?
1._____Dose_____mg 2._____Dose____mg

3._____Dose_____mg 4._____Dose____mg

New Allergies:_____

Has your Health insurance changed?

Primary Health Insurance: _____

Identification Number: _____Group Number:_____

Insured's Name: _____Relationship to Patient:_____

Insured's Date of Birth: _____Insured's Employer:_____

Secondary Health Insurance: _____

Identification Number:_____Group Number:_____

Insured's Name:_____ Relationship to Patient:_____

Insured's Date of Birth:_____

Insured's Employer: _____

High Point Plastic Surgery, LLC Medical History

Patient Name: Today's Date:
Patient No.: Surgeon Name:

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we can safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age: _____ Height: _____ Weight: _____ Occupation: _____

Reason for seeing a plastic surgeon: _____

Please Circle any areas of interest: Botox Restylane/Juvaderm Skin Care/Peels/Laser Liposuction
Facelift Eyelid Surgery Breast Augmentation Tummy Tuck Breast Lift / Reduction

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

1._____ Dosage_____ 4._____ Dosage_____ 7._____ Dosage_____
2._____ Dosage_____ 5._____ Dosage_____ 8._____ Dosage_____
3._____ Dosage_____ 6._____ Dosage_____ 9._____ Dosage_____

List all drug allergies and reaction:_____

_____

Have you ever used (circle any that apply)? LSD Cocaine Marijuana None
Are you a (circle one): Smoker Ex-Smoker Non-Smoker

If you are/were a smoker, how much are/were you smoking? _____ How Long? _____ Quit how long ago?_____

How much alcohol do you drink? _____ Type? _____

Family History Has any blood relative ever had the following:

	No	Yes		No	Yes		No	Yes
Breast Cancer			High Blood Pressure			Kidney Disease		
Melanoma			Heart Disease			Depression		
Stroke			Diabetes			Blood Clot		

Past Medical History Have you ever had the following:

	No	Yes		No	Yes		No	Yes
Heart Disease			Asthma			Thyroid Disease		
Arthritis			AIDS or HIV			Bleeding Tendency		
Anemia			Mitral Valve Prolapse			Stroke		
Diabetes			High Blood Pressure			Hepatitis		
Cancer (Type):			Stomach Ulcer			Blood Clots/DVT/PE		
Glaucoma			Kidney Disease					

Review of systems Do you have now or have had within the past year:

	No	Yes		No	Yes		No	Yes
Weight Change			Joint or Muscle Pain			Skin Rash		
Chronic Cough			Jaundice			Easy Bleeding		
Chest Pain			Depression			Easy Bruising		
Rapid Heart Beat			Seizures			History of sunburns		

Is there any possibility that you may be pregnant at this time? Yes No Number of pregnancies ____ Number of children____

List all surgeries that you have had (include plastic or cosmetic surgery), major illnesses or Hospital admissions with dates:

_____

_____

_____

Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers)? Yes No

Have you ever seen a cardiologist? Yes No Physician Name: _____

Date of last EKG: _____

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____

Signature of patient or parent if minor Date

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Payment Agreement

Our office will bill your insurance company with the following provisions. It is important to understand, though, that the contract regarding your medical benefits is between you, your employer, and your insurance company and it is important you understand its provisions. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims and payment for services.

Verification of Benefits: As a courtesy, our office is verifying your coverage under an insurance plan. Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. The patient or patient's guardian is solely responsible for any debt incurred with our office.

Insurance: Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment. We cannot accept the responsibility of negotiating claims with your insurance carrier or other persons. The patient is responsible for payment on his/her medical care. Regardless of the status of the claim, there must be action or payment on the account within 30 days from the date of service. No account will be carried past a 3 month period.

Reduction or Rejection of Your Claim: We cannot guarantee payment on your claim. If your insurance carrier pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance carrier does not relieve you of the financial obligation you have incurred with our office. Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company

Reasonable and Customary Charges: Our fees are generally different than what your insurance carrier allows. Therefore, you are responsible for any amount not paid by your insurance carrier regardless of the amount charged by our office and what amount your insurance carrier determines to be the reasonable and customary charge. It is understood and agreed that our office is in no way bound by the patient's insurance carrier guidelines on their reasonable and customary charges.

Deductibles: We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MEDICAL BENEFITS DIRECTLY TO MAIN LINE PLASTIC SURGERY PC/ DR JEAN.

I FURTHER AUTHORIZE YOU TO DEBIT MY CREDIT CARD IF YOU HAVE NOT RECEIVED PAYMENT FROM MY INSURANCE COMPANY WITHIN 60 DAYS OF RECEIVING TREATMENT.

Signature of Patient/Responsible Party	*Credit Card #*	*Expiration Date*	*V-Code*

Signature of Witness	*Name of Witness*	*Date*

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NOTICE OF PRIVACY PRACTICES

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.

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice, including, but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities, licensing, contacting, or arranging for other business activities. We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders
We may contact you to provide appointment reminders.

Treatment Information
We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to Department of Health and Human Services
We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation of determination of our compliance with relevant laws.

Family and Friends
Unless you object, we may disclose your medical information to family members, other relatives, or close personal friends when the medical information is directly relevant to that person's involvement with your care.

Notification
Unless you object, we may use or disclose your medical information to notify a family member, a personal representative, or another person responsible for your care of your location, general condition, or death.

Health Oversight Activities
We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure, or disciplinary actions, administrative and/or legal proceedings.

Organ Donation
If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Public Safety
We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Worker's Compensation
We may disclose your medical information as authorized by laws relating to worker's compensation or similar programs.

Business Associates
We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

AUTHORIZATIONS:
We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

Jason S.Cooper, MD
High Point Plastic Surgery, LLC
3535 Military Trail
Suite 204
Jupiter, FL 33458

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:
You have the following rights with respect to your medical information:

You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.

You have the right to receive communications from us in a confidential manner.

Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

You have the right to receive an accounting of the of the disclosures of your medical information made by our practice during the last six years except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.

You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

Jason S. Cooper, MD
High Point Plastic Surgery, LLC
3535 Military Trail
Suite 204
Jupiter, FL 33458

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:
US Department of Health and Human Services
200 Independence Ave.
SW Washington, DC

20201

THIS NOTICE IS EFFECTIVE AS OF October 15, 2014

REVISION OF NOTICE OF PRIVACY PRACTICES
We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain.
If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy
Practices available upon request.

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Confidential Communication Request

Acknowledgement of Receipt of Notice of Privacy Practice

As required by Health Information Portability and Accountability Act of 1996 you have the right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some methods of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____***(print name)*** hereby request the use of the following confidential channels for the communication of information related to my personal health or treatment. This request supersedes any prior request for confidential communications I have made.

What telephone number(s) may we use to contact you?

Home _____

Mobile _____

Work _____

What email address may we use for correspondence? _____

May we send written correspondence to your home address? YES NO

May we discuss pertinent information with anyone else? YES NO

If yes, please state name and relationship to you:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

By signing below, I hereby authorize my health information, as more specifically described as a medical record or protected health information, to be used or disclosed at my request to the above named, Dr. Cooper's staff, and my primary or referring physician.

I hereby acknowledge that I have been presented with a copy of High Point Plastic Surgery, LLC Notice of Privacy Practices and been given the option to retain a copy.
Patient Name: (please print)_____

Signature:_____**Date:**_____
(If minor or disabled, Legal Guardian signature)