D. Scott Rotatori, M.D., P.A.

PATIENT INFORMATION

Patient Name _____
LAST *FIRST* *MIDDLE*

Today's Date_____Account# _____

Date of Birth_____Age ____ Sex _____ Race _____ SS#_____

Mailing Address_____City_____State_____ Zip _____

Home Phone_____Cell Phone_____

Employer_____Work Phone_____

Occupation_____ Email Address _____

**** Would you like to receive specials and newsletters through email?*** _____***Yes*** _____ ***NO***

Reason for Visit*_____

Have you been treated elsewhere for this problem? _____If so, by whom?_____

**How did you hear about our office? ***_____Patient ___ Physician____Online_____Other

If *patient* or *physician,* please indicate:

_____

May we write a letter to your referral source, thanking them for referring you?_____Yes_____No

Would you like your records from each visit here, released to (if yes, please check and sign below) *

Your Primary Care Doctor? ____ Yes ____ No _____
Signature Date

Your referring Doctor? _____ Yes ____ No _____
Signature Date

If checked ***yes,*** please indicate below:

Primary Care Doctor Name_____Address_____

Referring Doctor Name_____Address_____

PARENT OR SPOUSE INFORMATION

Name_____Relationship_____Date of Birth_____

Mailing Address (if different from Patient)_____

Home Phone_____Work Phone_____

Employer_____Address_____

EMERGENCY CONTACT PERSON

Emergency contact person (or friend) other than a relative, who does not reside with you:

Name_____Address_____Phone_____

PRIMARY INSURANCE INFORMATION

Insurance Company_____

Group or Individual_____

If Group, Name of Employer_____

Policy#_____Group#_____Insured's Date of Birth._____

Insured's Name_____Relation to Patient_____

Insured's SS#_____Ins. Co. Phone#_____

Mail Claims To:_____

SECONDARY INSURANCE INFORMATION

Insurance Company_____

Group or Individual_____

If Group, Name of Employer_____

Policy#_____Group#_____Insured's Date of Birth_____

Insured's Name_____Relation to Patient_____

Insured's SS#_____lns. Co. Phone# _____

Mail Claims To :_____

INSURANCE RELATED SERVICES

The patient is responsible for all fees for services rendered by D. Scott Rotatori, M.D., P.A. and is subject to individual insurance requirements. We accept payment in the form of cash, check, or credit card. Payment for surgery fees other than initial deposit is accepted **only** in cash, cashier's check or credit card.

*** Any checks returned by your bank to us as NSF will be subject to a fee of $30.00 and the amount of the check will be due immediately in cash or credit card payment only. ***

When insurance coverage applies, our office will as a courtesy *to* the` patient file claims directly to your insurance company to expedite payment Dependent upon your insurance benefits and coverage, you will be asked to pay co-payments, deductible amounts due, and any other related charges for non-covered services. Should your insurance not cover payment for all or any portion of services, you the patient are **ultimately responsible for any balances due. Any outstanding balances not paid will be sent to** Collections (unless other arrangements have been made).

I authorize release of medical information necessary to process this claim and also authorize direct payment from my insurance carrier of medical benefits to the physician. I hereby authorize D. Scott Rotatori, M.D., P.A. to furnish information to my insurance carrier/carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents.

DATE:_____SIGNATURE:_____

NON- INSURANCE RELATED SERVICES

The patient is responsible for all fees for any and all services provided by D. Scott Rotatori, M.D., P.A. I agree to pay for all services rendered by my physician and or any other Provider of Services per the officepolicy of D. Scott Rotatori, M.D., P.A.

MONIES FOR DEPOSIT TO HOLD SCHEDULED SURGERY DATES ARE NON-REFUNDABLE

DATE:_____SIGNATURE:_____

MEDICAL HISTORY

Height _____ Weight _____ Exercise?_____ Diet?_____

Do you use Tobacco?_____Alcohol?_____Drugs?_____

If yes, how much?_____

Have you had a recent weight loss or gain? If yes, please explain.

_____

Please list any allergies._____

Do you have a history of Sleep Apnea or Snoring? ___ Yes _____NO

Surgical History:_____

_____

_____

Other Hospitalizations: _____

_____

_____

Have you been treated for any medical problems? _____If yes, please explain: _____

_____

Have you ever seen a psychologist or psychiatrist? _____

Are you currently under treatment by a psychologist or psychiatrist?_____

_____Heart Problems:_____

_____Lung Problems:_____

_____Kidney Problems:_____

_____Coughing up or Vomiting Blood:_____

_____Blood in urine or stool:_____

_____Seizures or loss of consciousness:_____

_____High Blood Pressure:_____

_____Diabetes:_____

_____Cancer:_____

_____Hepatitis or yellow jaundice:_____

_____Thyroid Disease: _____

_____ Other:_____

List any other medications you are currently taking, including over-the-counter drugs and herbal supplements:_____

_____

Personal or family history of anesthesia or bleeding problems? If so, please explain:

_____

_____

D. Scott Rotatori, M.D., P.A.

Notice of Privacy Practices

- This notice describes how your health information may be used and disclosed and how you canaccess this information. Please review it carefully.
- At D. Scott Rotatori, M.D., P.A., we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this noticeand to follow the terms 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 your care.
- We may use of disclose your health information for payment of your services. For example, wemay send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. Forexample, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires 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 are not home, we may leave this information on your answering machine orwith the person who answers the telephone
- In an emergency, we may disclose your health information to a family member or another personresponsible for your care.
- We may release some or all of your health information when required by law.
- If this 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 withoutyour prior written authorization.
- You may request in writing that we not use or disclose your health information as describedabove. We will let you know if. we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health informationbeyond that above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephonenumber you prefer.
- You have the right to transfer copies of your health information to another practice. We will mailyour files for you.
- You have the right to see and receive a copy of your health information. With a few exceptions. 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 itto 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 nextappointment after the effective date of the change.
- 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 acomplaint.
- However, before filing a complaint, or for more information, or assistance regarding your healthinformation privacy, please contact our office at (407) 628-5476.
- This notice goes into effect as of April 14, 2003

Acknowledgement

I have received a copy of the D. Scott Rotatori, M.D., P.A.; Notice of Privacy Practices.

Signed_____Print Name_____Date____ _

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

D. Scott Rotatori M.D., P.A.

Contemporary Cosmetic Plastic Surgery

Cosmetic, Plastic and Reconstructive Surgery

www.scottrotatori.com

Certified-American Board of Plastic Surgery | Member -The American Society of Plastic Surgery

800 W. Morse Blvd. Suite 5
Winter Park, FL 32789

Phone: 407-628-5476
Fax: 407-628-4108

Patient Request for Allowances, Limitations

And/or Restrictions of Protected Health Information

Please note: The practice is not required to agree to your request. Please refer to Our Notice of Privacy Practices for additional information about such requests.

Patient to complete the following:

Name:_____Date of Birth:_____

Address:_____

_____

Type of Protected Health Information to be restricted or limited:

_____ _____

_____ _____

To whom may we release information: (ex: _ spouse, _ significant other, _ caretaker,_ etc.)

_____ _____

_____ _____

Note* Often spouses, significant others, caretakers, friends, may call on behalf of the patient especially after surgery to speak with the nurse or other staff members, or to confirm appointment dates and times. Without written consent of the patient we cannot give out any information to anyone other than the patient in compliance with HIPPA law.

To whom may we not release information:

_____ _____

_____ _____

Signature of Patient or Legal Guardian | Date

D. SCOTT ROTATORI, M.D., P.A.

Plastic and Reconstructive Surgery

Electronic Communication Agreement

Electronic communications, including but not limited to, emails and text messages, for example (hereinafter "Electronic Communications"), provide an opportunity to communicate with the healthcare providers at D. Scott Rotatori, M.D., P.A. ("D. Scott Rotatori, M.D., P.A.").

The following is intended to assist you with your determination of whether you wish to electronically communicate with D. Scott Rotatori, M.D., P.A.

General Considerations

- As your healthcare provider, D. Scott Rotatori, M.D., P.A., will treat Electronic Communications with the same degree of privacy and confidentiality as written medical records. D. Scott Rotatori, M.D., P.A. has taken reasonable steps with internal information technology systems to protect the security and privacy of your personal identifying and health information in accordance with the security guidelines required by the Health Information Protection and Accountability Act of 1992, as amended ("HIPAA").
- Standard email services, including, but not limited to, AOL, Yahoo, Hotmail, and Gmail, are not secure. This means that the email messages, including any individually identifiable health information and other sensitive or confidential information that may be contained in such email messages, are not encrypted and could be misdirected, disclosed to, read or intercepted by, unauthorized third parties.
- Standard text messaging services are also not secure, meaning that any individually identifiable health information and other sensitive or confidential information that may be contained in such text messages, are not encrypted and could be misdirected, disclosed to, read or intercepted by, unauthorized third parties.

I have read and understood the above description of the risks and responsibilities associated with Electronic Communications with D. Scott Rotatori, M.D., P.A. I acknowledge that commonly used Electronic Communications are not secure.

Please check <u>one</u> of the three below statements:

A. ___ Having been informed of the risks associated with Electronic Communications, I consent to, accept the risk in and still desire to communicate with D. Scott Rotatori, M.D., P.A. via Electronic Communications. I understand that I can withdraw this consent authorizing D. Scott Rotatori, M.D., P.A.to communicate with me via Electronic Communications at any time by written notification to D. Scott Rotatori, M.D., P.A.

My email address is _____

My cell phone number is ( )-_____

B. ___ Having been informed of the risks associated with Electronic Communications, I consent to accept the

can withdraw this consent authorizing D. Scott Rotatori, M.D., P.A.to communicate with me via Electronic Communications at any time by written notification to D. Scott Rotatori, M.D., P.A.

- ✓ My email address is _____.
- ✓ My cell phone number is ( )-_____-_____.

C. ____ Having been informed of the risks associated with Electronic Communications, I ***do not consent to***, accept the risk in and desire to communicate with D. Scott Rotatori, M.D., P.A. via Electronic Communications. I understand that I can change my mind and provide a consent authorizing D. Scott Rotatori, M.D., P.A.to communicate with me via Electronic Communications at a later time by written notification to D. Scott Rotatori, M.D., P.A.

To the extent that I have checked Box A or B, I release and hold harmless D. Scott Rotatori, M.D., P.A., its provider(s) and their staff, employees, affiliates, agents, officers, and principals from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses of any kind that I may have resulting from Electronic Communications between D. Scott Rotatori, M.D., P.A. and me based on this authorization given to D. Scott Rotatori, M.D., P.A. to communicate with me via Electronic Communications.

_____
Patient Name (printed)

_____ _____
Patient Signature Date

_____
Witness