OCALA PLASTIC SURGERY & DERMATOLOGY

Board Certified Plastic Surgeons:
James Rogers DMD, MD · **Navinderdeep Nijher** MD · **Jennel Carreras-Montgomery** MD
Board Certified Dermatologist: **Jessin Blossom** MD, FAAD

Patient Name (Please Print): _____ Date of Birth: _____/_____/_____

Address: _____City, State & Zip _____

Phone (home)_____ (cell) _____

Age: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Reason for appointment: _____ Referred by: _____

Employer: _____Employer phone: _____

EMAIL: _____

** Preferred Pharmacy: _____ Pharmacy Phone: _____

** Primary Care Physician: _____ Phone: _____

INSURANCE INFORMATION

Please provide your insurance card to be scanned into your patient chart

Is this Workman's Compensation? ☐ Yes ☐ No

Type of insurance? ☐ Medicare ☐ Medicaid ☐ Private Insurance ☐ Auto Insurance ☐ Homeowners

Policy Holder name:

Social Security: _____ Date of Birth _____

Work phone: _____

Please remember that insurance is considered a method of reimbursing the patient fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is yourresponsibility to pay any deductible amount, coinsurance, or any other balance not paid by your insurance. To control the cost of billings, we request that charges for your office visits be paid at the conclusion of each visit. If this amount is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

EMERGENCY INFORMATION

In case of an emergency notify: _____

Relationship to patient: _____ Phone: _____

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to Ocala Plastic Surgery & Dermatology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
I hereby authorize said assigned to release all information necessary to secure the payment including the diagnosis and records of any treatment or exam rendered to me during the period of medical and/or surgical care. I understand that I am financially responsible for all charges whether covered by my insurance or not and I authorize Ocala Plastic Surgery & Dermatology to send a letter to the state insurance commissioner if any insurance services rendered is not paid within 45 days.
I hereby authorize the taking of photographs for the purpose of documentation which will be a part of my permanent record, and which may be used for medical education.

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____

OCALA PLASTIC SURGERY & DERMATOLOGY

PATIENT MEDICAL HISTORY FORM

Name: _____ **Date of Birth:** _____

Primary Care Physician: _____ **Age:** _____ **Sex:** Male / Female

Preferred Pharmacy: _____ **Pharmacy phone #:** _____

LAB if required (ple**ase circle)** Ameripath/Dermpath LabCorp Quest Korpath

Current Reason You Are Here Today: _____

MEDICAL HISTORY: (Please circle all that apply)

Anemia	Eye Disease _____	HIV/AIDS
Anxiety/Depression	Excessive Scarring	Hypo/Hyper Thyroid
Arthritis/Rheumatoid or Psoriatic	Gerd	Kidney Problems
Artificial Joints	Heart Attack	Lymphoma
Asthma/COPD	Heart Disease	Pacemaker
Bleeding Disorder	Heart Failure	Radiation Treatments
Cancer/type _____	Heart Valve Replacement	Seizures
Coronary Artery Disease	Hepatitis	Stomach Problems
Chronic Lung Disease	High Blood Pressure	Stroke
Diabetes/type_____	High Cholesterol	NONE OF THE ABOVE

Other: _____

SKIN HISTORY: (Please circle all that apply)

Actinic Keratosis	Dry Skin	Keloid scars	Redness/Dark	Wrinkles
Acne	Eczema	Melanoma	SCC	
BCC (basal cell)	Flaking or itchy	Precancerous	Spots	
Bleeding/Bruising	scalp	Moles	Sunburn	NONE OF THE
Cold Sores	Itching	Psoriasis	(blistering)	ABOVE

If you've previously had skin cancer, please list body location(s)**:** _____

Other skin issues: _____

Do you wear sunscreen? Yes No Do you use indoor tanning? Yes No Never

Number of alcoholic drinks per day (circle) None Less than 1 per day 1-2 per day 3 or more per day

Do you smoke/vape? (circle) Former Never Current (packs/pods per day/week) _____

Any psychiatric problems, nervous breakdown or currently under the care of a psychiatrist? Yes No

Family Medical History of Melanoma? Yes No Who? _____

Family Medical History of Cancer? Yes No Who? _____ Type? _____

Family Medical History of Heart Issues? Yes No Who? _____ Condition? _____

PHYSICAL EXAM: Height_____ Weight _____lbs. Bra Size: _____

PAST SURGERIES & HOSPITALIZATIONS: (please list all surgeries - including cosmetic)

_____ _____

_____

_____ _____

_____ _____

_____ _____

MEDICATIONS (Please enter all current medications including vitamins and/or supplements including dosages)

MEDICATION	**DOSE** (mg, pill, etc) **&** **Times per day**

☐ I do not take any medicines, vitamins or supplements

Do you have any allergies/reactions to medication or anesthesia? Yes No Please explain: _____

_____

Bleeding Tendencies: _____

ALERTS:

Allergy to adhesive
Allergy to lidocaine
Allergy to Topical Antibiotics
Blood thinner
Bone Marrow Transplant
Defibrillator
Healing Problems
MRSA
Pacemaker
POTS
Pregnancy or planning for in future
Rapid Heart Rate w/Epinephrine
Require Antibiotics prior to surgery

Other: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

This will authorize (facility): to release general medical, as well as psychiatric/psychological, drug/alcohol abuse and HIV testing information from my health record in accordance with the following Florida Statutes: 90.503, 394.459, 395.017, 396.112, 397.053 and 381.609.

A general medical authorization and subpoena duces tecum, without a specific authorization to release psychiatric/ psychological, drug/alcohol and HIV testing information must have this waiver from the patient or his/her empowered representative.

PLEASE PRINT

Patient's Legal Name: _____ Date of Birth: _____

Telephone: _____ Social Security Number: _____

INFORMATION IS TO BE RELEASED TO: _____

INFORMATION TO BE RELEASED (check):

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Progress Notes
- ☐ Other Information (Specify Below): _____
- ☐ Consultation Report
- ☐ Physician Orders
- ☐ Operative Reports

This authorization is for the listed date(s) of treatment:

From: _____ To: _____

RECORD IS TO BE USED FOR: _____

I understand that I have the right to refuse this authorization and that the facility named above as the releasing facility is released from all legal liability that may arise from the release of information requested.

Prohibition on redisclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited.

This authorization will be valid for one year after the date of my signature as it appears below.

Patient Signature: _____ Date: _____

Empowered Representative Signature: _____ Date: _____

(Relationship to patient: _____)

Witness Signature: _____ Date: _____

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OCALA PLASTIC SURGERY & DERMATOLOGY FINANCIAL POLICY

Ocala Plastic Surgery & Dermatology believes that in our commitment to excellence, it is best to establish a patient account policy in order t avoid any misunderstandings. Our Insurance Billing Coordinator will be glad to discuss your account with you at any time. Our primary responsibility is to deliver quality health care services. We wish to spend our time and energy toward that responsibility. To achieve these goals, we need your assistance, and your understanding of our payment policy:

Initial Consultations – Patients are expected to pay for their initial consultation at the time of visit. Exceptions to thiswould be Medicare, Workman's Compensation, and patients having a group policy with which we have a contractual agreement. We accept cash, checks, MasterCard, Visa, Discover Card, American Express, other credit cards and checkcards with the MasterCard or Visa Logo.

Small Office Procedures – You will be contacted prior to your scheduled procedure to let you know your financial responsibility. This is just an estimate based on the information we have prior to surgery, if something changes duringthe procedure, this will change the amount you owe. We will refund or balance bill after your insurance company hasprocessed your claim.

Planned Surgery – There will be a required "pre-payment"/" deposit for surgery" at the time of the patient's pre-op visit (which is usually 1 week before planned surgery). You will be notified of the amount prior to your surgery. All insuranceis verified prior to a patient having surgery. If the insurance company has approved the surgery, then we will, as a courtesy, file the services after surgery is performed. You must realize, however, that:

1) Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2) Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who paya percentage (such as 50% or 80%) of "U.C.R." as defined as usual, customary, and reasonable fees for this region. Thus, most companies consider our fees usual, customary, and reasonable. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Full payment of surgical cost will be required at your pre-op visit, prior to surgery, unless you have a policy with which we have a contractual agreement.

Fees – During your initial consultation, you should receive a detailed breakdown of approximate charges. This breakdown should consist of the following charges that will constitute your billing:

1) Surgeon's fee

If your procedure is performed at Paddock Park Surgery Center, additional charges will apply.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I understand that I am responsible for all expenses incurred, including doctor's fees (and Paddock Park Surgery Center, if applicable). I also understand and agree that if this office receives no payment within sixty days, my signature acknowledges that I will be responsible for the entire unpaid balance regardless of the reason for denial. I also understand that I am responsible for any additional charges incurred if my account is turned over to a collection agency for non- payment.

Patient Signature: _____ Date: _____

Responsible Party: _____ 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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We use your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and *administrative proceedings:* We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amended Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to requestthat we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:
Center Director
3320 S.W. 34th Circle
Ocala, Florida 34474
352-629-8154

Effective Date: April 14, 2003

I,_____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgement was not obtained:

_____

Staff Witness seeking acknowledgement:

_____

Date: _____

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Ditzel (In office Minor Procedure)

- If we are non-participating with your insurance company, you will be expected to pay the full amount at the time you schedule your procedure (at least 2 weeks prior to your procedure).
- As a courtesy we will submit your claim to your insurance company for you.
- We do not collect for nor bill anesthesia, pathology, or lab charges. If your procedure is non-cosmetic, you may incur these costs and receive a bill from another provider for these charges.
- Ocala Plastic Surgery & Dermatology uses Ameripath, & KorPath for all specimens sent out to be tested. **If your insurance company requires you to use a specific laboratory, please let us know.**

Surgery (Paddock Park Surgery Center or Hospital)

- Our insurance department will call you prior to your History and Physical (H&P) notifying you how much you will owe for your surgery. If we are non-participating with your insurance company, you will be expected to pay the full amount prior to your procedure.
- The amount given to you by our insurance department will be the amount due at your History & Physical appointment and will be collected in full upon your check-in for that appointment. You have the option of making incremental payments as long as the amount is paid in full by your H&P date.
- As a courtesy we will submit your claim to your insurance company.
- Charges due for Hospital surgery - H&P and surgeon.
- Charges due for PPSC surgery - H&P, surgeon, and facility.
- We do not collect for nor bill anesthesia, pathology, or lab charges. If your procedure in non-cosmetic, you will receive a bill from another provider for these charges.
- Ocala Plastic Surgery & Dermatology uses Ameripath/Quest and KorPath for all specimens being sent for testing. **If your insurance company requires you to use a different laboratory, it is your responsibility to notify us.**

  Our cosmetic patients are sent to **UF Health** Pathology Laboratories for surgical lab/blood work as self-pay patients. **Your insurance company will NOT pay for lab work done for cosmetic procedures.**

Patient Signature:_____ Date: _____

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Please list any family member or any other persons that you authorize to communicate with our staff regarding your medical or financial care or concerns. This includes confirming appointments.

(SPOUSE, CHILD, CHILDREN, CAREGIVER, ETC)

MEDICAL & FINANCIAL RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby authorize Ocala Plastic Surgery & Dermatology to release my medical or financial information if requested by:

Name	Relationship	Daytime Phone Number
Name	Relationship	Daytime Phone Number
Name	Relationship	Daytime Phone Number
Name	Relationship	Daytime Phone Number

_____ _____

Signature of Patient or Legal Guardian of Patient Date

May we leave a detailed message on your answering machine or voicemail?
(circle one) YES _____ (your initials) NO _____ (your initials)

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Consent for Use of AI-Assisted Dictation

As part of our ongoing commitment to providing the best possible care, your provider may use an artificial intelligence (AI) note-taking tool to assist with clinical documentation during your visit and does not replace your providers professional judgement. This tool helps your provider spend more time focused on you and your concerns, rather than on taking notes. A temporary recording, transcript, or summary of the conversation may be created and used to help generate the clinical note for that visit. Your provider reviews every note for accuracy, makes any needed corrections and must approve it before it becomes part of your medical record and once approved the temporary recording and transcript are automatically deleted.

This AI tool is designed to protect the privacy and confidentiality of your personal health information. Information from your visit is used only for your ongoing medical care and is safeguarded in accordance with applicable data privacy requirements, including HIPAA. Your information is secured and encrypted, and business associate agreements are in place to support data privacy and HIPAA compliance. Please speak with your provider if you have any questions or concerns about this tool.

By signing this form, you consent to the use of AI-assisted dictation as described above. You understand that participation is voluntary, is not a condition of receiving care from your clinician and may be withdrawn at any time.

Patient Name (printed) : _____ Account# : _____

Patient Signature: _____ Date: _____

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THANK YOU FOR COMPLETING THIS INFORMATION

Thank you for completing our new patient forms for Ocala Plastic Surgery and the Paddock Park Surgery Center. Please be sure you have completed this paperwork packet in its entirety, print all pages, and bring them with you along with your current driver's license or photo ID and your current insurance card if applicable to your first visit. You can print them by clicking on the print button below.

IMPORTANT: Please remember, these forms contain personal and confidential information and should be protected by you while at home or in transit to our offices.

Print Form