



NEWMAN PLASTIC SURGERY
CHARLES E. NEWMAN, JR, MD
DZI-LONG NEWMAN, PA-C
PLASTIC AND RECONSTRUCTIVE SURGERY
Patient Information Form

Today's Date: _____

Patient's Full Legal Name: _____

Patient's Preferred Name: _____ Age: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Please circle best contact number:

Home Phone: _____ Cell: _____ Work: _____

Email: _____ May we contact you by email? Y N

Social Security Number: _____ Employer: _____ Occupation: _____

Marital Status: _____ Name of Spouse: _____

Primary Care MD: _____ Phone: _____

Nearest Relative (not living at same address): _____ Relationship: _____ Phone: _____

Persons with whom we may discuss your medical care (please list with contact number):

Person financially responsible: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION (If Applicable) Please have card ready for copying.

Primary Ins Co: _____ Secondary Ins Co: _____

ID No. : _____ ID No: _____

Group No. _____ Group No.: _____

If the Policyholder is anyone other than the patient, please complete the following:

Policy Holder's Name: _____ Relationship to patient: _____

Insured's DOB: _____ Policy Holder's SSN: _____

Referral source: _____

<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Established Patient	Name:
<input type="checkbox"/> Internet	<input type="checkbox"/> Other	Specify:
<input type="checkbox"/> Physician	Name:	Ph:

Authorization to Release Medical Information & Assignment of Benefits:

I authorize **Newman Plastic Surgery** to furnish my insurance company(s) and/or other physicians all information, which I may be requested concerning my health. I also assign the claim payments to be made payable to **Newman Plastic Surgery** and/or **Charles Newman, Jr, MD.**

Insurance co-payments are due at the time of service. Giving fraudulent insurance information could be considered theft of services. I understand that this account is my responsibility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at the legal rate.

Signature of Patient/Responsible Party

Date



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Medical History

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: M F Current Height: _____ Current Weight: _____

Specific Reason for Seeing Plastic Surgeon: _____

Previous cosmetic procedures and dates: _____

Habits: Tobacco: Y N Amount: _____ Coffee/Tea/Soda: Y N Amount: _____
 Alcohol: Y N Amount: _____ Daily Exercise: Y N Amount: _____

Prescription Medications(include dose) : _____

Vitamins/Herbal _____

Regular Aspirin Use: Y N NSAIDs/Ibuprofen(Motrin, Advil): Y N
Medication Allergy: Y N Name & Reaction: _____
Latex Allergy: Y N Source & Reaction: _____
 Tape Allergy Y N Type & Reaction: _____

Personal Medical History:

Abnormal Bleeding: Y N	Cancer: Y N	Hepatitis: Y N	Acid Reflux/Heartburn: Y N
Diabetes: Y N	Anemia: Y N	Fainting Spells: Y N	High Blood Pressure: Y N
Asthma: Y N	Seizures: Y N	Heart Attack/Disease: Y N	Mitral Valve Prolapse: Y N
Blood Clots: Y N	Sleep Apnea: Y N	Heart Surgery/Stents: Y N	HIV/AIDS: Y N
Blood Transfusion: Y N	Other Not Listed: Y N		

Please describe all "Yes" responses: _____

GYN history:

Number of Pregnancies: _____ Did you Breastfeed? Y N Total Duration: _____

LMP: _____ Any plans for additional pregnancies? Y N Date last Mammogram _____

Previous Surgery(date): _____

Family Medical History: Kidney Disease: Y N Heart Attack/Disease: Y N Abnormal Bleeding: Y N
 Diabetes: Y N Tuberculosis: Y N High Blood Pressure: Y N Cancer: Y N
 Anesthesia Problems: Y N Other Not Listed: Y N

Please describe all "Yes" responses: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____



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AUTHORIZATION FOR THE USE OF PHOTOGRAPHS

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent

For various reasons Dr. Newman is often asked to show before and after photos of patients. Many patients have given permission to use their photos anonymously. We now ask that you do so as well.

AUTHORIZATION FOR BEFORE & AFTER PHOTO

I hereby authorize Dr. Charles Newman, Jr. to use my preoperative and postoperative photos in his before and after presentation to other patients interested in the same procedures. I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all representations. I understand that this consent has no bearing on medical care. This release will remain in effect for 7 years unless revoked in writing or Charles Newman, Jr, MD and/or Newman Plastic Surgery has taken action in reliance to this consent.

Signature

Date

Print

AUTHORIZATION FOR WEBSITE

I hereby authorize Dr. Charles Newman, Jr to use my photos for website presentations. I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all presentations. I understand that this consent has no bearing on my medical care. This release will remain in effect for 7 years unless revoked in writing or Dr. Charles Newman, Jr and/or Newman Plastic Surgery has taken action in reliance to this consent.

Signature

Date

Print



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PLASTIC AND RECONSTRUCTIVE SURGERY

Acknowledgment of Receipt of Privacy Notice

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

Print Name of Patient or Legal Representative

Signature of Patient (or Legal Representative)

Date

Signature of Employee

Title of Employee Date

Comments:



NEWMAN PLASTIC SURGERY

CHARLES E. NEWMAN, JR, MD
DZI-LONG NEWMAN, PA-C
80 WEST GORE STREET
ORLANDO, FL 32806

TEL 407.481.9505

FAX 407.481.9506

Payment Agreement

Billing: An itemized statement covering all medical services received will be mailed to you on a monthly basis. Charges or payments for services received during the last few days before your billing date may appear on the following monthly statement.

Verification of Benefits: As a courtesy, our office is verifying your coverage under an insurance plan. We cannot guarantee payment on your claim. The patient or patient's guardian is solely responsible for any debt incurred with our office. If an error is made in the determination of coverage, the patient is still responsible for the charge.

Insurance: 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: Your insurance policy is a contract between only you and your insurance carrier and it is important you understand its provisions. 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 to Dr. Newman for the surgical procedure. We must emphasize that we cannot accept the responsibility for collection or negotiation with your insurance carrier. This is your responsibility.

Reasonable and Customary Charges: Dr. Newman's surgical fee is 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 Dr. Newman and what amount your insurance carrier determines to be the reasonable and customary charge. It is understood and agreed that Dr. Newman is in no way bound by the patient's insurance carrier guidelines on their reasonable and customary charges.

Deductibles: All deductibles (if applicable) are to be prepaid prior to surgery. If an error is made by your insurance carrier when the amount of the deductible is verified from the insurance carrier, the difference owed will be your responsibility.

I have read the above agreement and have received a copy of it. I fully understand and agree to the contents in full of the above policy.

Patient or Legal Guardian Signature

Date

Witness Signature

Date



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Financial Policy Regarding Revision and Complications

Every plastic and reconstructive surgeon has a few patients who will require revision or have some complications requiring additional surgery. As you have been or will be told, one cannot guarantee a result. In cosmetic procedures there are certain problems that will happen statistically no matter how good the care or how careful the doctor and team are. Examples of problems that may be encountered are bleeding or an unfavorable scar after a surgical procedure. In both of these cases, it may be necessary to return the patient to surgery, either on an emergency basis (as in the case with bleeding) or an elective basis (as in the case of scarring). If revisional surgery occurs, the patient is responsible for surgeon's fee, facility and anesthesia.

We hope that no complication arises and no revisional surgery is necessary in your case. However, no plastic surgeon can guarantee this to patients. It is important for the patient undergoing an elective surgical procedure to understand this financial policy. If you have any questions regarding this policy, the office staff would be happy to discuss it with you.

My signature below indicated that I understand and agree to the above policy and agreement.

Signature _____ Date _____

Witness _____



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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, training of medical students, 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.

Disaster Relief

We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

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.

Abuse or Neglect

We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings

We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement

We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

Coroners, Medical Examiners, and Funeral Directors

We may disclose your medical information to a coroner, medical examiner, or a funeral director.

Organ Donation

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

Research

We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.

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:

Dzi-Long Newman
Newman Plastic Surgery
80 West Gore Street
Orlando, FL 32806
407-481-9505

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 (or following August 1, 2007) 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:

80 West Gore Street
Orlando, FL 32806
407-481-9505

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 April 14, 2003.

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.