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:____

☐ Yellow Pages	☐ Established Patient	**Name:**
☐ Internet	☐ Other	**Specify:**
☐ 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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In Office Medical History

Date:________________
Name:____ DOB:________ ______Age__________________
Sex: M F Height: ____________ Weight:_____________ SSN:___________________________
Place of Employment:_________________________________ Occupation______________________
How did you hear about us: ____
Specific Reason for Seeing Plastic Surgeon:____
____
Previous cosmetic procedures (Including dates):
1.____________________________________3.____
2.____________________________________4.____
If you elect to have surgery with NPS who will be taking care of you:________________________

Tobacco Use: Y N Daily Amount:________ **Illegal Drug Use:** Y N **Do you have a STD:** Y N
Alcohol: Y N Amount: ________ **Daily Exercise:** Y N Amount: ___________

Prescription Medications
1.______________________Dosage____________________3.______________ Dosage_______________
2.______________________Dosage____________________4.______________Dosage_______________5._
_____________________Dosage____________________6.______________Dosage_______
Vitamins/Herbal Suppliments:____
Regular Aspirin Use: Y N NSAIDs/Ibuprofen(Motrin, Advil): Y N
Medication Allergy: Y N Type & Reaction: _____________________________________
Latex Allergy: Y N Reaction: _____________________________________
Tape Allergy Y N Surgical/ Paper Type & Reaction:__________________________
Have you ever had Anesthesia Problems: Y N Reaction:_____________________________________

Personal Medical History:
Abnormal Bleeding: Y N Cancer: Y N Anemia: Y N Eczema: Y N
Fainting Spells: Y N Asthma: Y N Ulcers: Y N Diabetes: Y N
High Blood Pressure: Y N Seizures: Y N Hepatitis: Y N Kidney Stones: Y N
Sleep Apnea: Y N HIV/AIDS: Y N Strokes: Y N Blood Clots: Y N
Heart Attack/Disease: Y N Hepatitis: Y N Tuberculosis:Y N Throid Disorder: Y N
Mitral Valve Prolapse: Y N Blood Transfusion: Y N Acid Reflux/Heartburn: Y N
Previous Radiation Therapy: Y N Heart Surgery/Stents/ Murmur: Y N Epilepsy: Y N
Skin Cancer/ Skin Disease: Y N (Type)____
Please describe all others not listed:____

All past surgeries (Including dates):
1.____________________________________3.____
2.____________________________________4.____
Ability to heal:
Do you form thick or raised scars: Y N Do you burn easily: Y N Do you get cold sores/ Fever blisters: Y N
Are you currently using waxing products: Y N History of poor scar quality or keloids: Y N

Do you have any of the following symptoms apply to you Circle all that apply:

Arthritis/Joint Deformity	Chronic Cough	Arthralgia
Chest Pain	Hearing Loss	Artificial Joints
Inflammation of veins	Sinus Disorder	Paralysis
Pacemaker	Frequent Urination	Numbness or Tingling
Phlebitis	Constipation	Shortness of breath
Convulsions	Gastro-Intestinal problems	MRSA
Unexpected weight loss or gain	Irregular heartbeat	Others not listed:

Female Questions:

Do you have regular periods: Y N Last Menstrual period: Y N
Are you currently pregnant: Y N Number of Pregnancies: _________ Did you Breastfeed: Y N
Total Duration:_________ Future pregnancies? Y N Are you currently lactating: Y N
Are you going through menopause: Y N Yeast Infection: Y N
Date last Mammogram_____________ Any abnormal findings? ___________________

Family Medical History: (Please list family members that you answer yes to)

Kidney Disease: Y N Who:_________ Heart Attack/Disease: Y N Who:_____________________

Abnormal Bleeding/ Clotting: Y N Who:________ Diabetes: Y N Who:_____________________

Tuberculosis: Y N Who:____________ High Blood Pressure: Y N Who:_____________________

Cancer: Y N Who:____________ Anesthesia Problems: Y N Who:__________________________

Autoimmune Disorders: Y N Who:_________________Breast Cancer: Y N Who:______________

Cleft Lip/ Palate: Y N Who:__________________Drug Allergies: Y N Who:__________________

Endocrine Disease: Y N Who:__________________Hearing Loss: Y N Who:_________________

Liver Disease: Y N Who:__________________Hemophilia: Y N Who:______________________

Malignant Hyperthermia: Y N Who:__________________Skin Cancer: Y N Who:_____________

Skin Disease: Y N Who:__________________Substance Abuse: Y N Who:__________________

Von Willebrand: Y N Who:__________________
Other Not Listed: _________________________
____

Primary Care Physician:______________________________Phone:_______________________
Referring Physician: _________________________________Phone:_______________________
Dermatologist:_______________________________________Phone:_______________________

NEWMAN PLASTIC SURGERY
CHARLES E. NEWMAN, JR, MD
DZI-LONG NEWMAN, PA-C
444 N MILLS AVENUE
TEL 407.481.9505 ORLANDO, FL 32803 FAX 407.481.9506

Payment Agreement

Billing: An itemized statement documenting all medical services received will be mailed to upon request. You will be billed for your financial responsibility on your account. Any unpaid balances will be turned over to collections after three billing attempts.

Verification of Benefits: As a courtesy, our office will attempt to verify your coverage and patient responsibility with your insurance carrier. We are not always able to do this with absolute accuracy due to changing deductibles, co-insurance changes and software problems. 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 or patient's responsibility, the patient is still responsible for the unpaid amount as dictated by your insurance company.

Insurance: We cannot accept the responsibility of negotiating claims with your insurance carrier or other persons. We will file the patient's claim and provide the insurance carrier with any information needed to satisfy the claim. However, after repeated failed attempts to collect from your insurance company, you may be responsible for payment of the claim. Although, your insurance company may authorize your treatment/surgery, they do have the right to deny payment at their will. If this occurs, the patient will be liable for payment.

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. Although are office is contracted with most insurance companies, 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/co-insurances (if applicable) are to be prepaid prior to surgery. If an error is made in calculating the amount of your deductible/co-insurance, the difference owed will be the patient's 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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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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CHARLES E. NEWMAN, JR, MD
DZI-LONG NEWMAN, PA-C
444 N MILLS
407.481.9505 ORLANDO, FL 32803 FAX 407.481.9506

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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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

____
Witness

____
Date

NOTICE OF PRIVACY PRACTICES

This notice describes how patient's health information may be used and disclosed, and how patients can access certain information. At Newman Plastic Surgery, we are required to keep your health information secure and confidential, by law. We are also legally required to present our patients this proper notification stating the following terms:

The law permits Newman Plastic Surgery the ability to use and disclose patient's health information to those involved in their treatment. We may use or disclose your health information with our business associates, for payment such as billing services, and for our normal healthcare operations. If this practice is sold, your information will become the property of the new owner. We have a written contract with each business associate that requires them to protect your privacy.

Your information may also be used to contact you. If you are not reached at the number provided we may leave information with the person who answers the telephone or on your answering machine. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We will need to release some or all of your health information, when required by law.

Except for the above, this practice will not use or disclose your health information without your prior written authorization. You may request, in writing, the non-disclosure of some or all of your health information. We will notify you stating if we are able to fulfill your request.

As a patient you have the right to:

- know of any use or disclosure we make with your health information, beyond the above normal uses
- receive communication about your health information in the manner your prefer
- transfer a copy of your health information to another practice
- see and receive a copy of your health information (few exceptions may apply)

Please provide a written request for the information you would like to receive noting the location and method of delivery preferred. Reasonable fees may apply.

You have a right to request an amendment or change to your health information. If you wish to include a statement in your file, please submit it in writing. No preexisting documents will be removed or altered, however new information may be added.

Notification will be given if any privacy or security measures are changed or breached. Any complaints may be filed with the Department of Health and Human Services at:

200 Independence Avenue, S.W.,
Room 509F
Washington, D.C. 20201

Web: http://www.hhs.gov
Email: OCRomplaint@hhs.gov

I have received a copy of the Newman Plastic Surgery Notice of Privacy Practices

Signed ___________________________Print Name ________________________Date ____________

If signing as a parent or guardian, please note patient's name _________________________________

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PLASTIC AND RECONSTRUCTIVE SURGERY

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:

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:

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.
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Orlando, FL 32803
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