

Mid Atlantic Plastic Surgery
Adam M. Mecinski, M.D.
84 Thomas Johnson Ct, Suite C, Frederick, MD 21702
P: 301-378-2015 F: 301-662-4011

PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Referring Physician or Hospital: _____ Primary Care Provider: _____

How did you hear about us? (circle all that apply) FMH Meritus Doctor Friend Website

PATIENT INFORMATION

Birthdate (mm/dd/yyyy): _____ Last 4 digits of SS: _____ Sex: (circle) Male Female

Address: Street _____ City _____ State _____ Zip _____

Cell Phone: _____ Home Phone: _____

Email address: _____

Marital Status: (circle) MARRIED SINGLE SEPARATED DIVORCED WIDOWED

Emergency Contact: Name _____ Phone _____ Relationship _____

PRIMARY INSURANCE

Insurance Company: _____ Employer: _____

Policy Holder Name: _____ Birthdate (mm/dd/yyyy): _____

Policy # or ID#: _____ Group #: _____

Policy Holder Address (if different than patient): _____

Patient Relationship to Policy Holder (circle): SELF SPOUSE CHILD

SECONDARY INSURANCE

Insurance Company: _____ Employer: _____

Policy Holder Name: _____ Birthdate (mm/dd/yyyy): _____

Policy # or ID#: _____ Group #: _____

Policy Holder Address (if different than patient): _____

Patient Relationship to Policy Holder (circle): SELF SPOUSE CHILD

ACCIDENT OR WORKERS COMPENSATION CLAIM ONLY

Type (circle): AUTO ACCIDENT HOMEOWNERS WORKERS COMPENSATION

Date of Injury: _____ State Accident Occurred In: _____

Insurance Carrier: _____ Auth or Claim#: _____

Adjuster Name: _____ Phone: _____

I authorize the Attending Physician to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand I am responsible for all medical fees during my treatment with the Attending Physician. If surgery is required, I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to the Attending Physician.

Signature: _____ Print Name: _____ Date: _____

HEALTH HISTORY

Last Name: _____ First Name: _____ MI: _____

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

Reason for your visit today: _____

List your significant medical problems: _____

*Both current and past

List your previous operations: _____

*with approximate dates

Allergies (Including iodine, tape, etc): _____

List all medications that you are currently taking, amount and how often:

Do you currently smoke? YES NO If yes, how much per day? _____

Do you drink alcohol? YES NO If yes, circle one: FREQUENTLY OCCASIONALLY RARELY

Have you been on steroids (Cortisone/Prednisone) in the last year? YES NO

HEALTH HISTORY (cont)

Have you had or do you currently have...

- | | |
|--|---|
| 1. Rheumatic Fever? Yes No | 18. Pulmonary Edema, Embolus or DVT? Yes No |
| 2. Damaged heart valves/MVP? Yes No | 19. Convulsion, Epilepsy? Yes No |
| 3. Heart Murmur? Yes No | 20. Stroke? Yes No |
| 4. Do you pre-medicate when you go to the dentist? Yes No | 21. Thyroid Trouble? Yes No |
| 5. High Blood Pressure? Yes No | 22. Diabetes? Yes No |
| 6. Low Blood Pressure? Yes No | 23. On Dialysis? Yes No |
| 7. Chest Pain, Angina? Yes No | 24. Stomach Ulcers? Yes No |
| 8. Heart Attack(s)? Yes No | 25. Fever Blisters of the lips? Yes No |
| 9. Irregular Heart Beat? Yes No | 26. AIDS or HIV infection? Yes No |
| 10. Cardiac Pacemaker? Yes No | 27. Problems of the immune system? Yes No |
| 11. Asthma? Yes No | 28. Mental Health Problems? Yes No |
| 12. TB? Yes No
(If yes, circle one) ACTIVE INACTIVE | 29. Dry Eye Symptoms? Yes No |
| 13. Emphysema? Yes No | 30. Contact Lenses? Yes No |
| 14. Shortness of breath when walking? Yes No | 31. Eye Disease/Glaucoma? Yes No |
| 15. Blood Disorder such as anemia? Yes No
Excessive Bleeding Tendency? Yes No | 32. Radiation or Chemo Treatment? Yes No |
| 16. Hepatitis? Yes No
(If yes, circle one) A B C | 33. Blood Transfusion? Yes No |
| 17. Jaundice or liver disease? Yes No | 34. Family History of Malignant
Hyperthermia? Yes No |
| | 35. Do you form large scars or keloids? Yes No |
| | 36. Pain your calves with walking? Yes No |

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____

I have reviewed the information provided by the patient on this history and physical form. I further discussed with the patient any pertinent medical responses.

Physician Signature: _____ **Date:** _____

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Form 1: General Notice to Patients

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.

A. The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, MID ATLANTIC PLASTIC SURGERY (“Provider”), to disclose the information in your medical records to the extent needed for the following purposes:

- For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other health care providers who are treating you or consulting in your care.
- For the purpose of arranging payment for your care. This would include, for example, your insurer or other third-party payor who is responsible for paying all or part of the cost of your care.
- For the purpose of Provider’s “health care operations.” This would include such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and the provision of legal and auditing services.

B. A Specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing disclosure and will contain any limitations on the authority to disclose your records.

C. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.

D. Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Dept of Health and Human Services.

I acknowledge that I was provided with a copy of the General Notice of my rights regarding release of my medical records.

Signature: _____

Print Name: _____ **Date:** _____

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Form 2: Release of Medical Information

E. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

F. You have the following rights with respect to your medical records/information:

- You have the right to request restrictions on the use and disclosure of your medical records/information; however, Provider is not required to agree to restrictions guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
- You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
- You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
- You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
- You have a right to receive an accounting (list) of disclosures of your medical records/information made by Provider. (Except for those disclosures that fall within the scope of Provider’s “health care operations” or disclosures made for payment or treatment purposes.)
- You have the right to receive a paper copy of this notice, at your request.

G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate.

H. If a patient believes that his or her privacy rights have been violated, the patient may complain to Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office.

J. Provider reserves the right to change its privacy practices and to make its new policies effective for all protected health information that provider maintains. If such changes are made, Provider will issue an updated “Notice to Patients” to all of Provider’s patients.

I acknowledge that I was provided with a copy of the General Authorization for Release of Medical Records, and that these policies may be changed by the provider and I will be given an update notice if this occurs.

Signature: _____

Print Name: _____ **Date:** _____

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DISCLOSURE OF INFORMATION TO FAMILY/FRIENDS

____ I do not want Mid Atlantic Plastic Surgery (“Provider”) to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

____ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

The authorizations provided for above are subject to the following limitations or restrictions:

DISCLOSURE OF INFORMATION TO MEDICAL PRACTICES

Please list the following doctors that you give permission to share copies of any Office Notes, Pathology Reports and Surgical Reports if requested by their offices:

Doctor: _____ Phone: _____

Doctor: _____ Phone: _____

Doctor: _____ Phone: _____

Doctor: _____ Phone: _____

Signature: _____

Print Name: _____ Date: _____

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FINANCIAL POLICY

Basic Policy: Payment for service is due in full at the time service is rendered unless insurance information has been provided to the office.

Facility Policy: The professional fee will be billed by Dr. Adam Mecinski/Mid Atlantic Plastic Surgery. You will receive a separate bill for the use of the surgery center or hospital and their services. You may also receive a separate bill for anesthesia or pathology if utilized. These are not included in our fee.

Insurance Billing: We bill most insurance carriers for you if you have provided the proper information to us. Referrals (if required) must be obtained and brought to our office for initial consultation and follow up visits. Co-Payments and deductibles are due at the time of service. Since your agreement with your insurance is specific to your own policy, we will work with you if there is an insurance problem, but our agreement is with you and may not be with your insurance. Any payment denied by your insurance will be your responsibility.

Non-Covered Services: Any service designated as non-covered by your insurance will require payment at the time services are provided or upon notice of insurance denial for "non-covered service." Any payment denied by your insurance will be your responsibility.

Assignment of Insurance Benefits: For services rendered by Adam M. Mecinski, M.D. / Mid Atlantic Plastic Surgery, I hereby assign any and all medical and or surgical benefits to which I am entitled. This assignment will remain in effect until revoked by me in writing, I understand that I am financially responsible for all charges whether or not paid by my medical insurance, workers compensation or other insurance plans. I hereby authorize Adam M. Mecinski, M.D. and/or Mid Atlantic Plastic Surgery to release all information necessary to secure reimbursement (including photographs). I have read, understood and agreed to the above financial policy for payment of professional fees.

Signature: _____ **Print Name:** _____ **Date:** _____

CREDIT CARD POLICY (Exclusions for Medicare patients w/ secondary insurance and State Insurance policy holders)

Mid Atlantic Plastic Surgery has implemented a secure web-based credit card payment solution. Your credit card information is stored in a compliant site which meets the Payment Card Security Standards (PCI/DSS). Your insurance company will be billed for your charges today and any future appointments. By signing below, you agree that any remaining allowed amount (i.e. Co-Pay, Co-Insurance, Deductibles) that are due as the patient's responsibility will be charged to your credit card on file. A receipt can be generated and sent via email if you have provided one. This will not compromise your ability to dispute a charge/payment or question you or insurance company's explanation of benefits. Please provide your credit card information below. If you have further questions, please feel free to ask.

I authorize Mid Atlantic Plastic Surgery/Andochick Center for Cosmetic Surgery to charge my credit card for the outstanding balance on my account.

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Card Number: _____ - _____ - _____ - _____ Expiration Date: ____/____ CVV# or Security Code on back: _____

Name on Card: _____ Patient's Name if different than card holder: _____

Email Address for receipt: _____

Signature: _____ Date: _____