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: __________________________

Pharmacy: Name __________________ Address __________________________________ Phone _______________

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:_____________

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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: FREQUENTALLY OCCASIONALLY RARELY

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

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HEALTH HISTORY (cont)

Have you had or do you currently have…

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

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:__________________________________

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:_____________________