Date: _____

PATIENT REGISTRATION

Last Name: _____ Middle Initial: _____ First Name: _____
Referring Physician: _____
Family Physician or Internist: _____

PATIENT INFORMATION

Birthdate (mm/dd/yyyy): _____ Age: _____ Sex: M_____ F_____
Occupation: _____ Retired _____ Student _____ Minor _____
Address: Street _____ City _____ State _____ Zip _____
Cell Phone _____ Home Phone _____
Email Address: _____
Employed By: _____
Marital Status: Married _____ Single _____ Separated _____ Divorced _____ Widowed _____
Spouse's Name: _____
Spouse Employed By: _____ Occupation: _____
Who should we contact in the case of an emergency? _____
Phone #: _____ Relationship: _____

Primary Insurance – Policy Holder Information

Policy Holder Name _____ Birthdate (mm/dd/yyyy): _____
Policy #: _____ Group # _____
Policy Holder Street Address _____ City _____ State _____ Zip _____
Policy Holder Employer _____
Employer Address _____
Patient Relationship to Policy Holder (*Circle*) Self / Spouse / Child

Secondary Insurance – Policy Holder Information

Policy Holder Name _____ Birthdate (mm/dd/yyyy): _____
Policy #: _____ Group # _____
Policy Holder Street Address _____ City _____ State _____ Zip _____
Policy Holder Employer _____
Employer Address _____
Patient Relationship to Policy Holder (*Circle*) Self / Spouse / Child

Provide the following information if visit is an Accident or Worker's Compensation Claim

Auto Accident _____ On the job? _____ Date of Injury _____
Authorization No. _____ Referring Doctor _____
Adjuster _____ Phone Number _____

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

Patient Name: _____ Date: _____

Referring Physician: _____

How did you learn of our office? (Circle all that apply)

Word of Mouth Internet Website Friends Previous Dr. A patient

Previous Patient Name _____ Doctor: _____

To our patients:

Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

*AGE: _____ HEIGHT: _____ WEIGHT: _____ OCCUPATION: _____

*REASON FOR YOUR VISIT TODAY? _____

*LIST YOUR SIGNFICANT MEDICAL PROBLEMS: _____

(Both current and past)

_____

_____

*LIST YOUR PREVIOUS OPERATIONS: _____

(And approximate Dates)

_____

_____

*DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? YES or NO (Including local anesthesia, Iodine, tape, etc.)

If YES, what happens? _____

*LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING, AMOUNT AND HOW OFTEN:

_____ _____

_____ _____

_____

	YES	NO
Have you been on steroids (Cortisone/Prednisone) in the last year?		
Do you currently smoke? If yes, how much per day? _____		
Do you drink alcohol? If yes, FREQUENTLY_____ OCCASIONALLY_____ RARELY_____		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	**Yes**	**No**	**HAVE YOU HAD OR DO YOU CURRENTLY HAVE…**	**Yes**	**No**
1. Rheumatic Fever?			19. Pulmonary Edema, Pulmonary Embolus, DVT (leg clots)?		
2. Damaged heart valves/mitral valve prolapse? Heart Murmur?			20. Convulsion, Epilepsy?		
3. Do you pre-medicate when you go to the dentist?			21. Stroke?		
4. High Blood Pressure?			22. Thyroid Trouble?		
5. Low Blood Pressure?			23. Diabetes?		
6. Chest Pain, Angina?			24. Are you on Dialysis?		
7. Heart Attack(s)?			25. Stomach Ulcers?		
8. Irregular Heart Beat?			26. Fever blisters of the lips?		
9. Cardiac Pacemaker?			27. AIDS or HIV infection?		
10. Asthma? 11. Tuberculosis? (if yes circle)			28. Problems of the Immune System? 29. Mental Health Problems?		
ACTIVE INACTIVE 12. Emphysema?			30. Dry Eye Symptoms?		
13. Shortness of Breath with walking?			31. Contact Lenses?		
14. Blood Disorder such as anemia?			32. Eye Disease/Glaucoma?		
15. Bleeding Tendency (Abnormal Bleed?) (excessive from a cut or tooth extraction)			33. Radiation Treatment or Chemotherapy?		
16. HEPATITIS: (if yes circle) **A B C**			34. Blood Transfusion?		
17. Jaundice, Hepatitis or Liver Disease?			35. Family history of Malignant Hyperthermia?		
18. Pain in your Calves with Walking?			36. Do you form large scars or keloids?		

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.

_____ _____

Date Signature of Patient

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.

_____ _____

Date Signature of Physician

Mid Atlantic Plastic Surgery
84 Thomas Johnson Court Suite C Frederick, MD 21702

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:

1. 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.
2. 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.
3. 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. Department of Health and Human Services.

(OVER)

Release of Medical Information (Form 2)

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:

1. 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.
2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
3. 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).
4. 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.
5. 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.)
6. You have the right to receive a paper copy of this notice.

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.

Please acknowledge receipt and review of this notice by signing our acknowledgement form. For further information, please call our Privacy Officer at 301-620-4200.

Mid Atlantic Plastic
Surgery
Dr. Adam Mecinski
84 Thomas Johnson Court Suite C Frederick, MD 21702

ACKNOWLEDGMENT OF RECEIPT OF GENERAL NOTICE – FORM 1

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

_____ _____
Name of Patient (printed) Date

_____
Signature of Patient (or legally responsible individual)

GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS – FORM 2

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.

_____ _____
Name of Patient (printed) Date

_____ _____
Signature of Patient (or legally responsible individual) Date

_____ _____
Witness Date

DISCLOSURE TO FAMILY/FRIENDS

_____ I do <u>not</u> 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:

_____

_____

_____ _____
Patient Name (Printed) Signature of Patient (or legally responsible individual)

_____ _____
Witness Date

Mid Atlantic Plastic Surgery

Adam Mecinski, M.D.

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.

Surgical Center 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 Surgical Center. You will also receive a separate anesthesia and laboratory fee if applicable.

For Patients with Insurance: 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 in full 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 and surgical fees.

Patient Name:

Patient/ Parent-Guardian Signature: _____ **Date:** _____

Relationship: Patient ☐ Parent/ Guardian: ☐

Witness: _____ **Date:** _____