

**Patient Information**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First M

Mailing Address: \_\_\_\_\_  
Street City State Zip

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_ How do you wish to be contacted?  Home Phone  Cell Phone  
 Work Phone  Email  By Mail

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Spouse's Work Phone: (\_\_\_\_) \_\_\_\_\_

In case of emergency, who should we contact?

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

**For Minor Patients Only**

Responsible Parties Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First

Mailing Address: \_\_\_\_\_  
Street City State Zip

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relation to Patient:  Mother  Father  Legal Guardian

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

**Insurance Information**

Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relation to Patient:  Self  Spouse  Parent

**Accident Information**

Is this due to an accident?  Yes  No Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_

Nature of Accident:  Car Accident  Occurred at Work  Dog Bite  Other: \_\_\_\_\_

To whom have you made a report of your accident?  None  Auto Insurance  Workman's Comp  Other: \_\_\_\_\_

**Referral Source**

Were you referred by a Doctor?  Yes  No If yes, by who? \_\_\_\_\_

Were you referred by a friend or relative?  Yes  No If yes, by whom? \_\_\_\_\_

If none of the above, please check whom referred you:

- |   |  |   |  |  |
|---|--|---|--|--|
| <input type="checkbox"/> Gym                                  | <input type="checkbox"/> WYSK            | <input type="checkbox"/> Newstalk 1230            | <input type="checkbox"/> WFLS              | <input type="checkbox"/> B101.5                |
| <input type="checkbox"/> Church Bulletin                      | <input type="checkbox"/> Free Lance Star | <input type="checkbox"/> Moss Clinic              | <input type="checkbox"/> La Positiva       | <input type="checkbox"/> Mary Wash. University |
| <input type="checkbox"/> Our Website                          | <input type="checkbox"/> Locate A Doc    | <input type="checkbox"/> Internet Search          | <input type="checkbox"/> Reputation        | <input type="checkbox"/> Yellow Pages          |
| <input type="checkbox"/> Geico                                | <input type="checkbox"/> Bridal Event    | <input type="checkbox"/> Spots. Co. Schools       | <input type="checkbox"/> Chunga            | <input type="checkbox"/> Billboard             |
| <input type="checkbox"/> American Society of Plastic Surgeons | <input type="checkbox"/> VIBE            | <input type="checkbox"/> Mary Washington Hospital | <input type="checkbox"/> News Story: _____ |  |

Are you planning for a special Event?  Yes  No

If yes, which type of event:  Wedding  Reunion  Vacation/Trip  Other: \_\_\_\_\_

Please check here if you prefer NOT to receive upcoming promotions by mail or email.

Please mark any problems you have now OR have had in the past.  None Apply

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Recent Cold/Flu	<input type="checkbox"/> Radiotherapy	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Frequent Heartburn
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Emotional Disorder
<input type="checkbox"/> Angina	<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting/Blackouts	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Leg Cramps/Pain	<input type="checkbox"/> Seizures	<input type="checkbox"/> Migraine/Headaches	<input type="checkbox"/> Steroid Use
<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Nerve Injury	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Sickle Cell
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Loose/Chipped Teeth	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Back Injury	<input type="checkbox"/> False Teeth/Caps	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Neck Injury	<input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Clotting problems
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Difficulty Opening Mouth
<input type="checkbox"/> Asthma	<input type="checkbox"/> Weakness	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Steroid Use	
<input type="checkbox"/> Other Problems not Listed: _____			<input type="checkbox"/> Unable to Exercise due to _____	

**Do you or have you ever suffered from a psychiatric illness?**  Yes  No

Patient's Height: \_\_\_\_\_ feet \_\_\_\_\_ inches      Patient's weight: \_\_\_\_\_ pounds      BMI \_\_\_\_\_

Gastric Bypass patient?  Yes  No      If yes, when? \_\_\_\_\_      Have you lost more than 75 pounds in one year?  Yes  No

Reason for consultation? \_\_\_\_\_

Are you currently under a physicians care?  Yes  No      Reason? \_\_\_\_\_

Could you be pregnant?  Yes  No      Date of last Menstrual period: \_\_\_\_\_

**Do you have Sleep Apnea?**  Yes  No      How is it being treated? \_\_\_\_\_

**Do you use tobacco?**  Yes  No      \_\_\_\_\_ Packs/Day for \_\_\_\_\_ Years.

Do you drink alcohol?  Yes  No      \_\_\_\_\_ Drinks/Week.

Do you use "street" drugs?  Yes  No      What types? \_\_\_\_\_

**Have you experienced any of the following during or after receiving anesthesia?**  None

<input type="checkbox"/> Allergic Reaction	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hoarseness/Sore Throat	<input type="checkbox"/> Headaches
<input type="checkbox"/> Delayed Awakening	<input type="checkbox"/> Prolonged Weakness	<input type="checkbox"/> High Temperature	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Muscle Soreness	<input type="checkbox"/> Nausea and Vomiting	<input type="checkbox"/> Difficulty with Breathing Tube	

Previous Surgeries/Procedures:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

<p><b>List Your Drug Allergies and Allergic Reactions</b> <input type="checkbox"/> If None check here</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Latex Allergy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Soybean Allergy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>List Your Current Medications, Vitamins, and Herbs</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Hormone Replacement?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Birth Control Pills</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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I hereby agree that the above information is correct and I hereby authorize Drs. Heppe, Bautista and Ginestra to release any and all medical information to my insurance carrier or attorney for purposes of claims administration. This authorization is valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign Drs. Heppe, Bautista and Ginestra all money to which I am entitled for medical and/or surgical expense relative to the services rendered by Drs. Heppe, Bautista and Ginestra.

Patient or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Patient's Name: \_\_\_\_\_

## PLASTIC SURGERY SERVICES OF FREDERICKSBURG OFFICE AND FINANCIAL POLICY

Thank you for choosing Plastic Surgery Services of Fredericksburg. We are pleased to be of service to you and we are committed to providing you with the best care possible. Please review the following policies and feel free to discuss your questions with our staff. A copy of these policies will be provided at your request.

**Insurance:** We will be happy to assist you with filing your insurance claim when the services you have received meet medical necessity requirements. We do participate with some insurance plans (please see posted list); however, we wish to emphasize the fact that your health insurance policy is a contract between you and your insurance carrier. It is important that you read and understand your policy and its requirements for coverage including pre-authorization of services. If we cannot obtain pre-authorization you will be responsible for any claims denied as a non-covered service. Filing your primary insurance is a service we provide if we participate with your primary insurance plan, but all charges are your responsibility from the date of service rendered. It is your responsibility for payment of any medical or surgical services provided by this office. If you provide outdated or incorrect insurance information, you will be responsible for any denied claims. Most plans have a timely filing period so it is important that the information you provide our practice is the most current available. In the event we do not participate with your primary insurance plan, our office will not file your insurance claim and payment will be expected at time of services or two weeks prior to any surgical procedure. We will be pleased to supply you with the appropriate billing codes as well as other necessary documentation so you can successfully file the claim with your plan, with the exception of Tricare beneficiaries.

**Secondary Insurances:** We do not file secondary insurances. If you need a copy of your original claim for your secondary carrier, please call the office and one will be mailed to you.

**Referrals and Pre-authorization:** If your insurance plan requires a referral from your primary care physician, it is your responsibility to make sure you have it prior to your appointment. If no referral has been obtained, it is your option to pay for the visit in full at time of treatment or reschedule. We will assist you with pre-authorization of all surgical procedures or procedures which may be considered medically necessary by your insurance company. If the service you wish to receive is considered NON-COVERED by your insurance plan, the patient or guarantor will be responsible for payment two weeks prior to surgery. Personal checks are accepted three weeks prior to surgery.

**Copays, Deductibles and Co-insurances:** Per your insurance company, your copay, deductible and co-insurance must be paid at the time services are rendered.

**Forms of payment:** We accept cash, check, Visa and Mastercard. If a check is returned, you will be charged a non-sufficient funds fee of \$50.00. In the event of non-payment, you will bear the cost of collection, and/or court costs and reasonable legal fees should this be required.

**Surgery Related Charges:** Elective procedures, such as cosmetic surgery, require a deposit and must be paid in full two weeks prior to the surgical procedure. Copays, deductibles and co-insurance are due at time of service for non-elective surgery that is covered by an insurance plan we participate with. In the event we do not participate with your insurance or the service is non-covered, payment is due two weeks prior to surgery. Patients will receive a price quote that outlines payment and terms for cosmetic and non-covered surgical services. A reschedule fee of \$200 will be charged if you reschedule less than two weeks prior to your procedure.

**Appointments:** Our phones are answered during office hours from 8:30 am - 5:00 pm, Monday-Friday. After 5:00 pm you may leave a message with our answering service. Non-emergency messages will be returned on the next business day. Our on-call provider will return emergency calls as soon as possible.

**Late Policy:** Every effort will be made to fit you into the schedule if you are more than 15-30 minutes late. If we are running behind, we will do our best to notify you and assist you in rescheduling your appointment, if you so desire.

**Missed Appointments:** If you need to reschedule or cancel your appointment, please give us at least 24-hour notice. Failure to do so will result in a fee.

**Test Results:** Patients are called with **abnormal** test results. This includes tests performed in the office or ordered by this office. If you have not been called, but would like your results reviewed with you, please call the office. Keep in mind the following: Blood tests require 3-5 days Cultures require 5-7 days Pathology (biopsies) require at least 1 week

**Prescriptions:** If you need a prescription refill or if you have lost your prescription, please leave a message with one of our staff. We will make every effort to call in or write your prescription within 48 hours of your phone call. When calling, you will be asked for your first and last name, your home/office number including a cell phone if available, the name of the prescription, and the name, phone number and address of your pharmacy. Please note, your insurance may not cover prescriptions that are related to cosmetic services. We will not pre-authorize prescriptions related to cosmetic services. Plastic Surgery Services of Fredericksburg may access information contained in the Virginia Prescription Monitoring Program files on all Schedule II, III or IV prescriptions dispensed to a patient.

**Fee for Completion of Forms or Letters:** A fee of \$20.00 per form will be charged for completion of forms or letters.

**VHI Reporting:** The Virginia Assembly passed HB2743 in 2001 which is a law requiring ambulatory surgical centers, hospitals, and physicians to provide certain information on outpatient surgical procedures. Your Social Security Number is required to be reported.

**Medical Record Requests:** Our fee for this service is based on Virginia code 8.01-413B which require that records be provided within 15 days for a charge not to exceed fifty cents per page for the first 50 pages and twenty-five cents for each additional page and a fee not to exceed ten dollars for searching, handling and mailing the records.

**Labs or Outside Tests:** Our providers may order blood work, pathology, EKG or chest x-ray to be done after your visit today. You will receive a bill from the laboratory or radiologist that performed the studies requested. Please call the laboratory or radiologist regarding these bills. They have their own billing offices and you should contact the telephone number on your bill. In addition, there may be some tests that your insurance will not cover. You will be billed by the laboratory/radiologist upon denial of your insurance. If you feel that laboratory/radiologist may not have all of your insurance information or incorrect insurance information, please call the billing telephone number on your laboratory/radiology bill.

**Tricare Beneficiaries:** Our physicians are not authorized Tricare Providers and if you choose to be seen by Plastic Surgery Services of Fredericksburg you will be solely responsible for the bill. Neither you, nor our physicians, can submit a claim for any services you receive to Tricare. You will not be supplied with coding information to file a claim. By signing below you acknowledge that you have been informed and understand this requirement.

**Delinquent Accounts:** Account balances in excess of 90 days may be turned over to a collection agency due to failure of payment. You will be responsible for all collection, court, and or attorneys fees.

I have read Plastic Surgery Services of Fredericksburg financial and office policies. By signing below I agree to all terms set fourth by Plastic Surgery Services of Fredericksburg that apply to my account.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_



# Plastic Surgery Services of Fredericksburg Consent for Blood Testing (HIV, Hep B, Hep C)

I understand that under Virginia Law, if while examining or treating me, any person employed by or under the direction and control of Plastic Surgery Services is directly exposed to my body fluids in a manner which may transmit HIV, Hepatitis B, or Hepatitis C, I will be deemed to have consented to testing for HIV, Hepatitis B, Hepatitis C infection and to the release of the test results to the exposed person.

\_\_\_\_\_  
Patient or Legal Surrogate Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature