



## INFORMACIÓN DEMOGRÁFICA DEL PACIENTE

Apellido: \_\_\_\_\_ Nombre: \_\_\_\_\_ Inicial: \_\_\_\_\_

Dirección: \_\_\_\_\_ Apt: \_\_\_\_\_

Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código postal: \_\_\_\_\_

Tel. de línea: (\_\_\_\_\_) \_\_\_\_\_ Celular: (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Tel. Laboral: (\_\_\_\_\_) \_\_\_\_\_

Sexo: F \_\_\_\_\_ M \_\_\_\_\_ Edad: \_\_\_\_\_ Fecha de Nacimiento.: \_\_\_\_\_

Núm. Seguridad Social: \_\_\_\_\_ Estado Civil: \_\_\_\_\_

Ocupación: \_\_\_\_\_

Contacto de emergencia: \_\_\_\_\_ Parentesco: \_\_\_\_\_

Teléfono: (\_\_\_\_\_) \_\_\_\_\_

Médico de atención primaria: \_\_\_\_\_ Tel.: (\_\_\_\_\_) \_\_\_\_\_

Nombre del empleador: \_\_\_\_\_

¿A quien podemos agradecer por la referencia? \_\_\_\_\_

## INFORMACIÓN DE LA ASEGURADORA

Indique que tipo de seguro Usted tiene. Tambien, puesta nos una copia de sus tarjetas de seguro, el nombre del abogado u otro que corresponda en su caso:

Medicare      Private      Tricare      Medicaid      Workman's Compensation

Automobile Accident      Self Pay (Sin seguro)      Crime Victim's Fund

Por mi seguridad, prometo contestar este cuestionario de salud en su totalidad con información veraz.

Firma: \_\_\_\_\_

Fecha: \_\_\_\_\_

## Financial Consent:

Bluemont Plastic Surgery's reputation is built on results and experience – including experiences with medical bills. So our office has crafted this policy to be fair to everybody involved:

I request and consent to an evaluation and treatment by Bluemont Plastic Surgery (Bluemont) and Dr. Mark Domanski for myself or that of my dependent, the previously named patient. I intend this consent to cover the entire course of treatment.

I assign directly to Bluemont all insurance benefits, otherwise payable to me, for services rendered. I authorize payment directly to Bluemont, the amount due from my insurance company for services rendered.

Iniciales  
\_\_\_\_\_

Patients are referred to our office for specialty care for complicated problems. I acknowledge that **Dr. Domanski and Bluemont do NOT participate directly with any insurance company** or managed-care plans (except Medicare). **Bluemont, as a courtesy, will submit claims to insurance plans.**

Iniciales  
\_\_\_\_\_

**I understand that the billing office may need my assistance with appealing and reprocessing my insurance claims.** I authorize this office to file a grievance/appeal on my behalf for all services rendered. The goal of this is to **minimize patient out-of-pocket expenses.**

Iniciales  
\_\_\_\_\_

Since Bluemont is a non-participating plan provider, **insurance companies sometimes send a check for these services directly to the patient. If I receive a check in the mail, I will immediately send the payment to Bluemont Plastic Surgery, P.C.** I can endorse the insurance check by writing "Pay to the Order of Bluemont Plastic Surgery" on the back and sign my name directly below. I will mail the check, together with any insurance correspondence, Explanation of Benefits (EOB), to Bluemont Plastic Surgery.

I authorize the use of my signature on all insurance submissions. I understand and agree that all services rendered to me or to my dependent are my responsibility, are to be charged directly to me, and that I am personally responsible for full payment. I acknowledge that I will be held responsible for any and all collection expenses incurred including a 30% attorney fee on any balance referred to any attorney for collection as a result from my delay in payment.

Mark Domanski, M.D. and Bluemont may use and disclose my health care information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services, determining benefits, or for related activities. Bluemont may also contact and disclose my health information to my employer or human resources department to appeal my claim for self-funded insurance policies. If the service was paid for via credit card, debit card, or check, Bluemont may use and disclose my health care information to my credit card, debit card, or bank, for the purpose of obtaining payment for services rendered. I agree to waive any and all chargeback rights or claims for any amounts paid for by credit card or debit card. Bluemont files police reports for credit card fraud.

**In respect for other people's time, if I am unable to keep my office appointment, I will either give 24 hours notice or I will be subject to a charge of \$80 at Bluemont's discretion.**

Nombre: \_\_\_\_\_

Firma: \_\_\_\_\_

Fecha: \_\_\_\_\_

## ¿Cómo podemos ayudarle?

Si su visita es sobre una herida después de un accidente, por favor incluya FECHA del accidente. \_\_\_\_\_

### Historial médico: ¿Tiene usted o ha tenido alguno de los siguientes problemas o enfermedades?

problemas con la anestesia	epilepsia	enfermedad pulmonar
artritis	enfermedad gastrointestinal	embolia pulmonar
asma	ataque cardíaco	problemas de salud mental
trastornos de coagulación	problemas del corazón	abortos involuntarios
trastornos en la sangre	hepatitis	apnea del sueño
cáncer	alta presión sanguínea	accidente cerebrovascular
herpes labial	VIH	ulceras estomacales
trombosis venosa profunda	enfermedad del riñón	problemas de tiroides
depresión	alergia al látex	tuberculosis
diabetes	enfermedad del hígado	problemas de cicatrización de heridas

¿Ha sido admitido en el hospital alguna vez?, motivo? \_\_\_\_\_

### Historial médico familiar: ¿Sus familiares de primer grado (padres, hermanos, hijos) han tenido algunos de los siguientes problemas o enfermedades? \_\_\_\_\_

### Medicamentos:

Toma ibuprofeno o aspirina de forma regular? \_\_\_ Sí \_\_\_ No (Estos medicamentos aumentan el riesgo de sangrado)

Incluya TODOS los medicamentos y suplementos herbales (vitaminas, hierbas, pastillas para dormir, etc.)

Medicación	Dosificación	Motivo por el cual lo toma

Si Usted toma más de 3 medicamentos, escriba "Ver lista" y púesla nos su lista de medicamentos.

### ¿Tiene alergias a algún medicamento? ¿Qué reacciones ha tenido?

Medicación	Reacción



## Photo-documentation and Privacy Policy:

**A picture for a plastic surgeon is like an X-ray for a bone surgeon.** Your privacy is important, so we have a written policy.

I consent to the taking of photos or video footage of me or parts of my body in connection with the past or future care provided by Bluemont Plastic Surgery, P.C. ("BPS"). I provide this authorization as a voluntary contribution in the interests of my medical care and public education. For example, **photo documentation can help me better understand my healing process.**

I understand that such photographs will be retained by BPS and may be released for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, advertising, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods. Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.

I also grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. (ABPS).

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my provider. However, **forgoing the benefit of photo-documentation may make tracking and understanding my healing more difficult.**

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire 35 (thirty-five) years from the date written below.

I release and discharge Dr. Domanski, BPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs. If computer imaging is used in my evaluation, I understand that the alteration is purely for the purpose of illustration and discussion and in no way constitutes an expressed or implied warranty as to my final results and appearance.

There are many ways to communicate with you. Methods of communicating are by telephone, text, social media, answering service if available, email, and regular mail. If an emergency arises, keep us alerted to your progress so we may aid in any necessary treatments. Please do not leave a message (or send emails) after hours or on weekends on the office answering machine if any urgent or emergent situation exists, as there is a delay in retrieving such messages. All attempts will be made to preserve your privacy in accordance with HIPAA rules.

Federal Law mandates that you have the right as a patient, to expect your health information to be protected from disclosure to parties unrelated to your past, present or future healthcare. The Health Insurance Portability and Accountability Act (HIPAA) protects your records without your written consent. A copy of our Privacy Practices is available. If you would like a copy of our policy for your files please see the receptionist. We reserve the right to change the terms of this notice and our privacy policies at any time.

I certify that I have read the above Authorization and Release, fully understand, and agree to its terms.

Nombre: \_\_\_\_\_

Firma: \_\_\_\_\_

Fecha: \_\_\_\_\_