Bluemont
PLASTIC SURGERY

PATIENT DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____M.I.:_____

Address: _____Apt: _____

City: _____ State: _____ Zip code: _____

Home Phone: (_____) _____ Cell Phone : (_____) _____

Email: _____ Work Phone : (_____) _____

Sex: F_____ M_____ Age: _____ Date of Birth: _____

Social Security#: _____ Marital Status: _____

Occupation: _____

Emergency Contact: _____ Relationship:_____

Phone: (_____) _____

Primary Care Physician: _____ Phone: (_____) _____

Employer Name: _____

Who referred you to our office? _____

INSURANCE INFORMATION

Circle and provide a copy of your insurance cards, attorney's name, or other as applicable in your case:

Medicare Private Tricare Medicaid Workman's Compensation

Automobile Accident Self Pay (No insurance) Crime Victim's Fund

For my safety, I promise to answer this health questionnaire truthfully and completely (front and back).

Signature: _____ Date: _____

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.

Initials: _____

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.**

Initials: _____

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.**

Initials: _____

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.

Name: _____

Signature: _____ Date: _____

How can we help you? If an injury, please include DATE of injury.

_____

_____

Past Medical History: Do you or have you have had any of these?

anesthesia problems	epilepsy	lung disease
arthritis	gastrointestinal disease	pulmonary embolism
asthma	heart attack	mental health issues
bleeding disorders	heart problems	miscarriages
blood disorders	hepatitis	sleep apnea
cancer	high blood pressure	stroke
cold sores	HIV	stomach ulcers
deep vein thrombosis	kidney disease	thyroid problems
depression	latex allergy	tuberculosis
diabetes	liver disease	wound healing problems

If you have ever been admitted to a hospital, what was it for? _____

_____

Family Medical History: Have any of your immediate relatives (parents, siblings, children) had any of the above?

_____

Medications:

Aspirin or Ibuprofen on a regular basis?__Yes__No (these medicines increase your risk of bleeding)

Include ALL medications and herbal supplements (vitamins, herbs, sleep aids, etc,)

Medication	Dosage	Reason you take it

If you take more than 3 medications, write "See list" and provide us with your med list.

Allergies to medication? What reactions have you have?

Medication	Reaction

If you have more than 2, write "See list" and provide us with your med allergy list.

Surgical History: (include cosmetic and dental procedures):

_____ Date:_____

_____ Date:_____

_____ Date:_____

Social History:

Do you currently smoke, use tobacco or nicotine products? Yes / No

How many packs per day? _____

Number of years? _____

If you have stopped smoking when was your quit date? _____

Do you consume alcohol? Yes / No

Ever had an issue with alcohol like a DUI? Yes / No

Have you ever injected a recreational drug? Yes / No

Favorite exercise? _____

Height:_____ Weight: _____

Has your weight been stable over the last six months? Yes / No

For Female Patients considering procedures, surgery, or injections:

Are you or could you be pregnant? Yes / No Are you breastfeeding?_____

Do you use any birth control? Yes / No What type? _____

Do you have children? Yes / No Number of pregnancies?_____

Are you considering having any more children? Yes / No

If you have had a mammogram, when was the last one? _____

Is there anything in your background not listed on this form, which you think, is medically important? _____

_____

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.

Name: _____

Signature: _____ Date: _____