Arrowhead Plastic Surgeons, Inc.
Patient Information

DOCTOR: BAIBAK KESLER DALAGIANNIS | ACCOUNT #

PATIENT'S NAME:
FIRST MIDDLE INITIAL LAST

ADDRESS:
STREET CITY / STATE ZIP

PHONE: ( ) | DATE OF BIRTH: | SOCIAL SECURITY #:

SEX: ☐ MALE ☐ FEMALE | MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED

WHO IS YOUR PRIMARY CARE PHYSICIAN?

WHO REFERRED YOU TO US?

PATIENT EMPLOYMENT: ☐ FULL TIME ☐ PART-TIME ☐ RETIRED ☐ SELF EMPLOYED ☐ OTHER

EMPLOYER INFORMATION:
NAME
ADDRESS CITY / STATE ZIP

EMPLOYER PHONE: ( ) | EMPLOYER FAX: ( ) | EMPLOYER CONTACT:

ARE YOU HERE FOR A WORK RELATED INJURY?

RESPONSIBLE PARTY

☐ SAME AS PATIENT INFORMATION ABOVE | NAME:
FIRST MIDDLE INITIAL LAST

ADDRESS:
STREET CITY / STATE ZIP

PHONE: ( ) | DATE OF BIRTH: | SOCIAL SECURITY #:

EMPLOYER INFORMATION:
NAME
ADDRESS CITY / STATE ZIP

EMPLOYER PHONE: ( ) | EMPLOYER FAX: ( ) | EMPLOYER CONTACT:

OVER ➞

Arrowhead Plastic Surgeons, Inc.

Emergency Contact

Contact's name:

First | Middle Initial | Last

Address:

Street | City / State | Zip

Home Phone: ( )	Work Phone: ( )	Relationship to Patient:

Primary Insurance

Insured Party:	Date of Birth:
Relationship to Patient:	Employer:
Insurance Type:	
Identification Number:	SS# / Group Number:

Secondary Insurance

Insured Party:	Date of Birth:
Relationship to Patient:	Employer:
Insurance Type:	
Identification Number:	Group Number:

Consent

I hereby authorize Arrowhead Plastic Surgeons, Inc. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician rendering the covered services for the next 12-month period.

I authorize Arrowhead Plastic Surgeons, Inc. to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

I understand and agree that I am financially responsible to Arrowhead Plastic Surgeons, Inc. for any balance not covered by the above assignment.

Signature | Date

Date: _____ Patient Account # _____

ARROWHEAD PLASTIC SURGEONS, INC.
PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Arrowhead Plastic Surgeons, Inc. ("APS"), for your medical needs. We are committed to providing excellent medical care. As part of our professional relationship, it is important for you to understand our financial policies. **The patient is ultimately responsible for payment for his or her treatment and care at APS.**

HEALTH INSURANCE

You are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by your insurance plan. Payment is due at the time of service. As a patient, it is your responsibility to know and understand your health insurance benefits regarding covered services, deductible, co-payments, coinsurance and referrals. Patients are required to provide APS with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Services that are considered by your insurance company to be non-covered, out-of-network, or not medically necessary will be your responsibility.

The following services are NOT included in APS's professional fees: anesthesia, laboratory, pathology, and radiology charges. These charges will be billed separately by the medical entities providing you with service.

MEDICARE PATIENTS

Medicare patients are responsible for any deductibles and difference between the amount approved and the amount paid by Medicare and your secondary insurance when applicable. Please be aware that certain services provided may not be covered by Medicare. If the services are not covered by Medicare, APS will notify you prior to the time services are provided and will provide you with an "Advance Beneficiary Notice" (ABN), which will help you decide whether you want to receive services, knowing you are responsible for payment.

WORKERS' COMPENSATION

Patients who are injured on the job and have a valid workers' compensation claim are required to supply APS with the following information at the time of service: claim number, name of the insurance carrier, date of injury, name of employer at time of injury, and name and contact information of the claims adjuster. Without this information, the patient will be held responsible for all charges incurred, and payment will be due at time of service. Should your workers' compensation claim be denied, APS will attempt to bill your private health care insurance carrier. If you do not have private health insurance coverage, you are required to enter into a payment agreement with APS for regular monthly payments. **Filing a workers' compensation claim does not guarantee payment of the services rendered.**

SELF-PAY

You will be considered "self-pay" if you have no insurance coverage. **For self-pay patients, a payment of $75.00 is required prior to scheduled surgery.** If you are unable to pay the $75.00 please contact the Billing Manager at 419-887-4529 prior to your scheduled appointment or surgery date.

REFERRAL / AUTHORIZATION

If your insurance carrier requires a referral or prior authorization before you can be seen by a specialist, it is your responsibility to obtain such referral or authorization before being seen at APS. If payment is denied for lack of referral/authorization, you will be responsible for payment in full.

STATEMENTS

Statements are sent to patients on a monthly basis and will show outstanding balances. After insurance pays, patients are responsible for all outstanding balances in a timely matter. If you are unable to settle your account within 90 days, please contact the APS Billing Department at 419-887-4529.

OVER ➞

PAYMENTS

APS accepts the following methods of payment: checks, cash, money orders, Visa, MasterCard, Discover, and American Express. If you pay by credit card, debit card or financing, APS may need to disclose your protected health information to credit card companies, banks, or financing companies in order to obtain payment. By signing below, you authorize APS to disclose your protected health information to any credit card company, bank, or financing company if they request this information to process your payment or if you dispute the charges after services are provided. APS encourages complete post-operative care and follow-up to address any issues that may arise. A fee of $40.00 will be charged for all returned checks.

All patient responsible balances that remain delinquent after 90 days may be referred to a collection agency. You will then be responsible for all collection fees, court costs, attorneys' fees and any other charges incurred in the collection of the balance due.

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PATIENT ACKNOWLEDGEMENT:

I have read, understand, and agree with the above Patient Financial Responsibility Policy and agree to be legally bound to its terms and conditions.

_____ _____

Printed Name of Patient or Responsible Party Signature of Patient or Responsible Party

_____

Date

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.

ARROWHEAD PLASTIC SURGEONS, INC.

Notice of Privacy Practices for Protected Health Information

I. USES AND DISCLOSURES OF YOUR HEALTH INFORMATION.

A. Treatment, Payment, and Operations. Arrowhead Plastic Surgeons, Inc. (sometimes referred to as "we" or "us") is permitted to use your medical information for purposes of treating you, to obtain payment for providing medical services to you, and to assist in its health care operations. We may also use your medical records to assess the appropriateness and quality of care that you received, improve the quality of health care, and achieve better patient outcomes. An understanding of what is in your health records and how your health information is used helps you: ensure its accuracy and completeness; understand who, what, where, why, and how others may access your health information; and make informed decisions about authorizing disclosures to others.

(i) Use and disclosure for treatment purposes. A physician or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. We will also provide your primary physician, other health care professionals, or a subsequent health care provider, copies of your records to assist them in treating you.

(ii) Use and disclosure for purposes of payment. We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

(iii) Use and disclosure for healthcare operations. Health care operations consist of activities that are necessary to carry out our operations as a healthcare provider, such as quality assessment and improvement activities. For example, members of our medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

B. Appointment Reminders. We may contact you at home to provide appointment reminders unless you specify otherwise in writing to us.

C. Other purposes for which we can use your protected health information without written authorization from you. In addition to using or disclosing your protected health information for purposes of treatment, payment, and health care operations, we may use or disclose your protected health information *without your written authorization* and without giving you an opportunity to object in the following situations:

(i) As *Required by Law*, so long as the disclosure is limited to only those portions relevant to the requirements of the law.

(ii) For Public Health Activities, including for the purposes of controlling or preventing disease (including sexually transmitted diseases), injury, or disability. We may also disclose to governmental agencies authorized to receive reports of child abuse or neglect. We may disclose protected health information to the Food and Drug Administration relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

(iii) Medical Surveillance of the Workplace and Work-related Injuries. We may provide your protected health information to your employer if we are asked by your employer to provide medical services to you for purposes of medical surveillance of the workplace or a work-related illness or injury.

(iv) Victims of Abuse, Neglect, or Domestic Violence. To the extent authorized or required by law, and in the exercise of our doctor's professional judgment, we believe the disclosure is necessary to prevent harm, we may disclose protected health information to law enforcement officials.

(v) Health Oversight Activities. We may disclose your protected health information to a governmental health oversight agency overseeing the health care system, governmental benefit programs, or compliance with governmental program standards.

(vi) Judicial and Administrative Proceedings. We may disclose your protected health information in response to an order of a court or a valid subpoena.

(vii) Law Enforcement Purposes. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or we may provide limited information for identification or location purposes.

(viii) Information About Deceased Individuals. We may disclose your protected health information to coroners and medical examiners to carry out their official duties, and to funeral directors as necessary to carry out their duties to the deceased individual.

(ix) Organ, Eye, or Tissue Donation. We may disclose protected health information to organ procurement agencies for the purpose of facilitating organ, eye, or tissue donation or transplantation.

(x) Research Purposes. We may disclose protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

(xi) Avoidance of Serious Threat to Health or Safety. We may disclose protected health information if we believe in good faith that such disclosure is necessary to prevent or lessen a serious and immediate threat to health and safety of a person or the public.

(xii) Certain Specialized Governmental Functions. If you are Armed Forces or foreign military personnel, we may disclose your protected health information to your appropriate military command. We may disclose your protected health information to a governmental agency as authorized by the National Security Act or for the protection of the President of the United States, as required by law.

(xiii) Correctional Institutions. If you are an inmate, we may disclose your protected health information to the correctional institution or law enforcement in the course of providing care to you or the health and safety of others responsible for your custody or other inmates.

(xiv) Disclosures for Workers' Compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

D. Other uses and disclosures of your protected health information will only be made with your prior written authorization. This includes, but is not limited to: (i) uses and disclosures of psychotherapy notes (if applicable); (ii) certain uses and disclosures for marketing purposes, including direct or indirect remuneration to Arrowhead Plastic Surgeons, Inc.; (iii) uses and disclosures that constitute a sale of your protected health information; and (iv) other uses and disclosures not described herein. You may revoke an authorization at any time, provided you do so in writing. We will honor such a revocation except to the extent that we had already taken action in reliance upon your prior authorization.

II. YOUR INDIVIDUAL RIGHTS. You have the following rights under federal law with respect to your protected health information and may exercise them in the following manner:

A. The Right to Request Restrictions on the Use of Protected Health Information. You have the right to request that we restrict the use of your protected health information. You have the right to request that we limit our disclosure of your protected health information to treatment, payment, and healthcare operations and disclosures to individuals (family members) involved in your care. Such a restriction, if agreed to by us, will not prevent permitted or required uses and disclosures of protected health information. We are not required to agree to any requested restriction. You also have the right to restrict certain disclosures to a health plan if and when you pay out of pocket and in full for the health care item or service.

B. The Right to Receive Confidential Communications of Protected Health Information by Alternative Means. We must accommodate a reasonable written request by you to receive communications of your protected health information by alternative means (e.g., via e-mail) or at an alternative location (e.g., at your place of employment rather than at home).

C. The Right to Inspect and Copy your Medical Records. You have the right to inspect and obtain a copy from us of your protected health information in our possession, including an electronic copy of your protected health information that we maintain electronically in a designated record. We may impose a reasonable cost-based fee for the labor involved and supplies used for creating the copy of your medical records.

D. The Right to Amend Protected Health Information. You have the right to have us amend protected health information in our possession. You must make the request in writing and provide supporting reason(s) for the requested amendment. If we grant the request, we will notify you, and we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

E. The Right to Receive an Accounting of Disclosures of Protected Health Information. You have the right to obtain an accounting of disclosures by us of your protected health information, other than for purposes of treatment, payment, and health care operations. Depending on whether your particular doctor has incorporated electronic health records into his or her medical practice, you may have the right to obtain an accounting of all disclosures of protected health information. The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

F. The Right to Obtain a Paper copy of this Notice Upon Request. You have the right to receive a paper copy of this Notice upon request.

G. The Right to Opt-Out of Fundraising Communications. In the event we choose to contact you for purposes of fundraising, you will be given the opportunity to opt out of such fundraising communications.

III. OUR DUTIES TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION.

A. Our Duties to You. We are required by federal law to maintain the privacy of protected health information and to provide you with notice of its legal duties and privacy practices with respect to your protected health information. We will maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information. We have the duty to mitigate any breach of privacy regarding your protected health information. In the event of any breach of privacy regarding your protected health information, Arrowhead Plastic Surgeons, Inc. is required to notify you.

B. Privacy Notice. Arrowhead Plastic Surgeons, Inc. is required to abide by the terms of its Privacy Notice as currently in effect.

C. Complaints. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may obtain and file a Patient Privacy Complaint with our Privacy Officer. You will not be retaliated against for filing a complaint.

D. Contact Person and Telephone Number. If you have questions and/or would like additional information, you may contact Arrowhead Plastic Surgeons, Inc.'s Privacy Officer at 1360 Arrowhead Road, Maumee, Ohio 43537, Attention: Privacy Officer, or at 419-887-7000.

E. Effective Date. This Privacy Notice is Effective July 1, 2015.

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL POST THE REVISED NOTICE IN THE OFFICE AND PROVIDE YOU WITH A COPY UPON REQUEST.

ACKNOWLEDGEMENT

I have read the foregoing Notice of Privacy Practices provided to me by Arrowhead Plastic Surgeons, Inc. and I have been given the opportunity to discuss the privacy practices at Arrowhead Plastic Surgeons, Inc. I understand that the practice may, at its discretion, change the terms and conditions of this Notice. Any questions I may have had been answered to my satisfaction. I understand the content of this Notice and I have been provided with a copy of the same.

_____ _____

Patient Signature Date

_____ _____

Printed Name Staff Initials

ARROWHEAD PLASTIC SURGEONS, INC.

Patient Name (Please Print):_____

I wish to be contacted in the following manner (check all that apply)

Oral Communication

❒ Home Phone _____ ❒ Okay to leave message with detailed information
❒ Leave message with a call-back number only

❒ Cell Phone _____ ❒ Okay to leave message with detailed information
❒ Leave message with a call-back number only

❒ Work Phone _____ ❒ Okay to leave message with detailed information
❒ Leave message with a call-back number only

Written Communication

❒ Okay to mail to my home address

❒ Email:_____

I permit the practice to discuss my PHI with and to disclose my PHI to the following individuals:

❒ Spouse: _____

❒ Adult Children: _____

❒ Personal Representative: _____

❒ Other: _____

_____ _____

Signature Date

Arrowhead
PLASTIC SURGEONS, INC.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

[redacted]

Patient Full Name (First, Middle, Last): _____

Date of Birth: _____ Patient Address: _____ Phone: _____

Dates of services (from - to): _____

[redacted]

I hereby authorize Arrowhead Plastic Surgeons, Inc. to (select one): ☐ Obtain from ☐ Release to ☐ Share/discuss with

Name/Facility: _____ Attention: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

[redacted]

Check the following information to be released for the dates of service indicated above. The disclosure may include paper, oral and electronic interchange.

___ Entire Medical Record (*Does not include HIV/AIDS Testing, Drug and Alcohol Information, or Psychotherapy Notes. To authorize the disclosure of this information, you must also check below*)

___ HIV/AIDS Testing
___ Drug & Alcohol Treatment Information
___ Billing Statement
___ Psychiatric Diagnostic Evaluation
___ Progress notes
___ Current Treatment Plan
___ Medications
___ Discharge Summary
___ Records Pertaining to care on the following dates ONLY: _____
___ Other (must specify): _____

[redacted]

Purpose(s) of Disclosure: ___ Coordination & Continuity of Treatment ___ Personal ___ Legal ___ Insurance
___ Transfer from Practice ___ Other (explain): _____

[redacted]

This authorization for the release/obtaining of information will automatically expire ninety (90) days after the date of the authorization unless I agree to a shorter or longer authorization period as noted below. Maximum period is 365 days.

Expiration date: _____ Condition, date or event of earlier/later expiration: _____

- I understand that if the recipient of the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such recipient and will likely no longer be protected by federal privacy regulations. I understand that Arrowhead Plastic Surgeons, Inc. cannot control the recipient's use of the disclosed information.
- I understand that authorizing the use or disclosure of the above information is voluntary. I understand that Arrowhead Plastic Surgeons, Inc. will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this authorization.
- I understand that I can revoke this authorization at any time, except to the extent that action has been taken by Arrowhead Plastic Surgeons, Inc. in reliance on this authorization, by sending a written revocation to Arrowhead Plastic Surgeons, Inc., 1360 Arrowhead Road, Maumee, Ohio 43537, Attn: Administrator. Upon revocation of this authorization, further release of information shall immediately cease.
- For more information about your privacy rights, please refer to Arrowhead Plastic Surgeons, Inc.'s HIPAA Notice of Privacy Practices.

_____ ___ _____
Patient Signature Date

ARROWHEAD PLASTIC SURGEONS, INC.

Medical History Form

Date:_____

Please check YES or NO to each question below. For your benefit, please answer the questions as accurately as possible so we can determine your physical condition before any medical treatment. If you do not understand a question, or are uncertain of your answer please place a (?) next to that specific question.

NAME:_____ AGE:_____ FAMILY PHYSICIAN: _____

HEIGHT: _____ WEIGHT: _____ TELEPHONE (H):_____ (W): _____

REASON FOR VISIT: _____

HISTORY OF	Yes	No	PROSTHESIS / AIDS	Yes	No
Arthritis			Dentures / Crowned teeth		
Blood Disorders			Loose Teeth		
Bleeding Tendencies			Contact Lenses / Glasses		
Cancer / Tumors / Growths			Hearing Aids		
Diabetes			Artificial Limb		
Heart Disease			Cane / Crutches / Walker		
Angina / Chest Pain			Metal Implants		
Murmur / Mitral Valve Prolapse			Pacemaker		
High Blood Pressure			Ostomy Equipment		
Hiatal Hernia / Reflux			Urinary Catheter		
Kidney Disease			ALLERGIES / LIST		
Liver Disease / Jaundice			Drugs		
Hepatitis			Food		
Shortness of Breath on Exertion			Skin conditions		
Asthma / Bronchitis			Latex		
Tuberculosis Exposure			Other:		
Neurological Disorder			HABITS		
Stroke			Alcohol Use: Amount?		
Seizures			Tobacco Use: Amount?		
Depression / Psychiatric Treatment			Anabolic/Androgenic Steroid Use		
Venereal Disease			Recreational Drug Use		
HIV Positive			IV Drug Use		
Recent Cold / Flu			Body Piercing: Where?		

If you answered "YES" to any of the above questions, please explain below:_____

_____

Prescription/nonprescription medications presently taken (including vitamins, herbal remedies):

_____

_____

Previous hospitalizations and/or surgeries:_____

_____

Have you or a relative, ever had a problem with anesthesia or a history of unexplainable high fever after surgery? If yes, please specify: _____

Are second opinions or predetermination's required by your insurance? YES:____ NO: ____

Please bring completed form with you to your appointment. Thank you, Arrowhead Plastic Surgeons, Inc.