PIONEER VALLEY PLASTIC SURGERY **(413) 731-7877**

Legal Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Text Messaging? (Yes/No)_____

Email _____

Age _____ Birthdate _____ Gender: ☐ Female ☐ Male ☐ _____

Marital Status: ☐ Single ☐ Married to: _____ ☐ Other: _____

Emergency Contact _____ Relationship to patient _____ Phone: _____

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Language:** _____

Preferred Pharmacy (Name, Address, Phone Number) _____

Patient's Employer _____ Occupation _____

Work Phone _____Ext. _____ Is it okay to call you at work? □ Yes □ No

Address _____
Street & Suite # City State Zip

Referring Physician _____ **Primary Care Physician** _____

How did you hear about Dr. Johnson? ☐ Internet: _____ ☐ Seminar: _____

☐ Doctor ☐ Friend/Relative _____ ☐ Other _____

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. phone _____

Insured name: _____ DOB _____ Employer _____

Referral required: ☐ Yes ☐ No Copay? ☐ Yes ☐ No If yes, $ _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. phone _____

Referral required: ☐ Yes ☐ No Copay? ☐Yes ☐ No If yes, $ _____

Insured name: _____ DOB _____ Employer _____

Signature _____ Date _____

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Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Preferred Name _____ **Reason for Visit** _____

Height: _____Feet _____Inches Weight: _____lbs

Do you have, or have you had, any of the following. Please circle ALL answers.

AIDS / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney problems	No	Yes
Arthritis	No	Yes	Facial pain	No	Yes	Motion sickness	No	Yes
Asthma	No	Yes	Fever blisters	No	Yes	Pneumonia	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Sinus problems/infections	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Skin cancer	No	Yes
Depression	No	Yes	Headaches / Migraines	No	Yes	Stroke	No	Yes
Diabetes	No	Yes	Heart trouble	No	Yes	Tuberculosis	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes	Ulcers	No	Yes
Eating disorder	No	Yes	High blood pressure	No	Yes	Other: _____		

List all surgeries, serious illnesses, and/or accidents and the year of occurrence:

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

Do you use recreational drugs? No Yes If yes, describe: _____

Do you smoke? No Yes If yes, how much? _____Pack(s)/day

For how long? _____years If you quit, how long ago? _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

In case of an emergency, would you accept a blood transfusion? No Yes

Do you have any history of problems with anesthesia? No Yes If yes, describe _____

Are you pregnant? No Yes

List <u>ALL</u> drug <u>ALLERGIES</u>: (Write **NKDA**, if No Known Drug Allergies)

List the names, dosages, and frequency of all **<u>medications</u>** you are presently taking or have taken within the last month:

The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____

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Patient's Name _____

Patient Family History

	Yes	Family Member		
Patient denies any contributing family history	☐			
Abnormal bleeding	☐	Parent	Sibling	Grandparent
Abnormal clotting	☐	Parent	Sibling	Grandparent
Anesthesia problems	☐	Parent	Sibling	Grandparent
Autoimmune disorders	☐	Parent	Sibling	Grandparent
Breast cancer	☐	Parent	Sibling	Grandparent
Brain tumor	☐	Parent	Sibling	Grandparent
Other cancer	☐	Parent	Sibling	Grandparent
Diabetes	☐	Parent	Sibling	Grandparent
Drug allergies	☐	Parent	Sibling	Grandparent
Endocrine disease	☐	Parent	Sibling	Grandparent
Heart disease	☐	Parent	Sibling	Grandparent
High blood pressure	☐	Parent	Sibling	Grandparent
Hemophilia	☐	Parent	Sibling	Grandparent
Kidney disease	☐	Parent	Sibling	Grandparent
Liver disease	☐	Parent	Sibling	Grandparent
Malignant hyperthermia	☐	Parent	Sibling	Grandparent
Skin cancer	☐	Parent	Sibling	Grandparent
Skin disease	☐	Parent	Sibling	Grandparent
Substance abuse	☐	Parent	Sibling	Grandparent
von Willebrand	☐	Parent	Sibling	Grandparent

Pioneer Valley Plastic Surgery

734 Longmeadow St., Suite 201
Longmeadow, MA 01106
(413) 731-7877
Pioneervalleyplasticsurgery.com

Authorization for Release of Medical Records and Reports

I hereby authorize_____
(your primary care and/or referring physician)
who has treated me or examined me or who may hereafter treat or examine me, to furnish Melissa Johnson, MD, with a full report regarding my physical condition and allow Melissa Johnson, MD, to examine and obtain copies of all hospital records and reports.

_____ _____
Signature of Patient Date

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Authorization to Release Medical Images (Photographs, X-Rays, etc.)

I hereby authorize Melissa Johnson, MD to take pre-operative, intraoperative, and/or post- operative photographs, slides and/or videotapes appropriate for my surgery.

I further authorize Melissa Johnson, MD to use the medical images for professional medical purposes deemed appropriate, including but not limited to using the medical images for purposes of medical publication, lay publication, medical education, patient education, or during lectures to medical or lay groups.

I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of the medical images.

_____ _____
Signature of Patient Date
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Notice of Privacy Practices
Patient Acknowledgement Form

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected information about you. You have the right to receive and review our Notice before signing this acknowledgement. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

Our privacy notice can be found at https://pioneervalleyplasticsurgery.com/privacy/

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

____________________________ Signature

Date _______________________

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PVPS Cancelled Appointments/No-Show Policy

1st Cancellation within 24 hours of appointment time: Our staff will give you a verbal reminder of this policy.

2nd Cancellation within 24 hours of appointment time: You will receive a written notice of having your second cancellation or no-show appointment. Written notice includes information about this policy and that if you have a 3rd cancellation or no-show, we will no longer be able to provide care for you.

3rd Cancellation within 24 hours of appointment time: You will receive written notice of the third cancellation or no-show appointment that will also confirm that we can no longer provide care to you.

____________________________ Signature

_______________________ Date

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General Consent for Care and Treatment

I consent to and authorize personnel with Pioneer Valley Plastic Surgery (individually and collectively known as "PVPS"), to administer care and treatment to me and to perform diagnostic and therapeutic procedures and tests and other care and treatment considered necessary or advisable by the providers who attend me.

I understand PVPS will send copies of my protected health information to my care providers for the purposes of medical treatment. In addition, I understand that PVPS will use and disclose my protected health information for payment and health care operations purposes as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that photographs, videotapes, digital, or other images may be recorded to document my care. I understand that PVPS or my treating physician will retain these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

I understand that the practice of medicine, including surgery, is not an exact science, and I agree that no guarantees have been made to me concerning the results of my treatment.

I understand that this consent will be valid for one (1) year from this date for any out-patient services.

I have read this consent form carefully and have had all my questions answered. I understand this consent form and agree to its terms.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name of Patient or Authorized Representative Print Relationship to Patient

_____ _____
Witness Date

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Financial Agreement

This financial agreement concerns: (a) my financial responsibility to pay for services rendered to me, (b) my assignment to Pioneer Valley Plastic Surgery of the right to receive payment from my third party payers, and (c) my consent and authorization to release my medical records and patient information.

RESPONSIBILITY FOR PAYMENT

I understand that I am financially responsible for all charges, co-payments and deductibles remaining after payments by my insurers or other third party payers, and for all charges that are not covered by any insurance or third party payer. Third party payers include private or public health plans, insurance carriers, Medicare, Medicaid, workers' compensation, auto liability, my employer, health maintenance organizations, or other managed care organizations. I also understand and agree that, to the extent permitted by my insurance contract or third party program, I am responsible for, and will pay, all charges and professional fees for services and supplies that are not paid for by my insurer or third party payer, because they have been prospectively determined to be not medically necessary, or are otherwise not covered by my insurance contract or third party payment program. I understand that I will receive bills from Pioneer Valley Plastic Surgery for services and supplies rendered to me, and that, if these bills are not paid when due or a repayment schedule is not established and adhered to, then such bills may be referred to a collection agency or an attorney.

ASSIGNMENT OF BENEFITS

I hereby assign my right to receive payment for benefits and give my permission to each of my third party payers to pay directly to Pioneer Valley Plastic Surgery or its billing agents and my individual providers or their billing agents for services that have been rendered to me. I specifically request that payment of any Medicare benefits payable to me be paid to Pioneer Valley Plastic Surgery or its billing agents or my individual providers and my individual providers or their billing agents for services that have been rendered to me. I understand that this assignment of benefits does not change or lessen my responsibility for payment, as described above.

RELEASE OF MEDICAL INFORMATION

I consent to and authorize Pioneer Valley Plastic Surgery to release, in writing or electronically, to each of my third party payers, my medical records and any individually identifiable health information, or a copy thereof, for treatment, payment, and health care operations purposes, including the review of processing of any claims related to services rendered to me, and I consent to and authorize each of my third party payers to have access to, to use, and to receive from Pioneer Valley Plastic Surgery such records and information. Third party payers include private or public health plans, insurance carriers, Medicare, Medicaid, workers' compensation, auto liability, my employer, health maintenance organizations, or other managed care organizations. I acknowledge and permit that a photocopy of this consent and authorization may be used in place of the original that I sign below. I understand that this consent will be valid for one (1) year from this date for any outpatient services or physician office services.

I have read all parts of this financial agreement carefully and have had all of my questions answered. I understand this agreement and agree to its terms.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name of Patient or Authorized Representative Print Relationship to Patient

_____ _____
Witness Date