FACIAL PLASTIC SURGERY CENTER
PATIENT PROFILE

Patient ID #:_____

FPSC MD: _____ **Refer MD:** _____ **Primary MD:** _____

PATIENT INFORMATION

Name: _____ Sex: ( )Male ( )Female

Address: _____ SSN: _____

_____ Birth Date: _____

City, State: _____ Zip: _____ Marital Status: ( )Married ( )Divorced ( )Single ( )Widowed

Phone #1: _____
( )Home ( )Work ( )Other

CONTACTS
_____

Phone #2: _____
( )Home ( )Work ( )Other

_____

PATIENT EMPLOYMENT

( )Employed ( )Retired Employer: _____

( )Student ( )Other Occupation: _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION ( ) Same as Patient

Name: _____ SSN: _____

Address: _____ Birth Date: _____

_____ Employer: _____

City, State: _____ Zip:_____ Occupation: _____

Phone #1: _____ Phone #2: _____
( )Home ( )Work ( )Other ( )Home ( )Work ( )Other

PRIMARY INSURANCE

Insured Party: _____ Insured Same as: ( )Other ( )Patient ( )Guarantor

Insured SSN: _____ Insurance Co: _____

Insured Birth Date: _____ Effective Date: _____

Insured Phone: _____ Insured ID#: _____

Relation to Patient: _____ Policy Group #: _____

SECONDARY INSURANCE

Insured Party: _____ Insured Same as: ( )Other ( )Patient ( )Guarantor

Insured SSN: _____ Insurance Co: _____

Insured Birth Date: _____ Effective Date: _____

Insured Phone: _____ Insured ID#: _____

Relation to Patient: _____ Policy Group #: _____

Rev: 04/21/04

FACIAL PLASTIC SURGERY CENTER

A Division of Otolaryngology Associates, PC

Mark I. Rubinstein, MD, FACS **Deborah J. Doyle, MD, FACS**

SUMMARY OF PRIVACY PRACTICES

This document summarizes the privacy practices of the Facial Plastic Surgery Center, a division of Otolaryngology Associates, PC, as required by the privacy regulation created under the Health Insurance Portability and Accountability Act of 1996. You may request a complete copy of our Notice of Privacy Practices at any time and one will be provided to you free of charge.

Medical information about you may be used and/or disclosed by our practice. The following information summarizes how we may use and/or disclose your protected health information (PHI), your privacy rights regarding your PHI and our obligations concerning the use and disclosure of your PHI.

Uses and Disclosures: We will use and disclose elements of your PHI in the following ways.
Without your signed authorization in routine situations:

- For treatment purposes (e.g. writing prescriptions, ordering lab tests);
- For billing and payment purposes (e.g. contacting insurance companies, sending out bills);
- For internal purposes (e.g. conducting quality of care reviews);
- To contact you about appointment reminders, treatment alternatives and other health related benefits and services;
- To family/friends that participate in your care;
- For disclosures required by federal, state or local law.

Without your signed authorization in special circumstances:

- To public health authorities regarding public health risks;
- To health oversight regulatory agencies as required by law;
- In response to a court or administrative order;
- To law enforcement officials;
- To organizations handling organ, eye or tissue procurement;
- In emergency situations or to avert serious health/safety situations;
- To the military if required by the appropriate authorities;
- To federal officials for intelligence activities if required by law;
- To correctional institutions or law enforcement officials if you are an inmate;
- To workmen's compensation or similar programs.

All other uses and disclosures will require us to obtain from you written authorization.

You have the following rights concerning your PHI.

Your Rights:

- **Confidential Communications:** To request that our practice communicate with you about your PHI in a particular manner or at a certain location.
- **Restrictions:** To request restricted access to all or part of your PHI. Request must be submitted in writing. We are not required to grant your request.
- **Access:** To inspect or receive copies of your PHI.
- **Amendments:** To request changes be made to your PHI. We are not required to grant your request.
- **Accounting:** To receive an accounting of the non-routine disclosures by us of your PHI in the six years prior to your request (but not before 4/14/03).
- **This Notice:** To get updates or reissues of this notice, at your request.
- **Complaints:** To complain to us or to the US Dept. of Health & Human Services if you feel your privacy rights have been violated. The law forbids us from taking retaliatory action against you if you complain.
- **Authorization for other Uses and Disclosures:** To obtain your written authorization for uses and disclosures not permitted by applicable law.

  For your convenience, we have developed simple forms for you to document your requests. These forms are available upon request and must be submitted to **Otolaryngology Associates, PC, ATTN: Privacy Officer, 8316 Arlington Blvd, Suite 300, Fairfax, VA 22031.**

Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy Contact: For more information about our privacy practices or to file a complaint about our privacy practices, please contact:

Otolaryngology Associates, PC
ATTN: Privacy Officer
8316 Arlington Blvd, Suite 300
Fairfax, VA 22031
(703) 573-7600

Effective Date: This notice is effective April 14, 2003.

Rev. 02/25/10

HIPAASum.doc

FACIAL PLASTIC SURGERY CENTER
FINANCIAL POLICY

This is an agreement between the Facial Plastic Surgery Center, a division of Otolaryngology Associates, as creditor, and the Patient/Debtor named on this form.

Payment Options: All previous balances are due at the time of service unless previous arrangements have been made with our Business Office. You may pay your out-of-pocket costs at the time of service by check, cash or credit card. Failure to make appropriate co-payments at the time of service may result in a service charge of $10. If you are unable to pay your full out-of-pocket costs at the time of service, you may make payment arrangements through our Business Office by calling 703-573-5979. These options include a payment plan not to exceed three months on amounts less than $250.00 and six months on amounts over $250.00. Automatic payments can be arranged via credit card.

Past Due Accounts: If at any time you have a balance due which is more than 90 days old and have not made appropriate payment arrangements with our Business Office, your account may be referred to an outside collection agency. If you have established a payment plan and default on the agreed upon plan, your account may be referred to an outside collection agency. If we have to refer your account to a collection agency, you agree to pay for all collection costs and attorney fees incurred. Further, you understand that if your account is submitted to a collection agency, or if your past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record. We will also notify your insurance carrier.

Pre-Authorization: Many insurance companies, including worker's compensation carriers, require pre-authorization and/or referrals prior to obtaining specialty care. It is your responsibility to contact your insurer AND/OR Primary Care Physician to determine the need for a referral and/or pre-authorization. Failure to obtain a referral and/or preauthorization may result in lower reimbursement or claim denial from the insurance company.

Divorce: The parent authorizing treatment for a child will be the parent responsible for the charges related to that care. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Forms & Medical Records: From time to time, various forms, including but not limited to, disability or FMLA forms need to be completed. There is a $10 fee to complete each form. There are also fees associated with the copying of medical records. Please inquire at the Front Desk by requesting a Medical Record Release Form.

Returned Check Fee: There is a fee of $25 for any checks returned by your bank.

Prescription Refills: Annual office visits are required for annual prescription refills. Prescription refills not obtained during office visits may be subject to a $20 service charge.

Missed Appointment Fee: The second time a patient does not arrive on time for an appointment, or cancels with less than 24 hours notice, a missed appointment fee of $25 may be charged. This fee must be paid before a new appointment is scheduled. Patients with four or more missed appointments may be asked to transfer their records to another physician.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name:_____ Responsible Party:_____
(If not the patient)

Signature:_____ Date: _____

FACIAL PLASTIC SUGERY CENTER (FPSC)
A Division of Otolaryngology Associates, PC (OA)
RELEASE OF INFORMATION

I, the undersigned, authorize representatives of FPSC/OA to speak with the persons listed below regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by FPSC/OA to the listed persons and thereby release FPSC/OA and their staff from all legal responsibility that may arise from the act hereby authorized.

_____	_____	_____
Authorized Person	Relationship to Patient	Phone Number
_____	_____	_____
Authorized Person	Relationship to Patient	Phone Number

_____ _____

Signature of Patient / Responsible Party Date

ASSIGNMENT OF BENEFITS

I, _____(Please print your name) hereby authorize FPSC/OA to apply for benefits for covered services rendered by FPSC/OA and to request that the payments from Medicare, Medicaid, Blue Cross/Blue Shield and/or _____ (other insurance company) be made directly to FPSC/OA if they choose to accept assignment, or to myself or to the party who accepts assignment.

I certify that the information I have reported with regards to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim to Medicare, Medicaid, Blue Cross/Blue Shield and/or _____ (other insurance as listed above).

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services provided to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (name of Medigap Carrier) any information needed to determine these benefits payable for related services.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at anytime in writing.

_____	_____	_____
Subscriber or Policy Holder Signature	Insurance I.D. Number	Date

RECEIPT OF PRIVACY PRACTICES WITH WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a written summary of FPSC's/OA's Privacy Practices. I understand that a complete copy of the group's Notice of Privacy Practices is available, at no charge, upon request.

_____ _____

Signature of Patient/Responsible Party Date

CHART #:

DRUG ALLERGIES: DATE:

ADULT ASSESSMENT

NAME AGE REF BY

CHIEF CONCERN(S):

PRIMARY CARE PHYSICIAN	(Last) PHYSICAL	(Last) CHEST X RAY	(Last) EKG

CURRENT MEDICATIONS: *(Include Vitamins & Herbal Supplements & Aspirin Type Compounds)*

FOOD, LATEX OR OTHER ALLERGIES:

MEDICAL PROBLEMS: *(Present or Past)*

LIST PREVIOUS NON COSMETIC SURGERIES: *(Including Teeth and Gums)*

LIST PREVIOUS COSMETIC SURGERIES: DATE PHYSICIAN

Any complications from previous surgery or reactions to anesthesia? Yes / No If Yes, Explain

Were you satisfied with the results of any previous cosmetic surgery? Yes / No If No, Explain

Could you possibly be pregnant? Yes / No Nursing? Yes / No Do you smoke? Yes / No How much?

Do you drink alcohol? Yes / No How much? Do you get fever blisters? Yes / No Date of last outbreak_____

Have you recently seen any other physician with regards to your present concerns? Yes / No

Are you presently under the care of a therapist or counselor? Yes / No History of dry eye? Yes/No Last ophthalmology exam_____

Have you any neurological problems such as *Bell's Palsy*, strokes, seizures, *Myasthenia Gravis* or any other musculoskeletal problems? Yes / No

If Yes, explain

Have you or any family members had any problems with:

☐ Bruising/Bleeding	☐ Heart Disease	☐ High/Low Blood Pressure	☐ Diabetes
☐ Nerve Problems	☐ Thyroid Problems	☐ Mental Illness/Depression	☐ Keloids
☐ Lung Problems	☐ Stroke	☐ Asthma	☐ Auto Immune Disease
☐ Lupus	☐ Female Organs	☐ Cancer	☐ Hepatitis

Have you had any of the following:	*Most Recent Date*		*Most Recent Date*
☐ Laser Skin Resurfacing	_____	☐ Laser Hair Removal	_____
☐ Collagen Injections	_____	☐ Botox	_____
☐ Non-Ablative Laser	_____	☐ Light/Medium Peel	_____
☐ Microdermabrasion	_____	☐ Silicone Injections	_____
☐ Other_____	_____	☐ Other _____	_____

PHYSICAL EXAM

NOSE

Alar Base	Septum	Mucosa
Turbinates	Polyps	Synechiae
Nasolabial Angle	Nasofrontal Angle	Skin Thickness
Cartilage Strength	Internal Nasal Valve	

EARS

Cartilage Strength	Symmetry

EYES	Right	Left		Right	Left
Steatoblepharon	Upper Lower	Upper Lower	Canthal Ligament	Upper Lower	Upper Lower
Ptosis			Scleral Show		
Lid Lag			Visual Acuity		

FACE

Bone Anatomy	Soft Tissue
Rhytids/Skin	Lesions

NECK

Chin Projection	Cervicomental Angle
Platysmal Bands	Rhytids
Adipose Deposits	

CT, MRI Findings

NOTES

RECOMMENDATIONS

FACIAL PLASTIC
SURGERY CENTER
A division of Otolaryngology Associates, PC

PHOTO RELEASE FORM

I hereby give permission to Drs. Rubinstein, Doyle, Bahadori, McKenzie, Soltany, Lee, Mantle, Batti or any assistant they may designate to take photographs for diagnostic purposes and to enhance the medical record. I agree that these photographs will remain their property. I further authorize him/her to use such photographs for teaching purposes, patient education or to illustrate scientific papers, books, or lectures if, in his/her judgment, medical research, public interest, education or science will be benefited by their use.

Signature: _____

Date: _____

Witness: _____

I also give permission to the above mentioned physicians to use these photographs on their website and/or on other material used for marketing purposes.

Signature: _____

Date: _____

Witness: _____