

**WELCOME TO OUR PRACTICE  
PLEASE TAKE A MOMENT AND REVIEW YOUR MEDICAL HISTORY**

**OCEAN PLASTIC SURGERY MEDICAL HISTORY**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name \_\_\_\_\_

Male  Female      STATUS:  Single  Married

Street Address

City/State

Zip Code

Home Telephone Number

Business Telephone Number

Cellular Telephone Number

Date of Birth

Age

Social Security Number

E-mail address

May we leave a detailed message on your phone regarding your care?  Yes  No

Is there anyone we may speak to regarding your care?  Yes  No

Name \_\_\_\_\_

Reason for Visit \_\_\_\_\_ Referred by: \_\_\_\_\_

I understand that a fee is charged for all visits, examinations, and medical reports. Fees for cosmetic procedures or surgery are payable in full prior to treatment. If you are scheduling an evaluation and submitting it under your insurance you will be charged your copay even if your evaluation and management is subsequently determined to be cosmetic. All deductibles will be collected beforehand for all procedures until your deductible is met.

**ACKNOWLEDGEMENT POLICIES:** I hereby acknowledge that in consideration for treatment rendered to me and/or my child or child in my care that I am responsible and will pay for all charges and fees by Ocean Plastic Surgery, P.A., Stephen E. Small, D.O. for the services rendered. I understand that although I may have insurance to cover the cost of treatment, I remain responsible for payment. All payments are due within thirty (30) days of receipt of the bill.

I hereby authorize Ocean Plastic Surgery, P.A., Stephen E. Small, D.O. to release and request any information acquired in the course of my examination or treatment and further authorize payment of the surgical and/or medical benefits directly to the physician. I understand that photographs might be necessary and grant authority to Ocean Plastic Surgery, P.A., Stephen E. Small, D.O. to take or have taken any photographs of the patient whose name appears above for the purpose of the medical record only.

\_\_\_\_\_  
Signature (Patient or Responsible Party)

\_\_\_\_\_  
Date

Ocean Plastic Surgery, P.A.  
Stephen E. Small, D.O.

**INSURANCE, SELF PAY AND CANCELLATION POLICIES**

**INSURANCE:** Our practice will gladly submit claims to participating insurance carriers. In order to do so, we need your cooperation. **Complete and current insurance information is required** in order for our office to submit a claim to your primary insurance plan. This information needs to be provided at EACH visit or you may be required to reschedule or make payment at the time of service. ***It is the patient's responsibility to notify our office of any changes or termination of their insurance.*** If you are using a parent's insurance, the parent must sign accepting financial responsibility if not covered.

**REFERRALS/AUTHORIZATIONS:** ***It is the patient's responsibility to make sure that a referral has been obtained for their primary care physician and to bring a copy of that referral to our office.*** If you do not have a referral, you will be asked to reschedule your appointment until that referral is obtained or you will be responsible for the entire cost of the visit.

**CO-PAYS, CO-INSURANCES AND DEDUCTIBLES:** **Deductibles will be collected beforehand for all procedures until your deductible is met.** ***Co-pays are the fixed amount that your insurance plan has stated is your responsibility to pay at each office visit.*** This amount will be collected prior to your office visit. If you have a coinsurance you will be billed for the additional amount once your insurance processes the claim.

**MEDICARE:** Our office does participate with Medicare Part B. We will bill Medicare for services provided. You may be asked to sign an ABN form prior to any procedures. You will be responsible for any deductibles or coinsurances. We will submit to a secondary major medical carrier.

**SELF-PAY:** ***If you do not have medical insurance coverage, payment is expected in full at the time services are rendered.***

**CANCELLATION POLICY:** We know that schedules change and there may come a time that you need to cancel an appointment. We ask that you give us one business days notice if you cannot make your original appointment time. Cancellation for cosmetic or insurance appointments less than one full business day or a no-show to your appointment (arriving later than 10 minutes is considered a no-show) will be billed \$50. This must be paid prior to rescheduling your next appointment. We will try to accommodate patients that might arrive late but you might need to be rescheduled to prevent other patients from being late for their appointments.

**RETURNED CHECKS:** If a check you issued as payment is returned by your bank, (for any reason), you will be charged a fee of \$35.00. Any future payments to our office must be made by cash, credit or debit card.

**\*\* PLEASE NOTE WE DO NOT PARTICIPATE WITH ANY MEDICAID PLANS\*\***

***I have read and understand the above policy regarding my financial responsibilities to the office of Dr. Stephen E. Small.***

***My failure to fulfill my financial obligations may cause interruptions or delays in my medical care.***

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Medical History**

Allergies \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Medications- Please provide a list of prescription medications. If you are on just a few medications you can list below.

Drug Name	Dose e.g.- mg/units	Frequency e.g.- daily

Medical Conditions-Check all that apply to you.

Blood thinners	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	Heart valve	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Copd	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Lip cold sores	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>
Keloids	<input type="checkbox"/>	GI disease	<input type="checkbox"/>

Women-Check all that apply to you

Pregnant	<input type="checkbox"/>	Breast feeding	<input type="checkbox"/>
Menopause	<input type="checkbox"/>	Bra size	<input type="checkbox"/>

Please list any other conditions or details that might not be listed above.

Primary Care Physician: \_\_\_\_\_

Name and phone number of pharmacy: \_\_\_\_\_

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**Surgical History- Please select the surgeries that apply**

<b>Pacemaker</b>		<b>Brain</b>	
<b>Cardiac Stents</b>		<b>Spleen</b>	
<b>Cardiac Bypass</b>		<b>Liver</b>	
<b>Gall bladder</b>		<b>Back</b>	
<b>Appendix</b>		<b>Hysterectomy</b>	
<b>Stomach</b>		<b>C-section</b>	
<b>Small bowel</b>		<b>Uterine</b>	
<b>Large bowel</b>		<b>Prostate</b>	
	<b>Right</b>	<b>Left</b>	
<b>Hip</b>			<b>Carotid</b>
<b>Ankle</b>			<b>Foot</b>
<b>Shoulder</b>			<b>Breast</b>
<b>Hand</b>			<b>Hernia</b>
<b>Knee</b>			<b>Lung</b>

**Social History-Please select or complete**

<b>Substances</b>	<b>Amount</b>	<b>Duration</b>	<b>Quit</b>
<b>Tobacco</b>	enter amount		
<b>Alcohol</b>	enter amount		
<b>Recreational</b>	enter drug		

**Family History**

<b>Parents</b>	<b>Living</b>	<b>Deceased</b>	<b>Age</b>	<b>Medical History</b>
<b>Father</b>				
<b>Mother</b>				

**Please list any other details of your surgical, social or family history.**

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**OCEAN PLASTIC SURGERY MEDICAL HISTO**

**Review of Systems-check all that apply**

**Constitutional:** Weakness  Tiredness  Dizziness  Vertigo  Headaches

Weight changes loss  gain

**Eyes:** Wears glasses  Contacts  Blurred Vision  Double Vision

Dry eyes  Watery/Itchy Eyes

**Ear Nos and Throat:** Ringing of Ears  Hard of Hearing  Ear Infections

Nasal congestion  Nasal Bleeding  Dentures  Sore Throat

Swollen Lymph Nodes  Difficulty Speaking  Difficulty Swallowing

**Cardiovascular:** Chest Pain  Chest Palpitations  Shortness of Breath

Pain while walking or climbing stairs

**Lungs:** Shortness of Breath  Wheezing  Cough

**Gastrointestinal:** Nausea  Vomiting  Pain  Change in bowel habits

**Musculoskeletal:** Muscle aches  Joint pain

**Skin and Breast:** Concerning Lumps  Concerning Moles  Rashes

**Psychiatric:** Anxiety  Depression

**Endocrine:** Urinary Frequency  Drinking excessive amounts of liquids

Hot and cold intolerance

**Neurologic:** Slurred speech  Memory Loss  Arm weakness R  L

Leg weakness R  L  Numbness Arm R  L  Leg R  L

## Practice Privacy Statement

### **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**

This is a formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice. Stephen E. Small D.O., OCEAN PLASTIC SURGERY, P.A.

II. This practice has a legal obligation to maintain all medical records and information in the strictest of confidence as required by law. What this means to the patient is that we must safeguard patient information. This means we cannot release information to others without your written consent, including conversations, reminder calls, test results and other information that may be of a confidential nature. Patient information about health care is identified as “PHI” or protected health information.

This change in policy requires that you, the patient, identify and clarify at the time of registration or re registration with this practice who we can talk to, how we can leave information on your behalf, and the process for ongoing continuity of your medical care. You can change this information at any time with either written notification or verbal notification, followed up in writing. Changes can only impact the care or information from that point in time forward. Your protected health information (PHI) is an intricate part of your medical care, and can be used or disclosed with your written consent as follows:

- For your treatment in this practice and other locations under the physicians immediate care. This may include any referral for services such as lab, x-rays, other diagnostic testing or treatment related to your condition or medical care needs. This may also include conversations with other physicians.
- For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes or operative notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services with your consent identified on the registration form
- Disclosure to your family and friends concerning any related health care. Those names provided by you on the registration form which can be modified at any time orally, followed by written consent.
- Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician or medical entity required immediate and full information for care on your behalf.

Certain disclosures can be made without your consent, and they are as follows:

- Disclosure required by the government or law enforcement agencies. Specific areas that require release include gun shot wounds, domestic violence, and victims of abuse or neglect.
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program.
- Information related to organ donation.
- Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.
- Information provided to avoid harm if there is a threat to patient or other safety.
- Specific governmental functions.
- Workers compensation review.

Your rights with respect to you protected health information.

- The right to request limits on the uses and disclosure at registration or any time during your care.
- The right to choose how we send this information to you, including an alternate address.
- The right to see and obtain copies of this information, but there may be copy and postage fees.
- The right to get a listing of who we have made disclosures to about your PHI.
- The right to correct and update your file through an amendment process if appropriate.

This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our office to see if we can resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Ocean Plastic Surgery, P.A.

Print Patient Name: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_