MP PLASTIC SURGERY

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PATIENT INFORMATION / AUTHORIZATION FORM
(Please Print Clearly)

Patient Name:_____ **Sex**: ☐ F ☐ M
(Last) (First) (MI)

Address:_____

City:_____ **State**:_____ **Zip**:_____

SS#:_____ **Date of Birth**:_____ **Age**:____ **Marital Status**: ☐ S ☐ M ☐ D ☐ W

DL# or ID#:_____

Home Phone:_____ **Work Phone**:_____ **Cell Phone**:_____

Email Address:_____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic/Latino
☐ Native Hawaiian or Pacific Island ☐ White ☐ More than one race ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to Answer

Patient Speaks English? ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Preferred Communication Method: ☐ US Mail ☐ Home Phone ☐ Cell Phone ☐ Work Phone

EMERGENCY CONTACT

Last Name:_____ **First Name:**_____

Relationship:_____ **Home Phone:**_____

Work Phone:_____ **Cell Phone:**_____

MEDICAL CARE INFORMATION

Primary Care Physician:_____ **Phone Number:**_____

Preferred Pharmacy:_____ **Phone Number:**_____

Pharmacy Address:_____

Referred by:_____

Do you have medical Insurance?: ☐ Yes ☐ No

Reason for visit?_____

Have you had plastic surgery before?: ☐ Yes ☐ No If yes, please describe_____

_____

HEALTH HISTORY

Height_____ **Weight**_____

List Allergies_____

Reaction_____

List all medications you are currently taking_____

_____

_____

List previous surgeries and dates_____

_____

_____

YES	NO	
☐	☐	**Do you have a history of heart disease, chest pain or high blood pressure?**
☐	☐	**Do you have trouble breathing, asthma, bronchitis or chronic cough?**
☐	☐	**Do you have a history of sleep apnea?**
☐	☐	**Do you have diabetes?**
☐	☐	**Do you or have you ever had hepatitis or liver disease?**
☐	☐	**Do you or have you ever had cancer?**
☐	☐	**Do you or have you ever had kidney or bladder disease?**
☐	☐	**Do you or have you ever had stomach trouble or ulcers?**
☐	☐	**Do you or have you ever had neck / back / arm / leg pain, numbness or weakness?**
☐	☐	**Do you take large amount of aspirin, ibuprofen or vitamin E? If so, why?**_____
☐	☐	**Do you have a history of bleeding problems?**
☐	☐	**Do you ever get fever blisters or "cold sores"?**
☐	☐	**Do you or did you smoke? If so, how much?**_____
☐	☐	**Have you ever had a reaction to local anesthetic?**
☐	☐	**Have you ever been under the care of a psychiatrist or psychologist?**
☐	☐	**Do you accept the fact that medicine is not an exact science?**
☐	☐	**Do you accept the fact that every medical / surgical treatment is associated with risks?**
☐	☐	**Females: Could you be pregnant? Last menstrual**_____

Please explain any question you answered yes_____

_____

_____

_____

Responsible Party Name:_____
(Last) (First) (MI)

Address:_____

City:_____ **State:**_____ **Zip:**_____

SSN#:_____ **Date of Birth:**_____ **Age:**_____

Relationship to patient:_____

Insurance Company:_____

Insurance Address:_____

City:_____ **State:**_____ **Zip:**_____

Policy #:_____

Group Name:_____ **Group #:**_____

Subscriber's Name:_____

Subscriber's Address:_____

City:_____ **State:**_____ **Zip:**_____

Subscriber Date of Birth:_____ **Relationship to Patient:**_____

Subscriber's SSN or ID#:_____

Insurance Company:_____

Insurance Address:_____

City:_____ **State:**_____ **Zip:**_____

Policy #:_____

Group Name:_____ **Group #:**_____

Subscriber's Name:_____

Subscriber's Address:_____

City:_____ **State:**_____ **Zip:**_____

Subscriber Date of Birth:_____ **Relationship to Patient:**_____

Subscriber's SSN or ID#:_____

Employer/School:_____ **Occupation:**_____

Employer/School Address:_____

Employer/School Phone Number:_____ **Employment Status:** ☐ Full Time ☐ Part Time

Father's Name:_____ **Contact Phone Number:**_____

Mother's Name:_____ **Contact Phone Number:**_____

ASSIGNMENT OF BENEFITS AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Maxim Pekarev, M.D. / MP Plastic Surgery, PLLC all medical benefits, if any, otherwise payable to me for services rendered. I assign my right to receive these payments to Maxim Pekarev, M.D. / MP Plastic Surgery, PLLC. I authorize Maxim Pekarev, M.D. / MP Plastic Surgery, PLLC to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my Health Insurance Plan will not direct payment to Maxim Pekarev, M.D. / MP Plastic Surgery, PLLC, I agree to forward any and all health insurance payments, which I receive for the services rendered directly to Maxim Pekarev, M.D. / MP Plastic Surgery, PLLC. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.
_____ (*initials)*

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Maxim Pekarev, M.D. / MP Plastic Surgery, PLLC for any services furnished to me by that group. I authorize the release of medical information needed to determine these benefits. My signature below authorizes payment to be made directly to Maxim Pekarev, M.D. / MP Plastic Surgery, PLLC and, if other health insurance is in effect as a supplemental policy, I further authorize payment to Maxim Pekarev, M.D. / MP Plastic Surgery, PLLC and also authorize the release of information to that company for payment of benefits. _____ *(initials)*

TREATMENT AUTHORIZATION

I authorize physicians, nurse practitioners and/or their assistants to provide the medical care, tests, procedures, services and supplies considered advisable by my provider. These services will be further explained to me in detail and I will be given additional opportunity to consent individually to procedures ordered by my physician prior to my receiving treatment. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consent timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B and C and HIV. _____ *(initials)*

Signature of Patient/Person Legally Responsible:_____

Relationship to Patient:_____

Date:_____

Your signature below acknowledges that you were made available the **Notice of Privacy Practices** that provide a description of information uses and disclosure practices. You accept and understand that you:

- Have the right to review the **NOTICE** prior to signing this consent.
- Accept that the practice reserves the right to change the **NOTICE** and its information practices.
- Have the right to request restrictions on the use or disclosure of your health information to carry out treatment, payment or healthcare operations and to correct error(s) in your record. The practice, however, is not required to agree to the restrictions requested and some services may be unavailable to you depending upon the requested restrictions.
- May revoke this consent in writing that YOU provide to the practice. The revocation does not apply to any uses of your information made by the practice in reliance upon this consent form and on the belief that your consent was still effective. Initials of patient or person authorized to sign HIPAA Notice for patient _____ (*initials*)
- I authorize for detailed messages to be left on an at home answering machine or voicemail service. _____ (*initials*)
- I authorize for detailed message to be left on a cell phone voicemail. _____ (*initials)*
- I agree and offer no objection to the verbal release of protected health information to the person(s) listed below. I also authorize them to pick up prescriptions, notes and other medical information on my behalf. _____ (*initials*)

Name	Relationship	Phone Number

PATIENT CONSENT FOR CONSULTATION

I give my permission for examination and photographs during consultation for the purpose of making an evaluation with regard to my care and treatment. _____ (*initials*)

PATIENT CONSENT FOR USE OF HEALTH INFORMATION

I give my 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. I understand that the Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blacked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy. _____ (*initials)*

I have read all parts of the patient information and authorization form supplied to me by Maxim Pekarev, M.D. / MP Plastic Surgery, PLLC.

_____ _____

Patient / Guardian Signature Date

_____ _____

Print Name of Patient Date of Birth

_____

Relationship to Patient