



Jon F. Strohmeyer, M.D., F.A.C.S.

Facial Plastic & Reconstructive Surgery

PATIENT INFORMATION FORM

DATE _____ REFERRED BY _____

NAME _____ HOME PHONE _____

CELL PHONE/ ALTERNATE _____

LOCAL ADDRESS _____ CITY _____ STATE _____

ZIP CODE _____ SSN _____ - _____ - _____ BIRTH DATE _____

SEX _____ AGE _____ EMAIL ADDRESS _____

MARITAL STATUS _____ SPOUSE /PARENT'S NAME _____

EMPLOYER _____ WORK PHONE _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME _____ PHONE _____

WINTER VISITORS – PLEASE GIVE ALTERNATE ADDRESS

PHONE _____

MEDICAL INFORMATION – PLEASE FILL OUT COMPLETELY

REASON FOR VISIT _____

DO YOU TAKE ASPIRIN OR ASPIRIN PRODUCT? _____ FREQUENCY _____

DO YOU SMOKE ? YES ___ NO ___ PHARMACY NAME/PHONE NUMBER _____

LIST ANY PAST FACIAL PLASTIC SURGERY _____

LIST ANY PAST SURGERY BODY _____

LIST ANY PAST ANESTHESIA _____

PROBLEMS WITH ANESTHESIA YES _____ NO _____

LIST ANY MEDICAL CONDITIONS _____

Heart _____ Lungs _____ Gastrointestinal _____ Psychiatric _____

REGULAR FAMILY PHYSICIAN _____

PLEASE READ THE ATTACHED "FINANCIAL POLICY" DISCLOSURE CAREFULLY. It will explain our policy in relation to Medicare And Insurance Companies that we have contracts with or that we participate with. After reading it carefully, please sign in the appropriate place to signify your understanding and willingness to comply with our policy.

FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager.

Unless other arrangements have been made in advance by either you or your health coverage carrier. "FULL PAYMENT" is due at the time of service. For your convenience we accept cash, check, VISA and MASTERCARD AMERICAN EXPRESS and DISCOVER.

REGULAR INSURANCE

IT IS OUR POLICY TO COLLECT AT THE TIME OF SERVICE. Dr. Jon Strohmeyer does participate with Blue Cross Blue Shield of Florida PPO. If you are covered by BCBS of Florida, you will be required to pay any co-pay, unmet deductible or non-covered service at the time of each visit. Regardless of your insurance company's guidelines, all unpaid balances will become your full responsibility 60 days after your visit. In the event your health plan determines a service to be NOT COVERED you will be responsible for the complete charge. Should you dispute the way YOUR insurance company handled your claim, it will be the patient's responsibility to follow-up with any appeals.

COSMETIC PROCEDURES

All cosmetic procedures must be PAID IN FULL 3 weeks BEFORE the procedure is scheduled to be performed, usually at the time of the pre-operative appointment. A 20% deposit is required to hold a surgery date. Cosmetic procedures are NOT COVERED by insurance and will NOT be filed to any insurance company.

PHOTOGRAPHY CONSENT

I consent to the taking of photographs by The Facial Plastic Surgery Center (Dr. Jon F. Strohmeyer) or designee of me in connection with the facial plastic surgery procedure(s) intended or performed. I understand that photographs may be taken before, during, and after my procedure(s) as a routine part of my medical care. I further understand that these confidential.

I have read and understand the policies of the practice and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by the practice.

Signature of Patient or Responsible Party

Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Patient Rights and Responsibilities

This Surgery Center has adopted the following list of Rights and Responsibilities for Patients:

PATIENT RIGHTS:

- Exercise these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for his/her care.
- Treated with respect, consideration, and dignity.
- Provided personal privacy, receive care in a safe setting, and be free from all forms of abuse and harassment.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians who will see him/her.
- Receive information from his/her physician about his illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
- Receive as much information from his/her physician about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies this information shall include a description of the procedure or treatment, the medically significant risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
- Actively participate in decisions regarding his/her medical care to the extent permitted by law, this includes the right to refuse treatment or change his/her primary physician.
- Full consideration for privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
- Confidential treatment of all communication and records pertaining to his/her care and his/her stay at The Facial Plastic Surgery Center. His/her written permission shall be obtained before his/her medical record can be made available to anyone not directly concerned with his/her care, except when release is required by law.
- Reasonable responses to any reasonable request he/she may make for service.
- Availability of methods for expressing grievances or suggestions through direct communication or patient satisfaction surveys.
- Leave The Facial Plastic Surgery Center even against the advice of his/her physician.
- Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
- Be advised if Surgery Center/personal physician proposes to engage in or perform human experimentation affecting his/her care of treatment; the patient has the right to refuse to participate in such research projects.
- Be informed by his/her physician or a delegate of his/her physician of his/her continuing health care requirements following his/her discharge from the surgery center.
- Receive an explanation of fees for service and payment policies.
- Know which Surgery Center rules and policies apply to his/her conduct and responsibilities as a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Be advised of the services available at The Facial Plastic Surgery Center include ambulatory surgical services, and extended post-anesthesia care arranged in advance for patients having surgical procedures.

PATIENT RESPONSIBILITIES:

- To read and understand all permits and/or consents you sign. If you do not understand, it is your responsibility to ask the nurse or physician for clarification.
- To provide, to the best of your knowledge, accurate and complete information regarding your health, medications (including over the counter products and dietary supplements) any allergies or sensitivities, and past treatments.
- To follow any pre-operative written or oral instructions, and treatment plan from your physician provider and surgical center.
- To notify the physician or surgical center if these instructions have not been followed.
- To provide an adult to transport you home after surgery if you have received medications and/or anesthesia.
- To provide for someone to be responsible for your care for the first 24 hours after your procedure.
- Inform your physician provider about any living will, medical power of attorney or other directive that could affect your care.
- To follow carefully any written or verbal post-op instructions from your physician(s) or nurse.
- To contact your physician regarding any post-operative question or problem.
- Be respectful of all the health care providers and staff as well as other patients.
- To assure all financial obligations for services are fulfilled as promptly as possible and assume ultimate responsibility for payment regardless of insurance coverage.
- To notify the surgical center if you feel any rights have been violated, or if you have a complaint or a suggestion for improvement by contacting the Administrator, or by returning your patient satisfaction survey form.

PATIENT CONCERNS AND/OR GRIEVANCES:

Persons who have a concern or grievance regarding The Facial Plastic Surgery Center, including but not limited to, decisions regarding admission, treatment, discharge, denial of services, quality of services, courtesy of personnel or any other issue are encouraged to contact the Administrator or write a statement to:

Administrator
702 Goodlette Rd N Suite 100 Naples, FL 34102

ADVANCE DIRECTIVES

An "Advance directive" is a general term that refers to your oral and written instructions about your future medical care, in the event that you become unable to speak for yourself. Each state regulates the use of advance directives differently. There are two types of advance directives: a living will and a medical power of attorney. If you would like a copy of the State advance directive forms, please ask us at your appointment.

OUR SURGERY CENTER'S ADVANCE DIRECTIVE POLICY:

The majority of procedures performed Surgery Center are considered to be of minimal risk. Of course, no surgery is without risk.

You and your surgeon will have discussed your procedure and the risks associated with your procedure, the expected recovery and the care after your surgery. It is the general policy of the Surgery Center that all patients are to be granted the benefit of resuscitative efforts in the event of a cardiac arrest regardless of the underlying disease and circumstances and transfer you to a hospital for further evaluation.

I received information on patient rights, patient responsibilities, physician disclosure, advance directive policy and grievance policy at least one day in advance of my surgery. I am a patient/parent or legal guardian of Jon F. Strohmeyer M.D.

I hereby acknowledge receipt of Dr. Strohmeyer's Notice of Privacy Practices and Disclosure of Physician Ownership

Patient/Responsible Party Signature

Date