



# DeConti

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## Plastic Surgery

Creating a more beautiful you.

### How did you learn about us?

Patient \_\_\_\_\_

Physician \_\_\_\_\_

Friend \_\_\_\_\_

Internet

Google

Yahoo

Bing

LookingYourBest.com

Yellow Pages

Large Book:

Large Display Ad: Physicians & Surgeons

Large Display Ad: Plastic Surgery

Newspaper

Magazine

TV

Radio

Seminar

Other \_\_\_\_\_

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### **FINANCIAL POLICIES**

#### HMO/PPO and Commercial Insurance

THE PATIENT IS RESPONSIBLE FOR OBTAINING INSURANCE REFERRALS. IF PRIOR APPROVAL IS NOT OBTAINED, THE PATIENT WILL BE RESPONSIBLE FOR THE BILL. IF INSURANCE DENIES PAYMENT FOR A SERVICE, THE PATIENT IS RESPONSIBLE FOR THE BILL.

COPAYMENTS AND DEDUCTIBLES MUST BE COLLECTED AT THE TIME OF SERVICE, according to the contracts signed by the physicians.

#### Medicare

Robert W. DeConti, M.D. is a Medicare provider. If you do not have secondary and/or tertiary insurance that pays your deductible and co-payments, then you are responsible to pay this amount.

#### Medicaid

Robert W. DeConti, M.D. is a provider for Medicaid and Medicaid Medallion. According to the physician contract with the Commonwealth of Virginia, Medicaid patients are responsible for the \$1.00 and \$3.00 co-payments per service and hospital visit and are expected to pay at the time of service.

#### Cosmetic Surgery Fees

Fees may be paid with a personal check **two weeks** prior to the scheduled surgery date. If less than two weeks until surgery, payment must be in the form of cash or credit card. If payment is not received one week prior to surgery, then the surgery will be canceled. If the surgery is canceled and not rescheduled, a \$500 administration fee will be retained. The remainder will be refunded.

THERE IS A \$75.00 FEE FOR ANY CHECK RETURNED FOR NON-SUFFICIENT FUNDS.

### **FINANCIAL AGREEMENT**

I hereby authorize, Robert W. DeConti, M.D., Inc. to furnish to my insurance company or companies, attorney, or legal representative, all information which said parties may request concerning my present illness or injury.

I hereby assign to Robert W. DeConti, M.D., Inc., all monies to which I am entitled under my insurance plan for medical and or surgical expenses relative to the services reported herein, including but not limited to, monies due me for allowable expenses covered under my insurance plan. Robert W. DeConti, M.D., Inc. will apply all monies received from my insurance company to my account. All overpayments will be refunded to me when my bill is paid in full. If the insurance company fails to make payments, or in the event that I received medical and/or surgical services that are not covered by my insurance plan, I understand and agree that I am personally responsible for such charges and for any other charges not covered by this assignment.

I agree to pay my account as it comes due and further agree that if I do not, I will pay all expenses incurred in collecting the same, including court costs, a thirty three and 1/3 percent (33 1/3%) attorney's fee of the outstanding balance, a one and 1/2 percent (1 1/2%) interest per month (18% annually) starting from the date of service, and \$400.00 per hour physician's fee for court time and trial preparation.

I agree to provide Robert W. DeConti, M.D., Inc. with the address and other information changes so that said doctor can properly send current bills to me.

DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_

Patient/Insured/Guardian

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**PATIENT NAME:** \_\_\_\_\_

### **CONSENT TO TREATMENT**

I hereby authorize Dr. Robert W. DeConti to examine and /or treat that which he deems necessary or advisable on me/patient.

In the event of any employee's exposure to my/patient blood and/or body fluids, I consent to laboratory testing of my/patient blood for Hepatitis and HIV antibody.

DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_  
Patient/Insured/Guardian

### **CONSENT TO PHOTOGRAPH**

I agree to allow Dr. Robert W. DeConti or his employees to take and/or release any photographs taken of me/patient for the purpose of publications, educational services, internet development or for the purpose of judicial cases or insurance review.

DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_  
Patient/Insured/Guardian

WITNESS: \_\_\_\_\_

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### **HEALTH HISTORY**

(PLEASE PRINT)

Date \_\_\_\_\_

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

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_ Sex: M F

Family Physician \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

### **MEDICATIONS**

(Name, Dose, and Frequency.  
Include Herbal and Vitamin Supplements)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **ALLERGIES**

(If no known allergies please specify below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU TAKE ASPIRIN REGULARLY?

Yes No

DO YOU TAKE/OR HAVE YOU TAKEN STEROIDS?

Yes No

HAVE YOU EVER HAD A BLOOD TRANSFUSION?

Yes No

### **CONDITIONS** (Circle all that apply)

AIDS	Congenital heart	High Blood Pressure	Scarlet Fever
HIV Positive	Diabetes	High Cholesterol	Stroke
Anemia	Epilepsy	Kidney Disease	Thyroid Disease
Emphysema	Liver Disease	Tuberculosis	Typhoid Fever
Anorexia	Glaucoma	Leukemia	Suicide Attempt
Arthritis	Goiter	Colitis	Ulcers
Bleeding disorder	Gout	Pacemaker	Venereal Disease
Bronchitis	Heart Attack	Heart Disease	Rheumatic Heart
Psychiatric	Bleeding Gums	Nose bleeds	Polio
Cancer	Hepatitis	Pneumonia	

OTHER \_\_\_\_\_

### **FAMILY HISTORY** (Circle and give relationship)

Arthritis	_____	Epilepsy	_____	Leukemia	_____
Asthma	_____	Goiter	_____	Bleeding Disorder	_____
Breast Cancer	_____	Heart Attack	_____	Ulcers	_____
Cancer	_____	High Blood Pressure	_____	Stroke	_____
Colitis	_____	High Fever after Surgery	_____	Thyroid Disease	_____
Heart Disease	_____	Suicide	_____	Diabetes	_____
Kidney Disease	_____	Tuberculosis	_____	Liver Disease	_____

OTHER \_\_\_\_\_

**SURGERIES & HOSPITALIZATIONS**

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION	OUTCOME

**SERIOUS ILLNESS/INJURIES**

DATE	TYPE OF ILLNESS/INJURY	OUTCOME

**HEALTH HABITS** (Circle substances you use and tell how much)

Alcohol \_\_\_\_\_      Drugs \_\_\_\_\_  
Tobacco \_\_\_\_\_      Other \_\_\_\_\_

**SYMPTOMS**

**WOMEN ONLY**

Is there a chance you are Pregnant?      Yes   No  
How many Pregnancies? \_\_\_\_\_      How many children born alive? \_\_\_\_\_  
How many Miscarriages/Abortions? \_\_\_\_\_      How many premature births? \_\_\_\_\_  
Any complications from Pregnancies? \_\_\_\_\_  
Date of last Breast Exam: \_\_\_\_\_      Result: \_\_\_\_\_  
Date of last Mammogram: \_\_\_\_\_      Result: \_\_\_\_\_

**MEN ONLY**

Treatment to genitals (private parts)?      Yes   No  
Discharge from penis?      Yes   No  
Prostate trouble?      Yes   No

=====

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Patient/Insured/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date

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### Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by *DeConti Plastic Surgery* for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of *DeConti Plastic Surgery*. I understand that diagnosis or treatment of me by Robert W. DeConti, M.D., F.A.C.S. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. *DeConti Plastic Surgery* is not required to agree to the restrictions that I may request. However, if *DeConti Plastic Surgery* agrees to a restriction that I request, the restriction is binding on *DeConti Plastic Surgery* and Robert W. DeConti, M.D., F.A.C.S.

I have the right to revoke this consent, in writing, at any time, except to the extent that Robert W. DeConti, M.D., F.A.C.S. or *DeConti Plastic Surgery* has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review *DeConti Plastic Surgery*'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the *DeConti Plastic Surgery*. This Notice of Privacy Practices also describes my rights and the *DeConti Plastic Surgery's* duties with respect to my protected health information.

*DeConti Plastic Surgery* reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Date

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Print Name of Patient or Personal Representative

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Description of Personal Representative