MOST PLASTIC AND RECONSTRUCTIVE SURGERY, PC

Dr. Daniel Most, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*This is an acknowledgment of receipt only.

I have received a copy of the Notice of Privacy Practices for Most Plastic & Reconstructive Surgery, PC.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____

Relationship of Patient Representative to Patient

MOST PLASTIC AND RECONSTRUCTIVE SURGERY, PC

NOTICE OF PRIVACY PRACTICES

Dr. Daniel Most, MD

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Uses and Disclosures

Treatment - Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment - Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations - Your health information may be used as necessary to support the day-to day activities and management of Most Plastic and Reconstructive Surgery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement - Your health information may be disclosed to law enforcement agencies to support government audits and inspectors to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting - Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders - Your health information may be used by our staff to send you appointment reminders.

Information About Treatments - Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your private health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Most Plastic and Reconstructive Surgery Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we main tain.

Requests to Insect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Medical Records Clerk. Your request will be reviewed and will generally be
approved unless there are legal or medical reasons to deny the request.

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to:

Most Plastic and Reconstructive Surgery
5205 Frederick St. Suite A
Savannah, GA 31405

You will not be penalized or otherwise retaliated against for filing a complaint.

MOST PLASTIC AND RECONSTRUCTIVE SURGERY, PC

Dr. Daniel Most, MD

PATIENT INFORMATION SHEET

☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Separated

Have you ever been seen by one of our doctors? ☐ No ☐ Yes, in what year?

Patient Legal Name _____ Nickname _____
Last First Middle

Sex _____ Date of Birth _____ Age _____ Social Security # _____

Home Address _____
Street City State Zip

Home Phone _____ Cell/Alternate Phone # _____

Employer _____ Work Phone # _____

Name of Closest Relative, Friend or Neighbor _____ Phone # _____

Patient Primary Care Physician _____ Phone # _____

Referred by Dr. _____ ☐ Phone Book ☐ Radio ☐ Postcard ☐ Web ☐ Other

Specific Reason for Visit _____
** Required Information **

Email Address _____ May we contact you through email? ☐ Yes ☐ No

Would you like to receive our quarterly newsletter through E-zine? ☐ Yes ☐ No

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Name of Responsible Party, if other than patient _____
Last First Middle

Home Address if different from above _____
Street City State Zip

Home Phone _____ Cell/Alternate Phone # _____

Employer _____ Work Phone # _____

I, _____ , represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and the treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of any medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment. I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

SIGNATURE _____ DATE _____

RELATIONSHIP: (Circle One) **PATIENT** **SPOUSE** **PARENT** **GUARDIAN**

MOST PLASTIC AND RECONSTRUCTIVE SURGERY, PC

Patient Information Label

Dr. Daniel Most, MD

Please Fill Out COMPLETELY. Do Not Leave Anything Blank.

MEDICAL AND SURGICAL HISTORY

Patient Name: _____ Sex: _____ Age: _____ Today's Date: _____

Weight: _____ Height: _____

Occupation: _____ Referred by: _____

Chief Complaint: _____

SIGNIFICANT MEDICAL HISTORY:

Medical Allergies Sensitivities: _____ Pregnant? N Y

List ALL medications (including aspirin, diet pills, herbal supplements, prescriptions, over-the-counter meds): _____

_____

_____

Are you a smoker? NO YES How many packs per day? _____ For how many years? _____

Have you ever used (circle): LSD / Speed / Cocaine / Marijuana None How much alcohol do you drink? _____

PAST MEDICAL HISTORY (Please check all that apply.)			
Cardiovascular	**Pulmonary**	**Medical**	**Other**
☐ Heart Attack	☐ Asthma	☐ Diabetes	☐ Bleeding Tendencies
☐ High Blood Pressure	☐ Shortness of Breath	☐ Heart Burn/Reflux	☐ Blood Clots in Legs/Lungs
☐ Irregular Heartbeat	☐ Emphysema/COPD	☐ Depression	☐ AIDS/HIV Positive
☐ Chest Pain (Angina)	☐ Bronchitis	☐ Steroid Treatment	☐ Hepatitis
☐ Mitral Valve Prolapse	☐ Sleep Apnea	☐ Seizures	☐ Dry Eyes
☐ Abnormal EKG	☐	☐ Mental Illness	☐ Kidney Disease
☐ NONE OF THE ABOVE	☐ NONE OF THE ABOVE	☐ NONE OF THE ABOVE	☐ NONE OF THE ABOVE

HAVE YOU EVER EXECUTED AN ADVANCED DIRECTIVE (DNR - Do Not Resuscitate)? (Circle One) YES / NO

FAMILY HISTORY:

Have you or anyone in your family ever had problems with anesthesia? YES / NO

If yes, who and what happened? _____

Any family history of: Heart Disease Lung Disease Other

Describe: _____

REVIEW OF SYSTEMS: Do you have any? (Circle): Fever Chills Nausea Vomiting Diarrhea NONE

PAST SURGICAL HISTORY: List all operations you have had, including plastic surgery.	
OPERATION	**DATE**
☐ I have not had any operations.	

Do you have any other health issues that we many need to be aware of? NONE YES. Explain:

_____

THANK YOU! Patient Signature: _____

INSURANCE INFORMATION

(Please fill out all of the appropriate information.)

PRIVATE INSURANCE - Primary

Policy Holder's Name: _____

Policy Holder's SSN#: _____ Sex: _____ DOB: _____

Policy Holder's Employer: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Child ☐ Other Effective Date of Coverage: _____

ID/Policy #: _____

Name of Insurance Company: _____

PRIVATE INSURANCE - Secondary

Policy Holder's Name: _____

Policy Holder's SSN#: _____ Sex: _____ DOB: _____

Policy Holder's Employer: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Child ☐ Other Effective Date of Coverage: _____

ID/Policy #: _____

Name of Insurance Company: _____

PRIVATE INSURANCE - Other

Policy Holder's Name: _____

Policy Holder's SSN#: _____ Sex: _____ DOB: _____

Policy Holder's Employer: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Child ☐ Other Effective Date of Coverage: _____

ID/Policy #: _____

Name of Insurance Company: _____

ACCIDENTS - Auto - Other

If your injury is a result of an auto accident, please fill out this section.

Policy Holder's Name: _____

Policy Holder's Address: _____

Auto Insurance Company Name: _____ Policy #: _____

Insurance Company Address: _____ Date Accident Occurred: _____

How Did Accident Occur: _____

_____

Attorney's Name: _____ Address: _____

WORKMAN'S COMPENSATION

If your injury is a result of an auto accident that occurred on the job, please fill out this section.

Employer: _____

Employer's Address: _____

Date of Injury: _____ Was Injury Reported to Employer? Yes ____ No ____

Tell us how the injury occurred: _____

_____

_____

_____

_____

Signature: _____ Date: _____

MOST PLASTIC AND RECONSTRUCTIVE SURGERY, PC

OFFICE POLICIES

Appointment Policy

- All appointments are scheduled. All walk-ins are scheduled into the next available appointment on the schedule.
- Please be on time. If you are 30 minutes late, you will be rescheduled.
- Please call if you can not keep your appointment. Recurrent "no-shows" are grounds for dismissal from our practice.
- Physician, office, and surgery emergencies impact schedules and result in unpredictable waiting periods. We make every effort to maintain our schedule and minimize any inconvenience to you. However, emergencies do occur. If a significant delay occurs we will inform you and we will gladly reschedule your appointment if you would prefer not to wait.
- Appointments are taken back in the order of the appointment time not the arrival time.

Professionalism Policy

- Our staff strives to be courteous at all times. If you feel you have received poor customer service, please notify the Office Manager.
- Being rude to or threatening staff is grounds for dismissal from the practice.
- Our physicians answer cell phone calls and pages related only to patient care. Please be equally courteous and do not use your cell phone while interacting with staff.

Insurance Policy

- Please remember that your insurance coverage is a contract between you and your insurance company, not between you and our practice. We make every effort to work with you and your insurance company, however, if there is a dispute over what your insurance company paid and what they said is your responsibility, please contact your insurance company before calling our billing department.
- Your insurance contract requires us to collect specific amounts. It is a contract violation for us to waive co payments, coinsurance, etc.
- If you are covered under a state funded program (Amerigroup, Wellcare, Medicaid or Peachcare) you are required to report if you have additional primary insurance: failure to do so is insurance fraud and these programs can require the patient to pay back money for the paid claims in error. Please let us know if you have primary commercial insurance at check in.

Financial Policy

- All fees are due at time of service.
- Nonpayment and failure to set up a payment plan will result in your account being turned over to a collection agency. You will incur additional collection fees of 33% added to your bill.
- Once an account has been turned over to collections all payments on your account must be made through the collection agency, not our office.
- Patients whose accounts have been turned over to collections will not be seen until the account balance is paid in full.
- If you write a check to us as means of payment and that check is returned to us for "non sufficient funds" you will incur a $35 NSF fee from our practice and you will no longer be able to use a check as a form of payment in our office.

Prescriptions and Forms

- All prescriptions must be obtained through an office visit with Dr. Most. If you need a prescription refill please call our office to schedule an appointment. No exceptions will be made.
- Forms take 2-4 weeks to complete. There is a $10 cash only charge to complete forms. Forms more than 10 pages will be an additional $2 dollars per page.
- Our physicians rarely call in medications. We believe that by seeing the patient, we can provide better care.

Expectations for Behavior

- You are responsible for you and your child's behavior in this office. You are also responsible for the behavior of all guests you bring to our office.
- Children should not be left unattended in the waiting room or exam room.
- Children should not play on or with the furniture.
- You are responsible for cleaning up any mess made by your child/guest. This includes food, drink, ink pen marks, etc.

Phone Call Policy

- Please do not call our after hours answering service regarding refills, forms, billing, etc. after hours, they can not assist you with this matter.
- Telephone triage calls during office hours are returned by the end of the business day. These calls are handled in order of medical importance first. Please do not call multiple times for the same problem as this may delay response time.

Medical Records

- If you are new to our practice you will need to transfer your medical records from your previous practice. A medical records release form must be filled out in order to complete the request.
- Often times these medical records will need to have been transferred BEFORE your first appointment so that the physician has time to review them.
- Should you chose to leave our practice for any reason we will gladly copy and send the medical records to the office of your choosing free of charge once a medical records release form has been filed out.
- If you would like a hard copy of your medical records there is a $15 copying fee. For large files additional fees may apply.

I agree to adhere to the above policies and procedures, by signing below I accept the terms and conditions of these office policies and procedures.

_____ _____

Patient Signature **Date**

MOST PLASTIC AND RECONSTRUCTIVE SURGERY, PC

Physician Practice Financial Policy & Release of Information

Dr. Daniel Most, MD

The following statement is a statement of our Financial Policy for services provided within our office and do not apply to any testing or diagnostic procedure performed outside of this physicians practice. We require you to read and sign this document prior to treatment by this facility.

PATIENT RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of services. As a courtesy, this practice will file your claim with your insurance carrier. However, the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the east. Surgical procedures, labs, and any other outpatient procedures may have a higher co-payment of fall under the deductible. It is the patient's responsibility to understand their insurance coverage. Patients are responsible to know what laboratory your insurance company requires you to use. You will hold Most Plastic & Reconstructive Surgery harmless in case you receive a bill from a non-covered lab.

When you receive a statement from the Most Plastic & Reconstructive Surgery practice, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with this balance due amount, you are to contact a billing representative at the phone number noted on the statement. Do not ignore the bill, as it may result in turning the balance to an outside collection agency for recovery and an additional fee of 33% will be added to your bill. Nonpayment of you bill can result in being discharged from the practice.

Consent/Authorization for Treatment and to Release Information/Disclose Personal Health Information

The signature below serves as authorization for medical treatment by the physician or nurse for the named patient. It also provides authorization for Most Plastic & Reconstructive Surgery to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured administrator, and/or other health payer representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization also serves as permission to obtain a copy of you complete medical record from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining medical records. I understand that I may withdraw this authorization to release medical information at any time, communicate to the practice either in writing or verbally, followed by a written withdrawal.

I understand that I am financially responsible to the Most Plastic & Reconstructive Surgery for any balance not covered by the insurance carrier.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize my insurance benefits to be paid to this Most Plastic & Reconstructive Surgery Practice. I hereby agree that if my bill has been turned over to a third party collection agency for non-payment, there will be a 33% collection fee added to my bill. This is pursuant to Georgia Statutory Law "O.C.G.A.-13-1-11."

_____ _____

Patient Name (Please Print) **Date**

_____ _____

Signature of Patient or Responsible Party **Date**