

MEDICAL HISTORY

NAME: _____

Referred by: _____

Reason for appointment: _____

LIST ALL PAST SURGERIES PLEASE BE SPECIFIC.

If you are a breast surgery patient, please include any family history of breast disease.

If you have Implants: note the year of surgery. Provide us with the type, lot and implant size.

Please complete the following, as it applies to you.

Height: _____ **Weight:** _____

Date of last mammogram: _____ Results: _____

Have you had an MRI? _____ Results: _____

Results of any previous breast biopsy: _____

Have you seen an Immunologist or Rheumatologist? _____

Results: _____

Present medications: (Including aspirin) _____

Drug allergies: _____

Do you smoke? How much daily? _____

Check all that apply to you:

Arthritis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>
Bleed easily?	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Bruise easily?	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Other	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>		<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>		<input type="checkbox"/>

Female

Number of pregnancies	<input type="text"/>	Number of children	<input type="text"/>	Breast fed children	<input type="text"/>
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PHOTOGRAPHIC CONSENT

NAME

DATE

The following is my consent for Dr. Chaney or a staff representative to photograph me for the following purposes.

Using respectful and discretionary measures, the photographs may be viewed by medical health care professionals, as well as non-medical individuals.

Patient's file

Photographs are required for the patient's file and will be utilized for comparative review during the course of treatment.

Office reference

These photographs may be used for educational purposes.

Seminar

May be used for statistical data, presentations and seminars. Photos will be used as discretely as possible.

Insurance

Photographs are necessary when submitting for insurance coverage.

Internet

The discreet use of photographs may be used exclusively on Dr. Chaney's educational website.

By signing, I am granting Dr. Chaney permission to use my photographs as checked above.

Date

Signature

Witness

HIPAA Notice of Privacy Practices

In order to abide by government regulations, you must sign this form before seeing Dr. Chaney. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created Privacy Regulations to describe how your health information may be used or disclosed.

The following highlights your privacy rights. We encourage you to read the full disclosure posted in our office or request a copy for your reference.

As your medical information is personal and confidential, we do not release any information without your permission. If the situation arises and we need to share your medical information with other medical entities or with your family/care-giver, you must sign your approval and acknowledgement at the end of this notice.

Our policy has always been to keep your records safe. Your records are kept in your personal patient folder with portions stored in our computer database. Your records tell what treatments and tests you have had, and what decisions the doctors have made. The release of information is most often to a family member, a caregiver or a health professional. Pertaining to the Privacy Act as a whole, the following are examples of possible requests, as given by the government. Many will not pertain to you, especially in the skin care department but are listed for your reference.

FOR YOUR MEDICAL TREATMENT AND PAYMENT

- Provide for your treatment
- Appointment reminders
- Information for payment
- Tell you treatment alternatives
- Evaluate your care
- Business associates

FOR YOUR PERSONAL REASONS

- Communicate with your family or caregiver
- Get an interpreter for you

FOR OTHER REASONS THAT HELP IMPROVE HEALTH

- Research
- Procurement organizations
- Marketing
- Public Health

OTHER SPECIAL USES

- Law enforcement request
- Correctional institutions
- Members of the military
- Non-violation notice
- Investigation or audits
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MANDATORY You must list **AT LEAST** one person we are able to talk to regarding your care. Please list any family, friends or others that we should know about, should they call regarding your care. Give their relationship to you.

By signing I am acknowledging that I understand my privacy rights.

Patient

Date

Witness

MICHAEL J. CHANEY M.D., F.A.C.S., P.A.
COSMETIC, PLASTIC, AND RECONSTRUCTIVE SURGERY

PAYMENT POLICY

Thank you for choosing my office for your cosmetic, plastic and reconstructive needs. The staff and I are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we *require* you to read and sign prior to any type of treatment. All patients must complete our patient information and insurance form before being seen.

- ❖ FULL PAYMENT IS DUE AT TIME OF SERVICE
- ❖ WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, AND DISCOVER
- ❖ WE ALSO OFFER CAPITAL ONE HEALTHCARE FINANCE AND CARE CREDIT FINANCE IN THE OFFICE

REGARDING INSURANCE

We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. **Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to you as the guarantor.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and may not be considered reasonable and necessary under Medicare Program and / or other medical insurance. We will notify you of this and have you sign proper paper work. In the event that we do not take your insurance, we will file your insurance for you at out of network benefits.

Usual and Customary Rates

Our practice is committed to providing the best treatment for all patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

Surgery

Payment, co – insurance and co-payments are due at the time of the pre-op appointment; otherwise you will be rescheduled or canceled.

Skin care

Payment is due upon receipt if skincare products or services rendered. All sales are final on products, no returns, exchanges, or refunds.

Patient signature _____ Date _____

Witness _____