MEDICAL HISTORY

INFORMATION IS STRICTLY CONFIDENTIAL. Please answer all questions completely, and to the best of your knowledge, to enable the doctor to make proper medical decisions.

LAST NAME_____ FIRST_____ AGE _____ SEX _____

HEIGHT _____ WEIGHT _____ RIGHT/LEFT HANDED _____ RELIGION_____
OPTIONAL

OCCUPATION_____ REFERRED BY _____

SURGERIES

☐ Breast Biopsy
☐ Breast Surgery (**list type & date**)

_____
_____
_____

☐ Abdominal Surgery (**list type & date**)

_____
_____

☐ Other (**list type & date**) _____

_____
_____
_____

☐ Anesthesia Problems (list type)

_____

FAMILY HISTORY
(**If yes, list relation)

☐ Cancer
☐ Heart Problems
☐ High Blood Pressure
☐ Blood Disease
☐ Lung Problems
☐ Circulation Problems
☐ Diabetes
☐ Stroke
☐ Drug or Alcohol Abuse
☐ Anesthesia Problems

FOR WOMEN

Pregnancies_____ # Deliveries_____

Contraception Type_____

Date of last mammogram _____

Result_____

Bra Size_____ (*optional)
*breast surgery patients required to answer

MEDICAL CONDITIONS

☐ High Blood Pressure
☐ Heart Murmur
☐ Coronary Artery Disease
☐ Heart Failure
☐ Arrythmia
☐ Cholesterol
☐ Lung Problems
☐ Cancer
☐ Arthritis
☐ Intestinal Problems
☐ Thyroid Problems
☐ Emphysema/Chronic Bronchitis
☐ Asthma
☐ Diabetes
☐ Kidney Problems
☐ Stroke
☐ Circulation Problems
☐ Vericose Veins
☐ TB
☐ HIV
☐ Liver Disease
☐ Hepatitis
☐ Blood Clots
☐ Bleeding Tendencies
☐ Sleep Apnea
☐ Psychological
☐ Drug Abuse
☐ Seizure
☐ Chronic Back Pain
☐ Wound Healing Issues
☐ Easy Bruising
☐ Other: _____

_____
_____

ADVANCED DIRECTIVE
(for patients **over 65**)
Do you have a surrogate decision maker?

☐ YES
☐ NO

LIST ALL FOOD & DRUG ALLERGIES ALONG WITH REACTION

_____
_____
_____
_____
_____

MEDICATIONS (list dose and frequency)
Include supplements.

_____
_____
_____
_____
_____
_____
_____
_____

PREFERRED PHARMACY

_____
NAME & LOCATION (**CITY & CROSSROADS**)

SMOKING

☐ No, never smoked
☐ Yes, but I quit as of _____
☐ Yes, I currently smoke _____packs per day for (#) of years _____

ALCOHOL Did you have a drink containing alcohol in the past year?

☐ No
☐ Yes
If yes, how often?:
☐ 1 or less a month
☐ 2-4 times per month
☐ 2-3 times a week
☐ 4 or more times a week

Average # of drinks per occurrence:_____

Race _____ Ethnicity _____ Language _____ ☐ DO NOT WISH TO REPORT

_____ _____
PATIENT SIGNATURE (OR RESPONSIBLE PARTY IF MINOR) **DATE**

PALO VERDE PLASTIC SURGERY

JOHN M. ROWLEY, M.D.

Certified American Board of Plastic Surgery

PATIENT INFORMATION (please print)

Patient's Last Name:_____ First:_____ Middle:_____ Gender:_____

Date of Birth:_____ Age:_____ Social Security No:_____ Marital Status: S M W D SEP

Address (street, city, state, zip):_____

Best Daytime Phone#:_____ cell/home/work (circle) Permission to leave a voice message? Y / N Permission to text message? V / N

Alternate Phone#:_____ cell/home/work (circle) Permission to leave a voice message? V / N Permission to text message? V / N

Email Address:_____ Permission to email? V / N

Employment Status: ☐EMPLOYED ☐SELF EMPLOYED ☐NOT EMPLOYED ☐RETIRED ☐STUDENT Occupation: _____

Name& Address of Employer:_____ Employer's Phone#:_____

Emergency Contact:_____ Relationship:_____ Phone#:_____

Address (street, city, state, zip)::_____

Primary Care Doctor:_____ Phone#: _____

Preferred Pharmacy Name & Location (city& crossroads) _____

How did you hear about us?: ☐Insurance Co. ☐Dr.: ☐Website: ☐Family/Friend:

Responsible Party (or parent, If minor) Last Name:_____ First:_____ MIddle:_____

Date of Birth:_____ Age: _____ Social Security No:_____ Marital Status: S M W D SEP

Best Daytime Phone#:_____ cell/home/work {circle) Permission to leave a voice message? V / N Permission to text message? Y / N

Alternate Phone#:_____ cell/home/work (circle) Permission to leave a voice message? V / N Permission to text message? V / N

Email Address:_____ Permission to email? V / N

Employment Status: ☐EMPLOYED ☐SELF EMPLOYED ☐NOT EMPLOYED ☐RETIRED ☐STUDENT Occupation: _____

Name& Address of Employer:_____ Employer's Phone#:_____

INSURANCE INFORMATION (please print)

Primary Insurance Company:_____ Polley Holder's Full Name: _____

Relationship to Patient:_____ Date of Birth:_____ Social Security No:_____

Polley Holder's Address:_____

Policy Holder's Phone#:_____ cell/home/work (circle) Permission to leave a voice message? Y / N Permission to text message? V / N

Polley Holder's Name& Address of Employer:_____ Employer's Phone#:_____

Secondary Insurance Company:_____ Policy Holder's Full Name:_____

Relationship to Patient:_____ Date of Birth:_____ Social Security No:_____

Policy Holder's Address:_____

Policy Holder's Phone#:_____ cell/home/work (circle) Permission to leave a voice message? V / N Permission to text message? V / N

Policy Holder's Name& Address of Employer:_____ Employer's Phone#:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

GIVING US PERMISSION TO LEAVE A VOICEMAIL, TEXT MESSAGE, OR TO EMAIL, INCLUDES WHAT MAY BE PROTECTED HEALTH INFORMATION (le: test results, appointment reminders, etc). UNLESS STATED OTHERWISE, WE WillPOTENTIALLY MAIL INFORMATION TO THE ADDRESS YOU PROVIDE. I authorize payments of medical bene- fits to the provider for services rendered, or to be rendered In the future, without obtaining my signature on each claim submitted, and I will be bound by the signature as thought personally signed the claim. I also authorize the release of medical information necessary, I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES, should this account be referred to a collection agency, I will also be responsible for any collection and/or legal fees. I have read and understand.

PATIENT OR RESPONSIBLE PARTY SIGNATURE

PRINT NAME

DATE

AUTHORIZATION FOR RELEASE of PATIENT PHOTOGRAPHS

I consent to the taking of photographs by Dr. John Rowley, or his designee, of me or parts of my body in connection with the plastic surgery procedure(s) be performed by Dr. John Rowley. I further authorize Dr. John Rowley, to utilize these photographs in the interests of public education and for practice marketing purposes.

I provide this authorization as a voluntary contribution and I understand that such photographs shall become the property of Dr. John Rowley, and may be retained by or released by Or. John Rowley *tor* the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, before and after portfolio of photographs **(both hard copy and website),** for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that In some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. John Rowley.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization In writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, It will expire ten years from the date written·below.

i release and discharge Dr. John Rowley. and all parties acting under his license and authority, from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand Its terms.

_____ _____

Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education and for practice marketing.

_____ _____

Signature Date

I certify that I have read the above Authorization and Release and fully understand its terms and ***do* not wish** to have my photographs used as described above.

_____ _____

Signature Date

Palo Verde Plastic Surgery
Dr. John M. Rowley, MD

Financial Policies

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE
Payment is required at the time services are rendered unless other arrangements are made in advance.
This includes applicable coinsurance, copayments and deductibles for participating insurance companies.
We accept cash, check (returned checks will be charged a $25.00 fee), VISA, MasterCard, Discover, American Express and CareCredit.
Patients with an outstanding balance 60 days or more overdue must make payment arrangements prior to scheduling appointments. We do use a collection agency to pursue past due accounts.

INSURANCE
We bill participating insurance companies as a courtesy to you. Benefits and eligibility will be confirmed prior to any procedure done by Dr. Rowley. An estimate will be given to you for the procedure. Because this is an estimation, after your claim is paid by the insurance company, you may receive a refund or a bill from us. You are expected to pay your deductible, copayments and coinsurance. Although requirement for prior authorization will be verified prior to any procedure, please be aware that some services provided may be non-covered ahd considered not reasonable and necessary under your insurance plan. It is your responsibility to know your coverage. **If** payment is not received from your insurance company, you may be expected to pay the balance in full.
If your insurance requires a referral in order for you to see a specialist, it is your responsibility to obtain the referral from your primary care physician.
It is your responsibility to notify us of any insurance coverage changes.

MANAGED CARE REFERRALS
If you are enrolled in a managed care insurance plan (i.e. HMO or POS), your insurance carrier requires that you obtain a referral from your primary care physician (PCP) before receiving services. We will work with your PCP to obtain that referral, however, services received without a referral or proper authorization will be your financial responsibility.

NON-CONTRACTED INSURANCE, INCLUDING AHCCCS/MEDICAID
Palo Verde Plastic Surgery is not contracted with all insurance companies, and none of the AHCCCS plans. Accordingly, we cannot provide services to patients with this type of coverage. If you are covered by and non-contracted or AHCCCS plan and choose to receive services from us, you are expected to pay privately for those services at the time of service. We will not submit claims to insurance companies we are not contracted with.

MISSED APPOINTMENTS/LATE CANCELLATIONS
Missed appointments represent a loss to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 48 hours in advance of the scheduled appointment. A $100.00 fee will be charged for a missed office procedure if you fail to notify us 48 hours prior to your appointment. Failure to pay cancellation/no show fees may result in denial to schedule an appointment until the amount due is paid in full. Excessive cancellations or missed appointments may result in discharge from the practice.

LAB AND PATHOLOGY
You may receive separate billing statements from an outside lab or pathologist for review of skin tissue removed or biopsied during your visit. These providers could have different arrangements with your insurance company that may lead to additional bills. Should you have questions regarding those bills, please contact their office directly.

FMLA/DISABILITYffIME OFF FORMS
There is a $25.00 fee for any FMLA/Disability/Time off forms that are requested from our office. A $10.00 fee will be charged for each additional form. Attorney fees may vary in price per request

Please sign below to indicate that you have read and agree to this financial policy.

Print Patient Name | Patient or Responsible Party Signature | Date

JOHN M. ROWLEY, M.D.
4545 E. Chandler Blvd. Suite 110
Phoenix, AZ 85048
480-759-3001 phone 480-759-1341 fax

Acknowledgment of Receipt of Privacy Notice

Original to be maintained in patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient or legally authorized individual signature	Date
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)

Original Effective Date: December 1, 2003
Effective Date of Last Revision (if any): _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PRIVATE HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS TJUS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This office is required by a federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice. The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of use of your health information for <u>treatment</u> purposes are:

During the course of your treatment, the physician determines he will need to consult with another specialist in the area, He will share the information with such specialist and obtain his/her input.

Example of use of your health information for <u>payment purposes:</u>

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests health information from us regarding medical care given. We will provide information to them about you and the care given, which may include copies or excerpts of your medical record, which are necessary for payment of your account. For example, a bill sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used.

Example of use of your health information for <u>health care operations</u>:

We obtain services from our insurers or other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical transcription, medical review, legal services, and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.

<u>Your Health Information Rights</u>

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office-we are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office; Request that you be allowed to inspect and copy your medical record and billing record you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it, to our office using the form we provide to you upon request. (We are not required to make such amendments);
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include uses and disclosures of information for treatment, payment, or health care operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; or to family members or friends or uses relevant to that person's involvement in your care or in payment for such care; or uses or disclosures to notify family or others responsible for your care of your location, condition, or your death; we may charge a cost-based fee for more than one accounting in a 12-month period.
- Request that confidential communication of your health .information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you wish to exercise any of the above rights, please contact our ***Office Manager***, in person or in writing, during normal business hou·rs and she will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the acknowledgment authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

<u>Our Responsibilities</u>

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

<u>To Request Information or File a Complaint</u>

If you have questions, would like additional information, want to report a problem regarding the handling of your information, or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact our ***Office Manager***. You may also file a complaint by mailing it or Emailing it to the Secretary ofHealth and Human Services.

- We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office,
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses We Can Make Without Your Written Authorization

Notification of Family/Friends

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family/Friends

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief

- We may use and disclose your health information to assist in disaster relief efforts.

Employers

We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute an authorization for the release of that information to your employer.

Deceased Persons

We .may disclose your health information to funeral directors, medical examiners, or coroners consistent with applicable law to allow them to earl}' out their duties. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Appointment Reminders, Marketing, and Treatment Alternatives

We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you, We will not disclose your health information without your written authorization.

Food and Drug Administration (FDA)

- We may disclose to the FDA your health information relating to adverse events with respect to food, supplements, products, and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' Compensation.

Public Health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse, Neglect & Domestic Violence

- We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.

Sign-in Sheet

- We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Inmates

- If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime on our premises; to report a crime in emergencies, and other appropriate situations permitted by law.

Health Oversight

- We may disclose your health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, with your authorization, discovery request, or other lawful processes if certain specific requirements are met.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

We may disclose your health information for specialized government functions as authorized by Jaw such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses

- Other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided in this Notice.

Website

- If we maintain a website that provides information about our office, this Notice will be on the website.

Research

- We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Fund Raising

- We may contact you as part of a fundraising effort. If you do not want to receive these materials notify our Privacy Officer.

Original Effective Date: December I, 2003

Effective Date of Last Revision (if any): _____