ADVANCED Plastic Surgery Center
1615 PETROGLYPH POINTE
PRESCOTT, ARIZONA 86301
928-777-0200

Billing Procedures

- All Co-Payments, Self Pay as well as Cosmetic Consult fees are due at the time of service. If you are unable to make this payment the day of your appointment please speak with our billing department prior to you consultation.
- Valid insurance information is required at the time of service. If you are unable to provide a copy of your current insurance card, you will be listed as self pay until you provide a copy of your insurance card. We request you provide current insurance information within 5 days of the date of service.
- All insurance companies have a timely filing limit for claims. Failure to provide correct insurance information in a timely manner to our office will result in patient/guarantor responsibility for the claim(s). Due to filing limits, we will no longer accept new insurance information for a previous service after 45 days. It will be the responsibility of the patient/guarantor to pay the claim and seek reimbursement from the insurance carrier.

OFFICE PAYMENT POLICY

- We are committed to providing you with the best possible care. Your clear understanding of our payment policy is important to our professional relationship. We, therefore encourage you to speak with us regarding any questions you might have about our fees and your financial obligations.
- It is important that you understand that you health insurance and/or you managed care plan are a contract between you and the insurance carrier. We are not a party to this contract. We provide services to you the patient, not to the insurance company. The insurance company is responsible to you, the patient, and you are responsible to the doctor.
- If your insurance carrier does not pay the account within three months after we have rendered service, you will be responsible for the payment in full. If you have not met your deductible, YOU, THE PATIENT, ARE RESPONSIBLE FOR THE DEDUCTIBLE PAYMENT AMOUNT.
- Please inform our staff of the type of insurance you have. ALWAYS bring your insurance card with you for your scheduled visit. If your insurance policy is in your spouse's name, please inform us.
- It is YOUR responsibility to bring in the authorization or referral form from your insurance or primary care physician. YOU ARE RESPONSIBLE FOR THE CO-PAYMENT AMOUNT.
- If you have MEDICARE, you are responsible for the deductible as well as the co-payment. If you have a senior care supplement coverage plan, we will file the claim with you insurance carrier.
- We accept cash, personal checks, Visa, and MasterCard. THIS RELEASE AUTHORIZES Mark D. Fetter, M.D. TO RELEASE ANY INFORMATION REQUEST TO MY INSURANCE CARRIER.
- I HEREBY AUTHORIZE PAYMENT DIRECTLY TO Mark D. Fetter, M.D. FOR THE MEDICAL BENEFITS FOR SERVICES PROVIDED
- I HEREBY AUTHORIZE PHOTOCOPIES OF THIS FORM TO BE VALID AS THE ORIGINAL

Insured/Authorized Person's Signature _____Date: _____

ADVANCED Plastic Surgery Center
1615 PETROGLYPH POINTE
PRESCOTT, ARIZONA 86301
928-777-0200

A Patient's Bill of Rights

It is recognized that a person relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. Medical Care. The right to quality care and treatment consistent with available resources and generally accepted standards. The patient has the right to refuse treatment to the extent permitted by law and government regulations, and to be informed of the consequences of his/her refusal.
2. Respectful Treatment. The right to considerate and respectful care, including effective pain management, with recognition of his/her personal dignity.
3. Privacy and Confidentiality. The right, within the law and military regulations, to privacy and confidentiality concerning medical care.
4. Identity. The right to know, at all times, the identity, professional status, and professional credentials of health care personnel, as well as the name of the health care personnel, and the name of the health care provider primarily responsible for his/her care.
5. Explanation of Care. The right to an explanation concerning his/her diagnosis, treatment, procedures, and prognosis of illness in terms the patient can be expected to understand. When it is not medically advisable to give such information to the patient, the information should be provided to appropriate family members.
6. Informed Consent. The right to be advised in non-clinical terms of information needed to make knowledgeable decisions on consent or refusal for treatment. Such information should include significant complications, risks, benefits, and alternative treatments available.
7. Research Projects. The right to be advised if the facility proposes to engage in or perform research associated with his/her care or treatment. The patient has the right to refuse to participate in any research projects.
8. Safe Environment. The right to care and treatment in a safe environment.
9. Medical Treatment Facility (MTF). The right to be informed of the facilities' rules and regulations that relate to patient or visitor conduct. The patient should be informed about smoking rules and should expect compliance with those rules from other individuals. Patients are entitled to information about the mechanisms for the initiation, review, and resolution of patient complaints.
10. Pediatric Considerations. Pediatric patients will be provided the same rights to medical care, respectful treatment, confidentiality, and a safe environment and privacy. Parents/legal guardians will be afforded the right to be informed of the identity of health care personnel, an explanation of care, including diagnosis, treatment and prognosis, and the right to refuse treatment for the patient to the extent permitted by law.

Responsibilities

1. Providing Information. The responsibility to provide, to the best of his/her knowledge, accurate and complete information about past illness, hospitalizations, medications, and other matters relating to his/her health. A patient has the responsibility to let his/her primary health care provider know whether he/she understands the treatment and what is expected of him/her.
2. Respect and Consideration. The responsibility for being considerate of the rights of other patients and health care personnel and for assisting in the control of noise, smoking, and the number of visitors. The patient is responsible for being respectful of the property of other persons and of the facility.
3. Compliance with Medical Care. The responsibility for complying with the medical and nursing treatment plan, including follow-up care, recommended by health care providers. This includes keeping appointments on time and notifying the facility when appointments cannot be kept.
4. Medical Records. The responsibility for ensuring that medical records are promptly returned to the medical facility for appropriate filing and maintenance when records are transported by the patients for the purpose of medical appointments or consultation, etc.
5. Pediatric Considerations. Parents/legal guardians have the same responsibility to provide medical information concerning the patient's illness, to be respectful and considerate of other patients and health care personnel, and to assist in reinforcing compliance by children with the treatment plan recommended by health care personnel. Parents/legal guardians and children are expected to abide by same rules and regulations, and to promptly bring concerns or observations about changes in the patient's condition to the attention of medical or nursing staff. Parents/legal guardians are expected to visit their children on a regular basis to provide emotional support.
6. Reporting of Patient Complaints. Patient's recommendations, questions, or complaints should be reported to the Patient Contact Representative. Please address any grievances or complaints to Krissi D. Office Manager/Advanced Plastic Surgery Center/1615 Petroglyph Pointe Dr/Prescott, AZ 86301 Phone: 928-777-0200

To file a complaint with your State Agency Contact: Center for Medicare & Medicaid Services HIPAA TCS Enforcement Activities/Complaint Submission

P.O. Box 8030
Baltimore, MD 21244-8030

For patients with Medicare Contact your Medicare Beneficiary Ombudsman at www.azleg.gov/ombudsman/defualt.asp PH: (602) 277-7292 or (800) 872-2879

Patients Responsibility

It is the patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur. The patient is expected to follow up on his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels is necessary.

Patient Signature _____Witness_____Date: _____

ADVANCED Plastic Surgery Center
1615 PETROGLYPH POINTE
PRESCOTT, ARIZONA 86301
928-777-0200

Health History

Patient Name: _____ Ht. _____ Wt._____ Date of Birth: _____

PRIMARY CARE DOCTOR: _____

1.) Do you have or have you had: Please Circle

Asthma	Bronchitis	Emphysema	Pneumonia	Anemia	Bleeding Disorder	Arthritis
Clotting Disorder	Heart Attack	Heart Disease	Seizures	Thyroid	HIV/AIDS	Breast Cancer
Hypertension	Stroke	Skin Cancer	Glaucoma	Diabetes (Type I or 2)		Hepatitis
Lung Cancer	Congestive Heart Failure		Renal Failure	Rheumatoid Arthritis		Depression
COPD	Anxiety	Cough/Cold	Fibromyalgia	Sleep Apnea		Chronic Back Pain

2.) Surgical History: PLEASE LIST ALL SURGICAL PROCEDURES

Surgery: _____ Year: _____ Surgery: _____ Year: _____

Surgery: _____ Year: _____ Surgery: _____ Year: _____

Surgery: _____ Year: _____ Surgery: _____ Year: _____

Surgery: _____ Year: _____ Surgery: _____ Year: _____

3.) Circle your answer to each of the following questions:

- Are you presently under a physician's care? Yes or No
- If so, for what condition? _____
- Have you been hospitalized in the past 5 years? Yes or No
- If so, for what reason? _____

4.) Circle any of the following to which you are ALLERGIC

Local Anesthetics Aspirin Penicillin Codeine Morphine Sulfa Vicodin

Other: _____

5.) Are you a smoker? Yes or No Frequency? _____

ADVANCED Plastic Surgery Center
1615 PETROGLYPH POINTE
PRESCOTT, ARIZONA 86301
928-777-0200

6.) Have you or your family ever experienced any problems associated with general anesthesia? Yes or No

7.) If so, explain _____

8.) Is there any information, not given above, which you think is important for proper health care treatment in your case? _____

9.) Medications :

Drug Name	Dose	Frequency

10.) Are you right handed or left handed? (Please Circle) RIGHT LEFT

11.) Recreational Drugs: (Please Circle) Never Now In Past

12.) IV Street Drugs: (Please Circle) Never Now In Past

13.) Alcohol Use: (Please Circle) Never Used Occasional Use Every Day Use

14.) Latex Allergy? (Please Circle) Yes No

15.) Preferred Pharmacy: _____ Location: _____

16.) Specialists (Seen Regularly)

Specialty:	Doctors Name:
Cardiologist	
Pain Management	
Rheumatologist	
Pulmonologist	
Ophthalmologist	

Patient's Signature: _____ Parent or Guardian _____

ADVANCED Plastic Surgery Center

1615 PETROGLYPH POINTE
PRESCOTT, ARIZONA 86301
928-777-0200

PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME:	**LAST:**	**FIRST:**	**M.I.:**	**GENDER: (CIRCLE ONE)**	**M / F**

SSN:	DATE OF BIRTH:	AGE:	TODAYS DATE:

TELEPHONE NUMBERS:	HOME:	CELL PHONE:	EMAIL:

ADDRESS:	CITY:	STATE:	ZIPCODE:

MARITAL STATUS: (CIRCLE ONE)	SINGLE	MARRIED	WIDOWED	DIVORCED

RACE: (CIRCLE ONE)	CAUCASIAN	AFRICAN AMERICAN	HISPANIC	ASIAN	OTHER:

OCCUPATION:	EMPLOYER:
PRIMARY CARE PHYSICIAN:	TELEPHONE NUMBER:

WOULD YOU LIKE YOUR RESULTS SENT TO YOUR FAMILY DOCTOR: YES / NO (CIRCLE ONE)

REFERRING PHYSICAN:	TELEPHONE NUMBER:
PREFERRED PHARMACY:	LOCATION:

(PLEASE NOTE THIS IS WHERE ANY PRESCRIPTIONS PRESCRIBED BY DR. MARK FETTER WILL BE TRANSMITTED ELECTRONICALLY)

PRIMARY INSURANCE INFORMATION:

INSURANCE COMPANY:	ID NUMBER:	GROUP NUMBER:
POLICY HOLDER'S NAME:	DATE OF BIRTH:	SSN: RELATION:
ADDRESS:	CITY:	STATE: ZIPCODE:

SECONDARY INSURANCE INFORMATION:

INSURANCE COMPANY:	ID NUMBER:	GROUP NUMBER:
POLICY HOLDER'S NAME:	DATE OF BIRTH:	SSN: RELATION:
ADDRESS:	CITY:	STATE: ZIPCODE:

I UNDERSTAND THAT THE OFFICE VISIT CHARGES ARE PAYABLE ON THE DAY OF SERVICE RENDERED. I AUTHORIZE MARK D. FETTER MD TO BILL MY INSURANCE COMPANY. REGARDLESS OF INSURANCE COVERAGE, I AM RESPONSIBLE FOR ALL BILLS BEING PAID IN A TIMELY MANNER. I UNDERSTAND THAT MY CONTRACT IS BETWEEN MARK D. FETTER MD AND MYSELF.

PRINT NAME:	SIGNATURE:	DATE: