JOHN B. FASANO, M.D. PLASTIC AND RECONSTRUCTIVE SURGERY

PATIENT INFORMATION

Last Name:_____ First Name:_____ Mi:____

Address:_____City:_____State:_____Zip:_____

Soc Sec #:_____Sex:_____Date of Birth:_____ Age:_____

Home Phone:_____Can we leave a message at this number:_____

Cell Phone:_____E-Mail address:_____

Marital Status: S___ M___ D___ W___ Occupation:_____

Employer:_____ Employer Address:_____

City:_____State:_____Zip:_____Phone:_____Ext:_____

Parent or Insured 's Name (if different from above):_____

Soc Sec #:_____Date of Birth:_____

Employer:_____Phone:_____

Employer Address:_____ City:_____State:___Zip:_____

Who referred you to us ?_____

Who may we contact in an emergency ?_____

Pharmacy Name & Location: _____

INSURANCE

We will need to copy your insurance card(s). If you do not have them, please fill in the following:

Primary:_____Secondary:_____

Address:_____Address:_____

City:_____State:___Zip:_____City:_____State:___Zip:_____

Phone:_____Phone:_____

ID Number:_____ID Number:_____

I will be paying today by: cash:_____check:_____credit card:_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge, and I will notify you of any changes in the above information.

Signature:_____Today's Date:_____

(Parent must sign if patient is a minor)

MEDICAL INFORMATION

Today's Date:_____Reason for today's visit:_____

Have you seen any other physician for this problem? _____

DRUG ALLERGIES: _____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE ON A REGULAR BASIS_____

_____

_____

Height _____Weight _____ Bra Size _____

DAILY INTAKE: Tobacco_____Alcohol_____Coffee_____Aspirin_____Insulin_____Steroids_____

MEDICAL HISTORY: DIABETES_____PACEMAKER____HEPATITIS____HIGH BLOOD PRESSURE____
ARTIFICIAL JOINT (S) ____PROLONGED BLEEDING ____ BLOOD TRANSFUSIONS ____
HISTORY OF MRSA ____MITRAL VALVE PROLAPSE___ PREGNANT _____ HIV____ __ _____

Please list all medical problems, past and present:_____

_____

_____

SURGICAL HISTORY: PLEASE LIST ALL OPERATIONS AND YEAR

_____

_____

FAMILY HISTORY: _____

_____

HAVE YOU OR ANYONE IN YOUR FAMILY EVER HAD A BAD REACTION TO LOCAL OR GENERAL ANESTHETIC?_____

Who is your primary physician?_____Phone: _____

Assignment of Benefits / Consent for Treatment / Release of Medical Information

I hereby authorize payment to be made directly to John B Fasano, Md of all benefits payable to me under the terms of my insurance contract with respect to professional services, including authorized Medigap benefits. Our office charges $25.00 for any returned check. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I also understand that I am financially responsible for any outside laboratory services rendered; this applies to any services that are not covered by my insurance company. This assignment will remain in effect unit revoked by me in writing, and I permit a copy of this authorization to be used in place of the original. I further authorize the release of any pertinent medical information regarding services rendered.

IPatient Signature:_____Date:_____

(Parent must sign if patient is a minor)

John B. Fasano, M.D., F.A.C.S.

Plastic & Reconstructive Surgery
509 Riverside Dr., Ste 206, Stuart, FL 34994
Tel(772)221-9111 Fax(772)781-0909

NOTICE OF PRIVACY PRACTICE

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

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU FOR TREATMENT

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other health care providers may be part of you medical care outside this office and may require information about you that we have.

FOR PAYMENT

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service your received here so your health plan will pay us or re-imbruse you for the service. We may also tell you health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

FOR HEALTH CARE OPERATIONS

We may use and disclose health information about you in order to run the office and make sure that you and other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

APPOINTMENT REMINDERS

We may contact you as a reminder that you have an appointment for treatment or medical care at this office.

TREATMENT ALTERNATIVES

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

HEALTH RELATED PRODUCTS AND SERVICES

We may tell you about health related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health related products and services. If you advise us in writing (at the address listed at the top of this notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes. You may revoke you consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time. If you do revoke your consent, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may us or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To avert a serious threat to health or safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or

the health and safety of the public or another person.

Required by Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and tissue donation

If you are in an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplant or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers Compensation

We may release health information about you for workers' compensation or similar programs.

Public health risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health oversight activities

We may disclose health information to health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroner, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information not personally identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and friends

We may disclose health information about you to your family members or friends if we obtain your agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family and friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is being discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in you care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on you progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that is in your best interest to allow another person to act on you behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than identified in the previous sections with out your written Authorization. We must obtain you Authorization separate from any Consent we may have obtained from you. If you give us authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke you authorization, we will no longer use of disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. If we have HIV or substance abuse information about you, we can not release that information with out a special signed, written authorization (different that the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have both your signed Consent and a special written Authorization that complies

with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to inspect and copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our privacy official in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to in certain circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to our privacy official. We may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an accounting of disclosures

You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you for the purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to our privacy official. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to request restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request

If we do not agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to our privacy official. We will not ask you the reason for your request.

Right to request confidential communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to our privacy official. We will not ask you the reason for your request. We will accommodate all reasonable request. Your request must specify how or where you wish to be contacted.

Right to paper copy of this notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our privacy official.

Changes to this notice

We reserve the right to change this notice, and to make revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the tip right hand corner. You are entitled to a copy of the notice currently in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our privacy official. You will not be penalized for filing a complaint.

PLEASE SIGN THIS PAGE :

John B. Fasano, M.D., F.A.C.S.

Plastic & Reconstructive Surgery
509 Riverside Dr., Ste 206, Stuart, FL 34994 Tel(772)221-9111 Fax(772)781-0909

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I agree that health information obtained by John B Fasano, MD may be disclosed to family members(specify if necessary:_____), legal representatives, and other doctors, nurses, technicians,office staff or other health care personnel who are or may become involved in your care and treatment. I have reviewed/received a copy of John B. Fasano's Notice of Privacy Practices.

_____ _____

Patient Name/Signature of Patient/Guardian ***Date***

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Office Personnel:_____ *Date:_____*

Reason:_____