WILLIAMSBURG PLASTIC SURGERY
JOHNSTUART M. GUARNIERI, M.D.
American Society of Plastic Surgery

Patient's Full Name ____
Date of Birth ______/_____/______ Age ______ Male_____ Female_____ Social Security # _____________________
Driver License #/ State _______________________________________ Marital Status _____________________________
Address____
Street City State Zip
Home Telephone # (______)__________________________ Cell Phone # (______)_______________________________
Email Address ____
Patient's Employer _________________________________ Work Telephone # (______)__________________________
Spouse's Name ____________________________________ Spouse's Employer_________________________________

How did you hear about us? ____

Is this visit: The result of an accident? Y / N Motor vehicle related? Y / N Work related? Y / N

Nearest Relative/ Friend ***not*** living with you: Name/Relationship ______________________________
Address ______________________________
Phone Number______________________________

Person to Notify in Case of Emergency: Name/ Relationship ______________________________
Phone Number ______________________________

Primary Care Physician: Name ______________________________
Address ______________________________
Phone Number ______________________________

Primary Insurance: Company _________________________ Address ______________________________
Phone Number _____________________ Policy # ___________________ Group #______________
Insurer's Name _____________________ Insurer's SSN _______________ Relationship ___________

Secondary Insurance: Company _________________________ Address ______________________________
Phone Number _____________________ Policy # ___________________ Group #______________
Insurer's Name _____________________ Insurer's SSN _______________ Relationship ___________

I authorize the release of information to the insurance company(s) named above as well as my referring / primary care physician and request that payments of medical benefits be paid directly to WPS. I understand that I am responsible for any balance left unpaid by my insurance company. I understand and agree that WPS obtaining insurance proceeds from my insurance company is a gratuity only and I agree to make payments myself if my insurance does not pay within a reasonable amount of time. If collection procedures are required and instituted against me, I agree to pay all the costs of collection including, but not limited to, the 33 1/3% attorney fees for obtaining an unpaid balance and 18% interest per annum from the due date of the bill. I also understand that I will be responsible for getting referrals to WPS and agree to pay any balance denied by my insurance company(s) for not having a referral.

Signature ____**Date** ______________________________

Reason for Consultation (in your own words, what is it that that you would like to see changed and in what way?)

____

____

____

Desire for Cosmetic Enhancement? Y / N What type? ______________________________

Desire for Dermal Fillers? Y / N Type? Botox Juvederm Restylane Scupltra Interested in Latisse? Y / N

Height _____ft. _____in. Weight _____lbs. My normal weight is _____lbs. Last time at this weight ____________

Allergies or Intolerance to Medications ______________________________

Medications taken daily, including name, dosage, and length of time ______________________________

____

____

Over the Counter Medications taken regularly, including aspirin, diet pills, sleeping pills, vitamins, herbs, etc. __________

____

____

____

Drug Dependence Y / N Alcohol Dependence Y/ N

Previous Surgery ______________________________

____

Anesthesia Problems (*nausea/ vomiting, slow to wake up, high temperature*) ______________________________

____

Past Hospitalizations (*please include childbirth*) ______________________________

____

____

Have you ever had?

Hepatitis/ Jaundice Yes _____ No _____ Any recurrences? When? ______________________________
Epilepsy/ Seizures Yes _____ No _____ Thyroid Problems Yes _____ No _____
High Blood Pressure Yes _____ No _____ Ulcers Yes _____ No _____
Heart Disease Yes _____ No _____ Migraines Yes _____ No _____
Heart Attack Yes _____ No _____ Cold Sores Yes _____ No _____
Mitral Valve Prolapse Yes _____ No _____ Stroke Yes _____ No _____
Prior Blood Transfusion Yes _____ No _____ Diabetes Yes _____ No _____
Psychiatric Problems Yes _____ No _____ Kidney Problems Yes _____ No _____
Arthritis Yes _____ No _____ Anemia Yes _____ No _____ Currently? Y / N
Keloids Yes _____ No _____ Sexually Transmitted Disease Yes _____ No _____
Emphysema, Asthma, Shortness of Breath Yes _____ No _____
Abnormal Bleeding Yes _____ No _____ When ______________________________
Cancer Yes _____ No _____ Type ______________________________

Have you or any family member had any breast cancer? Yes _____ No _____
If yes, please explain ______________________________
Have you or any family member had any history of skin cancer including basal cell, squamous cell, or melanoma?
Yes _____ No _____ If yes, please explain (including who and location on the body) ______________________________

____

Date of Last Physical ___________________ Physician's Name _____________________ Finding ______________________
Date of Last EKG ______________________ Date of Last Blood Work _____________________
Do you drink alcohol? Yes _____ No _____ How much and how often? ____________________________________
Do you smoke? Yes _____ No _____ For how long? ______________ How many packs per pay? ____________
If you have stopped smoking, for how long have you quit? ____
Do you use any other tobacco products or use a nicotine patch? Yes _____ No _____ Type _________________________
Do you use recreational/ IV drugs? Yes _____ No _____ Type ____

Have you had any testing for the following?
Tuberculosis Yes _____ No _____ Date _______________ Results ______________________________________
HIV Yes _____ No _____ Date _______________ Results ______________________________________
Hepatitis Yes _____ No _____ Date _______________ Results ______________________________________

Condition of Teeth
Caps/ Dentures Yes _____ No _____ Problem Teeth ____

Female Patients Only
Are you pregnant? Yes _____ No _____ Date of Last Menstrual Period ___________________________________
Children (please include names and ages) ____

____
Did you breast feed? Yes _____ No _____ For how long? ____
How did your breasts change after breast feeding? ____
Breast Lumps Yes _____ No _____ Biopsies Yes _____ No _____ Results ____________________
Date of Last Mammogram _________________ Findings __________________ Location __________________________

The law in Virginia provides that whenever any person who is rendering health care services to a patient is directly exposed to the patient's body fluids in a manner that may, according to the current guidelines of the Center for Disease Control, transmit human immunodeficiency virus (AIDS) or Hepatitis B or C viruses, that patient will be deemed to have consented to testing for infection with the AIDS virus, Hepatitis B or C viruses. This means that that patient may be tested for infection with the AIDS virus, Hepatitis B or C viruses without actual consent but with knowledge. The results of this test will be released to the person who is exposed to body fluids, also without actual consent.

Photo Release: Medical photographs and/or video tapes may be taken before, during, and after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs and/or videotapes for a stated purpose, such as patient education, before and after gallery, and/or insurance requests.
I hereby authorize Dr. Johnstuart M. Guarnieri and his associates or licensees to take pre-operative, intra-operative, and post-operative photographs and/or videotapes. I additionally authorize photographs and/or videotapes of my interview.
I hereby authorize you to release my medical records to insurance companies.
This authorization will expire upon written request by the patient.

1.) The above information is current and correct to the best of my knowledge.
2.) If computer imaging is used in my evaluation, I understand that the alterations is purely for the purpose of illustration and discussion and in no way constitutes an expressed or implied warranty as to my final results and appearance.

Signature ____ **Today's Date** _____/_____/_____
(Relationship to Patient)

WILLIAMSBURG PLASTIC SURGERY
JOHNSTUART M. GUARNIERI, M.D.
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Patient Consent for Use and Disclosure of Protected Health Information

Effective Date: April 14, 2003

It is the policy of our practice that the physician and staff preserve the integrity and the confidentiality of the Protected Health Information (PHI) pertaining to our patients. The purpose of the policy is to ensure that our practice and its physician and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Our practice and its physician and staff will adhere to the standards set forth in the Notice of Privacy Practices.

I understand that I have the right to review and/or receive a copy of the Notice of Privacy Practices prior to signing this consent, or at any other time upon request.

With my consent, Williamsburg Plastic Surgery (WPS) may use and disclose PHI about me to carry out Treatment, Payment, and Healthcare Operations (TPO).

By signing the form, I am consenting to WPS use and disclosure of my PHI to carry out Treatment, Payment, and Healthcare Operations, in compliance with the Health Insurance Portability and Privacy Act of 1996 (HIPPA).

I may revoke this consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent.

____ ________________________

Patient's Printed Name **Social Security Number**

____ ________________________

Signature of Patient or Legal Guardian **Date**

Acknowledgement of HIPPA Privacy Practice for Williamsburg Plastic Surgery

We are required by law to maintain the privacy of and provide individuals with this notice of legal duties and privacy practice with respect to protected health information. If you have any objections to this form, please ask to speak to our HIPPA Compliance Officer in person or by phone at our main office number (757) 345-2275.

Your Signature below only acknowledges that you have reviewed and/or received this Notice of you Privacy Practices:

____

Patient's Printed Name

____ ____________________________

Patient's Signature **Date**

The following list involves the options available to you, as a patient, for us to contact you regarding your health information or appointment confirmation. Please circle yes or no and initial each option.

I would like to be contacted by phone for all health information and appointments and it is agreeable to me that a message may be left on my answering service or machine.

YES **NO** **Initials ______________**

It is agreeable to me that my health care provider may contact me by email regarding any health information and appointments.

YES **NO** **Initials ______________**

My email address is: ____

It is agreeable to me for messages regarding any of my health information and appointments to me left with family members that may answer calls at my home.

YES **NO** **Initials ______________**

If there are individuals that you absolutely DO NOT WISH to have any information regarding your health and appointments, please list them below. PLEASE WRITE OUT INDIVIDAL NAMES.

___________________________, __________________________, __________________________ **Initials _______**

It is agreeable to me for my health care provider to discuss my conditions and treatment with the following individual(s). Example: Spouse, Children. PLEASE WRITE OUT INDIVIDUAL NAMES.

___________________________, __________________________, __________________________ **Initials _______**

ARBITRATION AGREEMENT

BECAUSE OF THE HIGH COST OF MEDICAL INSURANCE AND LITIGATION, THIS OFFICE REQUIRES THAT EACH PATIENT SIGN AN ARBITRATION AGREEMENT WHICH REQUIRES THAT ALL POTENTIAL DISPUTES BE RESOLVED NOT IN A COURT BUT BY ARBITRATION. THIS AGREEMENT IS NECESSARY TO BE TREATED BY ME.

ARBITRATION MEANS THAT YOU WAIVE YOUR RIGHT TO A JURY TRIAL and agree instead to settle any dispute through arbitration by an arbitration company, association or group or by an arbitration panel chosen by the physician or his group. The arbitration company, association or panel chosen by the physician herein signed will consist of three to five independent medical doctors chosen by the Arbitration Company, association, group or panel. The cost of such arbitration shall be shared equally by each party. Notice of such a request for arbitration shall be registered mail to the physician involved stating the grievance in detail and monetary demand. If such demand is not met with mutual agreement between the party and the individual within 12 weeks the party making the request or demand will then proceed with the arbitration at the time and place named by the physician, the arbitration panel, group, or association.

ARBITRATION AGREEMENT:

Date: Month:_________/ Day:________/ Year:________

Between

Johnstuart M. Guarnieri, M.D. and _______________________________________ agrees as follows:

Arbitration: In the event of a dispute of any nature arising between the parties at any time as a result of Johnstuart M. Guarnieri, M.D., providing medical services, advice, treatment, informed consent, prescriptions, tests, procedures, and operations, whether in the office or the hospital, in consultation or otherwise: the parties here to agree to submit the dispute to binding arbitration under the conditions listed above.

An award rendered by the arbitrator(s), arbitration association, group, or panel shall be final, binding upon the parties, and judgment on such award may be entered by either party in the highest court having jurisdiction.

Each party hereto specifically waives his or her right to bring the dispute before a court of law and stipulates that this agreement shall be a complete defense to any action instituted in any local, state, or federal court or before any administrative tribunal.

By signing this agreement, I agree to arbitration and waive any preconditions I might have such as consultation with an attorney, and I understand this agreement and am signing with this understanding and of my own free will.

Patient's Name Printed ____

Patient's Signature____

FINANCIAL POLICY

THIS INFORMATION HAD BEEN PREPARED FOR YOUR BENEFIT. IT CONTAINS OUR POLICIES REGARDING INSURANCE, BILLING, AND PAYMENT OF OUR SERVICES.

- A HEALTH INSURANCE POLICY IS A CONTRACT BETWEEN THE BENEFICIARY (YOU) AND THE INSURANCE COMPANY. The Practice of Williamsburg Plastic Surgery is not a party to that contract. Our business office will file a claim (s) to your insurance company as a courtesy only.
- All charges incurred are the responsibility of the patient, whether the insurance company pays or not. Not all services are a cover benefit in all contracts. If you have such a plan, it is your responsibility to inform the personnel at the front desk so that any authorization may be obtained prior to your visit. Failure to inform the office personnel about specific requirements of your plan will result in your being billed for charges incurred.
- All co-pays must be paid the day of your appointment.
- If your policy has a yearly deductible which must be met prior to claims being paid, we will bill any amount applied to your yearly deductible to you as a courtesy. This is your responsibility to pay.
- Self-pay and non-covered benefits are payable at the time of your appointment. Cash, check, and credit cards are our acceptable methods of payment. Our practice credit terms are 30 days. Any balances remaining unpaid for more than 30 days will be referred for collection action where you may be responsible for additional collection fees.
- If you provide our office with a check which is returned for non-sufficient funds, you will be charged a $35.00 processing fee in addition to the amount of your check. We will contact you and request payment in full in cash, money order, or certified bank check with ten days. We **will** take further action if you fail to respond within the specified time.
- Our biller will follow up on any unpaid insurance claims. However, your policy is an agreement between you and your insurance company. It is your responsibly to assure that services provided to you are paid.
- Adults and teenage children who present themselves for treatment, but whose parents are assuming financial responsibility, must arrive with proper insurance information and must be prepared to pay their co-payment and for any non-covered services.
- A $50.00 service charge will be incurred by you for failure to keep your appointment. This service charge will not be covered by your insurance plan. It will be your personal responsibility.

________________________________ ________________________

Patient's Signature **Date**

____

Patient's Name Printed

________________________________ ________________________

WPS Employee/ Witness Signature **Date**

Medicare Signature on File

Name of Beneficiary ______________________ **Medicare #** ______________________

I request that payment of authorized Medicare benefits be made on my behalf to Williamsburg Plastic Surgery for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature ______________________ **Date** ______________________

Supplemental Signature on File

Name of Beneficiary ______________________ **Supplemental Policy #** ______________________

I request that payment of authorized Medicare Supplemental benefits be made on my behalf to Williamsburg Plastic Surgery for any services furnished to me by them. I authorize any holder of Medicare information about me to release any information needed to determine these benefits payable for related services.

Signature ______________________ **Date** ______________________