Greer Plastic Surgery

6101 Heisley Road
Mentor, OH 44060
(440) 974-8577

PATIENT INFORMATION

Date:			Primary care Physician:		
Patient's last name: First: Middle:			Marital status (circle one) Single / Married / Divorced / Separated / Widowed		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Social Security:		Home phone: ( )			
Cell Phone: ( )	Email: Would you like to receive our specials by email? ❑ Yes ❑ No				
Street Address:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone: ( )			
How did you hear about us?	❑ Referred by another physician	❑ Internet search	❑ Family or Friend		
❑ Newspaper Ad	❑ Radio Ad	❑ Yellow Pages	❑ Social Media	❑ Other	
Race (circle One): White Hispanic African American		Ethnicity (circle one): Hispanic Not Hispanic	Language:		
Preferred Pharmacy:	City:	Phone Number:			

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone: ( )	Work phone: ( )

CONFIDENTIAL COMMUNICATIONS

I request that all communications to me (by telephone, mail or otherwise) by Dr. Jennifer Greer be handled in the following manner:

For written communication, send to:	For oral communications, call:
	( )

If you are unavailable at this number, may we leave an answering machine or voice mail message?

❑ Yes ❑ No

Do we have permission to disclose your health information with another person other than yourself?

❑ Yes ❑ No

If yes, name:	Relationship:

Patient signature:	Date

Revised 8/13/2019

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REVIEW OF SYSTEMS (CIRCLE IF APPLIES)
General: Chills Fever Weight gain Weight loss
ENT: Sore throat
Respiratory: Chest pain Shortness of breath at rest
Breast: Breast Lump Breast Pain
Cardiovascular: Chest pain at rest Dizziness
Gastrointestinal: Diarrhea Nausea
Peripheral Vascular: Pain/Cramping in legs after exertion
Skin: Mole (s) Skin Cancer
Psychiatric: Depressed mood Difficulty sleeping
Cancer Self- Management: Use of sunscreen Yes No

MEDICAL HISTORY					
Are you under a physician's care now? ❑ Yes ❑ No				Reason:	
Please list any medications you are currently taking:					
Have you had trouble with prolonged bleeding after surgery? ❑ Yes ❑ No			If yes, please describe:		
Have you had an unusual or allergic reaction to any drug or anesthetic (such as penicillin?)					
Please circle if you have, or have had, any of the following conditions:					
Allergies	Asthma	Anemia	Arthritis	High Blood Pressure	Kidney or Liver disease
Diabetes	Pregnancy	Hepatitis	Seizure disorder	HIV/AIDS	Blood clots
Other:					
Please list any previous surgery:					
Please list any past hospitalizations:					
Tobacco use? ❑ Yes ❑ No If yes, how much?					
Alcohol Use? ❑ Yes ❑ No If yes, how much?					

CANCELLATION POLICY: To give all our patients the best possible care, please respect the time we allow for each appointment.

If you need to cancel your appointment, we ask that you cancel <u>at least 24 hours prior to the scheduled time</u>. You must notify our office within 24 hours of your appointment or you will be charged $25.00. This policy also applies to not showing up for your scheduled appointment.

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Statement of Patient Financial Responsibility and Release to Provide Personal Health Information

If you are not covered by a health plan, or fail to provide the information necessary for us to file a claim, you are expected to pay for your services at the time of your appointment or meet with our financial representative to make other arrangements.

Dr. Greer will need to disclose some of your Personal Health Information (PHI) to either Medicare or your insurance in order to obtain payment.

In addition, some charges may not be covered by your insurance, including your deductible, your copayment, and any services which are not considered medically necessary (i.e. cosmetic procedures). You will be responsible for these charges.

For each month a balance remains unresolved, you may be charged a late fee of up to 1.5%. The practice may use the services of a collection agency to pursue unresolved accounts.

I have read the above policy, and understand that I am responsible for paying for provided services. I also understand that my PHI may be released to Medicare or my insurance company to obtain payment and that payment will go directly to Jennifer Greer, M.D. LLC:

Signature: _____ Date: _____

Patient Consent for Use of Credit Card, Debit Card, and Financing – Disclosure of Protected Health Information

If you pay by credit card, debit card or financing, we may need to release your protected health information to credit card companies, banks, or financing companies in order to obtain your payment. By signing this form, you irrevocably consent to allow Jennifer Greer M.D. LLC to disclose your protected health information to any credit card company, bank, or financing company if they request this information to process your payment.

If you pay with a credit card, debit card, or third-party financing, you agree not to dispute the charges after services are provided. We encourage complete post-operative care and follow-up to address any issues that may arise.

_____ (initial) I agree not to dispute credit, debit, or financing card payments after services are provided. I understand that Dr. Greer encourages patient follow-up to address any issues.

_____ (initial) I agree that this agreement is irrevocable.

Signature: _____ Date: _____

Explanation of terms:

- "Protected health information": This means your name and address. Credit card companies usually request this information to process a payment, and we cannot legally give them even your name without your permission.
- "Irrevocably consent": In general, you have the right to revoke our permission to release protected health information, e.g.if you initially wanted us to release records to another office, but changed your mind. In this particular instance, if you do not allow us to release your name to your credit card company, we cannot process your payment. This protects us from patients giving us a payment by credit card, then not allowing us to process the payment.
- "Agree not to dispute charges": There have been very rare instances where a patient pays for a cosmetic procedure with a credit card, then attempts to dispute the charge. If you are unhappy with any treatment, we encourage you to let us attempt to resolve the issue first. This does not give us the right to charge your credit card without your permission.

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We understand that legally required paperwork is long and confusing, so we have provided this summary for you. You may request the full form at any time, and it is also available at www.greerplastics.com.

Summary of Notice of Privacy Policy

We collect personal health information such as your name, address, and social security number in the course of your treatment. We are required by law to protect this protected health information (PHI), and explain how it may be used.

When can we disclose your PHI?

- Without your consent- for treatment purposes such as labs or x-rays, or to obtain payment
- As required by law- if it is a public health issue, in cases of abuse, for workers' compensation and certain other cases
- With your specific authorization- for any other instance, we cannot release your PHI without your permission.

What are your rights regarding your information?

- You can request restrictions on the use or disclosure of your PHI
- You have the right to receive confidential communications
- You have the right to inspect and copy your PHI
- You have the right to amend or change your PHI
- You have a right to receive a list of when and where your PHI was disclosed

Complaints:

You may file a complaint if your privacy rights have been violated. Please contact our privacy officer, Deborah Lawson, at office.manager@doctor .com. Please refer to the full Notice of Privacy Policy for further details.

I have read the information above, and I understand that Greer Plastic Surgery is required by law to provide me with this information. I also understand that I may request a full copy of the Notice of Privacy Practices at any time.

Signature: _____ Date: _____

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Photographic Consent

I understand that photographs will be taken before, during, and after my procedure(s) as a routine part of my medical care. I further understand that these photographs will be kept strictly confidential. I authorize Dr. Jennifer Greer or a representative to take photographs of me for medical purposes to be used for my care; insurance predeterminations; and examination, testing, credentialing and certification purposes by the American Board of Plastic Surgery Inc. **These photos will never be used in for marketing unless you sign a separate release allowing us to use them.**

Signature: _____ Date: _____

Would you like to learn more about any of the following services at a future visit?

☐ CoolSculpting (noninvasive fat removal)
☐ Laser Hair Removal
☐ Skin care products and treatments
☐ Laser treatments for younger skin
☐ Nonsurgical options to treat fine lines and wrinkles

Cosmetic Surgery of the:

- ☐ Eyes
- ☐ Breasts
- ☐ Face
- ☐ Stomach/waist
- ☐ Other: _____