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
Former name, if applicable:	Birth date: / /	Age:	Sex: ❑ M ❑ F ❑MTF ❑FTM
Home phone: ( )		Cell Phone: ( ) Would you like to receive text reminders for your appointments? ❑ Yes ❑ No	
Email Address:		Would you like to receive emails regarding new treatments, specials, and events at Greer Plastic Surgery? ❑ Yes ❑ No	
Street Address:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone: ( )	

How did you hear about us?

❑ Newspaper Ad	❑ Facebook Ad	❑ Internet search	❑ Other ______________________
❑ Referred by physician	❑ Social Media	❑ Family or Friend ______________________________________	

*** Preferred Pharmacy: City: Phone Number:

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 a 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 10/5/2022

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MEDICAL HISTORY		
Are you able to walk up a flight of stairs without getting out of breath?	❑ Yes	❑ No
Do you have a history of high blood pressure?	❑ Yes	❑ No
Do you have a history of kidney disease?	❑ Yes	❑ No
Do you have a history of liver disease?	❑ Yes	❑ No
Do you have a history of blood clots in your legs or arms? (DVT)	❑ Yes	❑ No
Do you have a history of an autoimmune disorder such as lupus, RA, or Crohn's?	❑ Yes	❑ No If yes, what type?
Do you have a history of diabetes or high blood sugars?	❑ Yes	❑ No
If yes, what was your most recent hemoglobin A1c?		
Do you have a history of cancer?	❑ Yes	❑ No
If yes, what kind of cancer?		
Have you had trouble with prolonged bleeding after surgery?	❑ Yes	❑ No
Have you been hospitalized in the past year?	❑ Yes	❑ No
If yes, what for?		
Please list any medications you are currently taking:		
Please list any medications you are allergic to:		
Please list any previous surgery:		
Please list any past hospitalizations:		
Tobacco, vaping, or nicotine 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>. If you have missed a scheduled appointment without cancelling 24 hours in advance, we will require a $100 deposit to schedule any future appointments for non-surgical treatments. This deposit will be used toward the treatment, but if you miss your appointment without cancelling 24 hours in advance the deposit is forfeit.

__________ I understand the cancellation policy.
initials

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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 Dr. Greer, at jgreer@greerplastics.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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**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 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**

We encourage complete post-treatment care and follow-up to address any concerns that may arise. We ask you to bring any concerns to us before resorting to filing a dispute with your credit card, debit card, or financing company.

If you do file a dispute, we may need to release your name, address, date of birth, and the dates you were treated to credit card companies, banks, or financing companies in order to obtain your payment. By signing this form, you consent to allow Jennifer Greer M.D. LLC to disclose this information, if requested.

_________ (initial) I agree to bring any concerns up with Dr. Greer and her team prior to disputing charges with my financing company or debit or credit card company.

_________ (initial) I understand that my credit card, debit card, or financing company may request some of my protected health information regarding my treatment with Dr. Greer.

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 and for examination, testing, credentialing, education, 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: ____________