Washington Plastic Surgery Group, L.L.C.

Barry J. Cohen, M.D., P.C. Adam G. Tattelbaum, M.D., P.C. Bennett C. Yang, M.D., P.C. Frederick H. Watkins, M.D., P.C.

****Required Information****

*** PATIENT'S FIRST NAME (Nombre) MIDDLE INITIAL LAST NAME (Apellido)**

*** STREET ADDRESS(Direccion)**

*** CITY (Ciudad) * STATE (Estado) * ZIP (Codigo Pasta)**

***Social Security Number (Seguro Social #):_____ *Date of Birth (Fecha de Nacimiento):_____/_____/_____**

***Primary Insured Members SSN#_____ *Primary Insured Members Date of Birth :_____/_____/_____**

***Age (Edad):_____ Sex: __M / F Marital Status: __Married / Single__ * Date of Injury: _____/_____/_____**

***(_____)_____ (_____)_____ (____)_____**

Home Phone Number (de Telefono de Su Hogar): Work Phone (Trabajo): Cell Phone Number (Numero de celular):

Email Address: _____ Can we contact you via email: Yes / No

Would you like to receive information on activities & events through e-mail Yes / No

Employer(Compania):_____Referredby: (Refererricial)ER,Internet,Friend,etc: _____

Primary Care Physician:_____ Phone # ( )_____

Should you elect to receive surgical treatment from this office, it will be necessary for us to receive a copy of your most recent physical examination from your primary care provider to ensure the completeness and accuracy of the medical records we maintain for you in this office

***Emergency Contact Name:_____ Relationship to patient:_____ Phone #_____**

***Reason for Office Visit: Please specify injury and affected area. If cosmetic, specify procedure(s)**

PRIMARY INSURANCE Company Name and Address **(_____)_____ Phone Number**

Primary Insurance Policy or I.D. Number:_____ GroupNumber:_____

SECONDARY INSURANCE Company Name and Address **(_____)_____ Phone Number**

Secondary Insurance Policy or I.D. Nmber:_____ GroupNumber:_____

Spouse/Parents Name (Responsible Party):_____ Phone Number: (_____)_____

****IF WORKER'S COMP**:**

Employer (Compania): _____ Work # (Trabajo): (_____)_____

Work Address: _____ Date of Injury: _____/_____/_____

_____ Point of Contact: _____

Claim Number: _____

****IF THIS IS AN ATTORNEY CASE**:**

Attorney Name: _____ Phone Number: (_____)_____

Attorney Address: _____

_____

I hereby authorize Drs. Cohen, Tattelbaum, Yang and Watkins of the Washington Plastic Surgery Group, L.L.C. to bill my insurance Company for service of rendered to me and/or my family. I understand that these payments are made directly to the doctor. I understand that this in no way relieves me of my primary responsibility to pay for services to me (or my minor child). I understand and agree that interest of 1.5% per month (18% annum) will be added as a late charge for any account not paid within 30 days of when the balance is due. If my account is referred to an attorney for collections I agree to pay any reasonable legal fees (25% is deemed reasonable), court costs, and other collection expenses. I certify that the information provided about my Insurance Company is correct I authorize the release of medical information requested by my Insurance Company. A copy of this form can be sent to my Insurance Company in lieu of a signature when necessary. I am responsible for the balance after the insurance payment.

* _____ * _____ * _____

SIGNATURE of Responsible Party **PRINT** Responsible Party Name Here Date

WASHINGTON PLASTIC SURGERY GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices for Washington Plastic Surgery Group, LLC.

PLEASE PRINT: Patient _____

PLEASE SIGN: Patient/ Legal Representative: _____

If signed by legal representative, relationship to patient: _____

DATE: _____

My signature below constitutes my acknowledgement that I have been informed of the insurance policy for Washington Plastic Surgery Group. I have read and agree to the terms below.

W.P.S.G. only participates with non- HMO Virginia and Maryland Medical Assistance. We do not participate with HMO's or commercial PPO's. However, we will be glad to assist you by submitting a bill to your insurance company. Whatever portion your insurance company denies is your responsibility. Should you have any questions or concerns please feel free to speak with a representative in our billing department.

PLEASE PRINT: Patient: _____

PLEASE SIGN: Patient/ Legal Representative: _____

If signed by legal representative, relationship to patient: _____

DATE: _____

WASHINGTON PLASTIC SURGERY GROUP
HISTORY & PHYSICAL

Name _____

Address _____

Phone _____DOB _____ Age _____

□ Single □Married □Div/Sep Occupation _____

Sex: _____ Hgt: _____ Wgt: _____

BP: _____ HR: _____ RR: _____

SaO2: _____Temp: _____

Do you smoke? □Yes □No How often? _____ Packs/day: _____

Alcohol use? □Yes □No Frequency? _____ Type: _____

Recreational Drug use? □Yes □No Frequency? _____ Type: _____

Current Medication: Include name, Over the Counter, ASA, Ibuprofen, Herbal medications, Diet Pills and Vitamins, dosage and frequency:

Medication	**Dosage**	**Frequency**	**Medication**	**Dosage**	**Frequency**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Vitamins			**Over the Counter Pain Medications**		
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies (include latex - please list):

Allergy	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries & Procedures (include year):

_____

_____

Past Medical History (*please circle positive history*):

Blood Disease:
Anemia, Leukemia, Lymphoma Hodgkin's, Lymphoma Non-Hodgkin's Cancer, Multiple Myeloma, Clotting Problems, Sickle Cell Anemia, History of Blood Transfusions

Bone & Joints:
Arthritis, Bursitis, Osterarthritis, Osteoporosis, Rheumatoid Arthritis, Scoliosis, Gout

Brain & Nerves:
Alzheimer's, Brain Cancer, Carpal Tunnel Syndrome, Dementia, Chronic Headache, Fibromyalgia, Lyme Disease, Meningitis, Migraines, Multiple Sclerosis, Epilepsy/Seizure Disorder, Neuropathy, Paralysis, Stroke, Parkinson's Disease, Polio

Chronic Infection:
Candidiasis (Yeast), Hepatitis B, Hepatitis C, HIV, Shingles, AIDS, MRSA / VRE, or other infection ie. Ring worm

Diabetes & Hormones:
Diabetes-Gestational, Type 1, Type 2, Parathyroid Disease, Parathyroid Disease, High Parathyroid, Low Parathyroid, Thyroid Problem-High/Low

Digestive:
Chronic Constipation, Chronic Diarrhea, Cirrhosis, Colon Cancer, Colon Polyps, Crohn's Disease, Diverticulitis/Diverticulosis, Heartburn/Reflux Disease, Hemmorrhoids, Irritable Bowl Syndrome, Lactose Intolerance, Liver Disease, Pancreatic Disease, Phenylketonuria, Gallstones, Rectal Bleeding, Stomach Ulcers, Ulcerative Colitis, Weight loss >50lbs., Bulemia, Anorexia

Ear Nose & Throat:
Cataracts, Conjunctivitis (Pink Eye), Ear Infection, Hay Fever, Glaucoma, Hearing Impairment, Nosebleeds, Tonsillitis, Vision Problem, Sinus Problems, Sleep Apnea, CPAP machine

Heart & Blood Vessels:
Angina, Bleeding D/O, Carotid Artery Obstruction, Congestive Heart Failure, Coronary Artery Disease/Atherosclerosis, Deep Venus Thrombosis (blood clots), Heart Attack, Heart Murmur, High Blood Pressure, High Cholesterol, Irregular Heartbeat, Mitral Valve Prolapse, Pacemaker/AICD, Phlebitis (blood vessel infection/inflammation), PVD, Reynauds

Kidneys & Urinary Tract:
Cancer - Bladder, Cancer - Kidney, Cancer - Kidney, Incontinence, Kidney Disease, Kidney Stones, Renal Failure, Urinary Tract Infection

Lungs:
Asthma, Bronchiectasis, Chronic Bronchitis, Chronic Obstructive, Pulmonary Disease, Emphysema, Lung Cancer, Pneumonia, Pulmonary Embolus, Tuberculosis

Men's Reproductive:
Cancer - Prostate, Cancer - Testicular, Enlarged Prostate, Erectile Disfunction, Testicular Mass (varicocele, hydrocele, spermatocele)

Mental Health:
ADD/ADHD, Alcoholism, Anorexia, Anxiety, Autism, Binge Eating, Biploar Disorder, Bulimia, OCD,Panic Attacks, Personality Disorders, Postpartum Depression, PTSD, Insomnia, Depression, Schizophrenia, Seasonal Affective Disorder,Social Anxiety Disorder

Muscles & Tendons:
Back Injury, Hernia, Neck Injury, Sprain, Tendon Tear, Basal Cell Skin Cancer, Skin Cancer - Carcinoma, Melanoma,
Skin Cancer - Squamous, Cell Carcinoma, Varicose Veins, Warts, Wounds & Skin Ulcers

Skin:
Acne, Athlete's Foot, Cellulitis, Dermatitis, Dry Skin, Eczema, Psoriasis, Rash, Ring Worm, Rosacea

Women's Reproductive:
Abnormal Vaginal Bleeding, Cancer - Breast, Cancer - Cervical, Cancer - Endometrial/Uterine, Cancer - Ovarian, Endometriosis, Fibrocystic Breast Tissue, Fibroid Uterus, Ovarian Cysts, Premenstrual Syndrome
Number of children _____ Date of last breastfeeding _____ Date of last mammography _____

Anesthesia Problems: None, N&V, Difficult Intubation, Malignant Hyperthermia
Hx of Anesthesia recall? Yes_____ No_____

Date of Last Physical Exam: _____

Family History: (Cancer, MH, etc): _____

DO YOU:		**ARE YOU:**	
1. Snore louder than talking	yes/no	1. Tired after sleeping 3 or more times a week	yes/no
2. Snore 3 or more times a week	yes/no	2. Have you fallen asleep while driving	yes/no
3. Pause in breathing 3 or more times a week	yes/no		

Exercise Tolerance (check which applies): I exercise: ____daily ____weekly ____monthly ____not at all

I can climb: ___1 flight ___2 flights ___3 flights of stairs without getting short of breath ____none at all

Hypertension history	**yes/no**	**BMI >30**	**yes/no**

PATIENT SIGNATURE: _____ DATE:_____

MD SIGNATURE:_____ DATE:_____
(I have reviewed this patient's PMHx & ROS)

SURGERY CENTER OF POTOMAC
PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

***Each patient treated at the** Surgery Center of Potomac has the right to:*

Be treated with respect, consideration and dignity at all times; receive respectful care given by competent personnel with consideration of his/her privacy concerning their medical care;

Receive accurate information regarding the competence and capabilities of the organization;

Receive a copy of the Center's HIPAA Privacy Notice upon admission and request;

Receive information regarding fees for services and payment policies;

Know that good quality of care and high professional standards are continually maintained and reviewed, and information regarding the competence and capabilities of the organization are updated and available;

Be given the name of his/her attending physician, the names of all other physicians directly assisting in his/her care, and the names and functions of other health care personnel having direct contact with him/her;

Know the Surgery Center rules and regulations that apply to his/her conduct as a patient;

Know the Physicians Dr. Barry Cohen, Dr. Adam Tattelbaum, and Dr. Bennett Yang have equal ownership of the Surgery Center of Potomac;

Receive information on after-hour and emergency care;

Be given an informed consent by the physician prior to the start of any procedure;

Have access to an interpreter when needed and whenever possible;

Receive full information in layman's terms concerning diagnosis and treatment; if it is not medically advisable to give this information to the patient, the information shall be given to the responsible person on his/her behalf; if a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf. If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.

Be advised of participation in a medical care research program or donor program; the patient shall give consent prior to participation in such a program; a patient may also refuse to continue in a program that he/she has previously given informed consent to participate in;

Receive medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability, or source of payment; exercise his or her right to voice grievances regarding treatment or care that is (or fails to be) furnished. The patient may express suggestions, grievances or complaints to the organization or to agencies external to the facility. The patient will be given information on the grievance process and agency contacts. Patients may file complaints with the Maryland Office of Health Care Quality, Spring Grove Hospital Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Md. 21228 in writing or download forms at www.dhmh.state.md.us/ohcq/complaint.complaiknt.htm or by phone at 410-402-8000, or 877-402-8218; 4).

File through Medicare at www.Medicare.gov/Ombudsman or 1-800-Medicare.

Make decisions concerning health care, including the right to accept or refuse treatment and have a physician explain the medical consequences of his/her refusal of treatment;

Make an advance directive, including a living will, and have access to our policies and procedures regarding advance directives. Surgery Center of Potomac does not comply with patient Advanced Directives. Any patient that requires resuscitation at our facility will be resuscitated and transferred immediately to the hospital for further care and treatment. Prior to transfer the patient's emergency contact or responsible person, and the facility accepting the patient transfer will be notified. Surgery Center of Potomac follows the guidelines of the Maryland Health Care Decisions Act. Information and forms on Advance Directives may be obtained in several ways: 1.) Contact the Surgery Center at 240-747-5650 and request the information and forms, 2.) Download information and forms from website www.oag.state.md.us/HealthPol/index.htm, 3.) Contact the Md. Institute of Emergency Medical Services Systems (MIEMSS) at 410-706-4367 for information on Palliative Care/Do Not Resuscitate Orders (DNR).

Each patient treated *at the Surgery Center of Potomac has the responsibility to:*

Follow instructions given by his/her attending physician, anesthesia provider, and nurse(s) regarding preoperative and postoperative care;

Provide the Surgery Center staff with all medical information which may have a direct effect on the care provided at the Surgery Center;

Provide a copy of their advance directive to the attending physician and Surgery Center (if applicable);

Provide the Surgery Center with all information regarding third party insurance coverage;

Fulfill financial responsibility for all services received as determined by the patient's insurance carrier and the Surgery Center.

Patient Signature: _____

Date: _____