PLASTIC SURGERY CENTER OF ST. JOSEPH, INC.
Michael D. De Priest, M.D., F.A.C.S.
2111 N. Woodbine • St. Joseph, MO 64506 • (816) 364-6446 • FAX (816) 364-5320

PATIENT INFORMATION (CHILD)

SSN _____ - _____ - _____ DATE _____

LAST NAME FIRST NAME MIDDLE

ADDRESS CITY STATE ZIP COUNTY

AGE DATE OF BIRTH SEX RACE ETHNICITY

CIRCLE ONE OR BOTH

RACE 1-WHITE 5-NATIVE HAWAIIAN/PACIFIC ISLANDER
2-BLACK OR AFRICAN AMERICAN 6-OTHER
3-AMERICAN INDIAN/ALASKAN NATIVE 7-MULTI-RACIAL (two or more races)
4-ASIAN 9-UNKNOWN

ETHNICITY 1-HISPANIC OR LATINO 2-NEITHER HISPANIC OR LATINO

PHONE CHILD'S DOCTOR

MEDICAL HISTORY:

Current medications? Please List: _____

Allergies to Medications? Please List: _____

Significant medical problems and/or surgeries? Please List: _____

PARENT INFORMATION:

FATHER'S NAME

HOME ADDRESS - CITY, STATE, ZIP

HOME PHONE WORK PHONE

S.S. NUMBER _____

DATE OF BIRTH _____

EMPLOYER _____

INSURANCE COMPANY

ADDRESS

PHONE POLICY #

SUBSCRIBER

MEDICAID # _____

MOTHER'S NAME

HOME ADDRESS - CITY, STATE, ZIP

HOME PHONE WORK PHONE

S.S. NUMBER _____

DATE OF BIRTH _____

EMPLOYER _____

INSURANCE COMPANY

ADDRESS

PHONE POLICY #

SUBSCRIBER

REFERRED BY _____

HAVE ANY OF YOUR CHILDREN BEEN SEEN IN THIS OFFICE? ☐ YES ☐ NO

NAME: _____

THE POLICY IN OUR OFFICE, IS THAT THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBILE FOR ALL FEES FOR SERVICES RENDERED.

SIGNATURE OF PARENT REQUESTING CARE DATE

MICHAEL De PRIEST, M.D., F.A.C.S.
PAYMENT AND INSURANCE PROCEDURES

The Consultation Fee is to be paid the day of your first appointment. All payments are expected at the time services are rendered including the dressing change and office visit charges.

INSURANCE

We file your insurance claims as an additional service for you. We do not determine the amount of coverage you will receive. This is done by your insurance company. Any question you may have concerning your insurance benefits should be directed to your insurance representative.

Very few companies will pay the full amount of the surgical fee. For that reason, we ask that your deductible be paid at the time your surgery is scheduled. If this is not feasible, you can make payments in which case the deductible amount is due at the end of a 2 month period. Please advise us what your deductible is at that time.

DEDUCTIBLE: $_____

I do hereby understand that in the case that my insurance company **NOT** pay my surgery fees in full, I am duly responsible for the balance of my account, to be paid upon receipt of my statement. Interest on account balances over 30 days will accrue at a rate of 1½% per month (annual rate of 18%). I understand should I default on payment of my account, relative financial information may be shared with your collection agency for purposes of collecting owed monies.

I hereby authorize payment of medical benefits and release of information requested to **MICHAEL D. De PRIEST, M.D.**

X _____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I authorize **MICHAEL D. De PRIEST, M.D.** to disclose complete information concerning his medical findings and treatment of the undersigned from the initial office visit until date of the conclusion of such treatment, to those individuals who, in **MICHAEL D. De PRIEST, M.D.'s** sole determination, are required to receive such information for the purpose of *medical treatment, medical quality assurance and peer review.*

X _____ _____

PATIENT'S SIGNATURE **DATE**

SUPPLEMENTAL INSURANCE CONSENT

We want you to receive the best reimbursement possible from your health insurance. As a service, we will fill out insurance forms for you. Please **READ** and **SIGN** below.

I authorize release of information to any and all insurance companies. I authorize payment direct to **MICHAEL D. De PRIEST, M.D.** I understand that I am responsible for my bill. I authorize use of this form on all my insurance submissions and authorize you to act as my agent in helping me obtain payment from my insurance companies.

X _____ **DATE** _____

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:
ALL MEDICAL RECORDS

Persons Authorized to Use or Disclose information
Information listed above will be used or disclosed by:
MICHAEL D. De PRIEST, M.D., F.A.C.S.
Name of person or organization

Name of person or organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

Name of person or organization

Name of person or organization

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Plastic Surgery Center of St. Joseph, Inc. You should contact Terri Nelson to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of patient (Print or type)

Signature of Patient Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

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HIPAA Notice of Privacy Practices

_____ [Name]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

PLASTIC SURGERY CENTER OF ST. JOSEPH, INC.

FINANCIAL POLICY

The physician and staff of this practice strive to offer comprehensive, quality care to you and your family. Following are the financial policies of our practice.

Insurance: Our practice participates with many health insurance carriers. We will file your insurance claim as a courtesy to you. You must provide our office a copy of your current insurance care AT THE TIME OF SERVICE or we will not be able to file your claim as claims are filed on a daily basis. If you cannot provide us with your current insurance information at the time of service, you will be expected to pay for you visit. We will provide you with a receipt so you may submit for reimbursement from you insurance company. Insurance policies are specific to each group insured. It is your responsibility to know the benefits and provisions of your policy. If you have any questions or concerns regarding benefits on your policy, please direct them to your insurance company. **Your insurance policy is a contract between you and the insurance company. You are ultimately responsible for any charges incurred in our office whether you think your insurance should pay for those services or not.**

Billing: If you are having surgery at the Plastic Surgery Center of St. Joseph, you will receive **two billing statements.** One bill will be for the surgeon's fee and the other bill will be for the facility fee. If you are having a lesion removed, you will also receive a bill from Heartland Regional Medical Center and a bill from the pathologist.

Co-pays and deductibles are to be paid **at the time of service.** If you have a deductible over $500, we will only collect a maximum of $500 at the time of your surgery. You may make monthly payments on the remainder of your deductible. Services that are non-covered by your insurance policy will need to be paid at the time of service. Some examples of non-covered services include cosmetic mole or benign lesion removal or skin tag removal. If you are a member of an **HMO** insurance plan, your Primary Care Physician is contractually bound to direct your care. You may not receive services from us without the referral from your primary care physician. Only you Primary Care Physician can approve your referrals. **We cannot call for referrals.**

Worker's Compensation Claims – If you have suffered an injury at your place of employment, your claim will need to be filed with your employer's worker's compensation carrier. You must provide this office with the necessary information to file your claim **AT THE TIME OF YOUR VISIT. YOUR EMPLOYER MUST BE NOTIFIED AND GIVE PERMISSION TO SEEK TREATMENT FOR ANY ON THE JOB INJURY.** We cannot file worker's compensation claims to your medical insurance. If you cannot prove us with the necessary information to file your claim, you will need to pay for your visit and seek reimbursement from your employer.

Motor Vehicle Accident Claims – WE DO NOT FILE THIRD PARTY CLAIMS. If you are being seen for injuries that were caused by a motor vehicle accident or other accident not being billed to your private insurance, it will be **your** responsibility to file your claims. We will give you the necessary insurance forms or information to do so. We **do not** wait for third party settlement. Payment for services needs to be rendered at the time of your appointment.

Cosmetic Surgery Pre-payment – The physician will give you a cost breakdown of cosmetic surgery. This amount needs to be **prepaid one week prior to surgery.**

When You Have a Balance Due – You will not receive a statement from our office until we have filed your claim and received a response from your insurance company. You will then receive a statement for any co-insurance, deductible or non-covered service amount due. We expect to receive full payment within 15 days of the statement date. Accounts which become delinquent (30 days past due) will be subject to a 1½ % per month late fee. If your account reaches 90 days past due with no payment arrangements, your account will be referred to an outside agency **(General Account Collection Services)** for collection proceedings up to, and including court proceedings. Your account will also be listed with the three major credit bureaus as a "bad debt". Once your account has been sent to the collection agency, you may be dismissed as a patient from this practice until the amount is "paid in full". Future appointments, **regardless of insurance coverage**, will be on a "cash basis only". Once we have received payment from your insurance company, a full refund will be issued to you.

Returned Checks – For every returned check, there is an additional $25 fee. Should you not make complete cash restitution of the returned check; the check will be turned over to the Prosecuting Attorney's Office.

If you have any questions regarding this financial policy, please ask a member of our staff. If you have special circumstances and need to make other arrangements for payment of your account, please ask to speak with the Administrator for financial arrangements.

I have read, understand, and agree with the financial policy of this practice.

_____ _____

Patient or Financially Responsible Party Date

_____

Witness