TUTELA PLASTIC SURGERY

PATIENT INFORMATION

Name: _____ _____ _____ **Sex:** _____ **Age:** _____ **Date of Birth** 11/11/20 /____
First M.I. Last Month Day Year

Address: _____
street apt # city state zip code

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Fax Number:** _____

Email Address: _____ **Social Security #:** _____

Occupation: _____ **Employer Name:** _____

Race: _____ **Ethnicity:** _____ **Marital Status:** _____

Language: _____ **Height:** ____ **ft** ____ **in** **Weight:** _____

EMERGENCY CONTACT

Name: _____ **Relationship to Patient:** _____ **Phone #:** _____

PHARMACY INFO

Pharmacy Name: _____ **Town:** _____ **Phone #:** _____

HOW DID YOU FIND DR.TUTELA?

Instagram: ____ **Realself:** ____ **Ad:** ____ **Patient:** _____ **Physician:** _____
Patient's Name Physician's Name

INSURANCE INFO (If you are having a cosmetic procedure you do not need to fill this section out)

Primary Insurance: _____ **Policy/ID #** _____

Secondary Insurance: _____ **Policy/ID #** _____

Relationship to Insured: _____ *If policy is through spouse or parent, please fill out below*

Name: _____ **Social Security #** _____ **Date of Birth:** / /

TUTELA PLASTIC SURGERY

1. PAYMENT: As a matter of policy, payment in full is due at the time of service except for those services which have been pre-authorized in advance. We accept cash, checks, American Express, Mastercard and Visa.

2. YOUR RESPONSIBILITIES: Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. With the exception of Medicare, we are non-participating providers. As such, for your insurance company to consider reimbursement, you must have out-of-network benefits. We will attempt to pre-certify scheduled procedures to help insure that you have those benefits and to determine your co-payment rate and/or unmet deductible, we will make every effort to work with you in order to minimize your out-of-pocket expense, but ultimately, all charges are your responsibility.

A.) MEDICARE PATIENTS: We are participating providers in the Medicare program. We will accept assignment on all ***pre-approved*** claims. Patients are responsible for meeting their annual deductible and paying for the 20% coinsurance. We will also file with secondary/ supplemental carriers if applicable. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

3. ASSIGNMENT OF BENEFITS: IN CONSIDERATION OF SERVICES RENDERED, I HEREBY ASSIGN TO THE PROVIDER OF SERVICES AND/OR HIS ASSIGNEE BENEFITS ARE MADE ON MY BEHALF TO THE PROVIDER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. I ALSO UNDERSTAND THAT I WILL BE HELD RESPONSIBLE AND AGREE TO PAY ATTORNEY'S FEES AND PROCESSING FEES WHICH COULD BE AS MUCH AS 1/3 THE AMOUNT OF YOUR BILL THAT MIGHT BE INCURRED TO COLLECT PAYMENT IN FULL. I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO MY INSURER WHEN NEEDED TO DETERMINE BENEFITS PAYABLE. _____ ___/___/___

patient's signature and date (parent's signature if patient a minor)

AUTHORIZATION OF TREATMENT: I hereby authorize Tutela Plastic Surgery to give me reasonable and proper care by today's standards. I further authorize and direct the above named clinical practice to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information requested to substantiate payment for medical services rendered. I also permit representatives thereof to examine and make copies of all records relating to such treatment. I hereby assign and transfer over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care, to cover the costs of medical services rendered.

4. RELEASE OF INFORMATION: I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physicians of Tutela Plastic Surgery.

I have read the above and agree to the terms. _____ ___/___/___

patient's signature and date

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I, _____ have been informed that the U.S. Government requires I sign this Notice
Print Patient Name

of Privacy Practices. The privacy regulations were created by the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) to protect patient privacy. I understand that the full text of the Act is available to me upon request. In order to request any amendments, restrictions or disclosures I must make a written request to the office privacy officer.

_____ ____/____/____

Patient Signature Date

***You may request a copy of the privacy practice policy to take home with you.**

TUTELA PLASTIC SURGERY

Welcome and thank you for selecting the Tutela Plastic Surgery

We wish to provide you with the best medical and surgical care. Administratively as well, it is our desire to be as attentive as possible to your financial needs. In general, we expect payment in full at time of service. However, as a courtesy we will submit the medical claim to your insurance company and will allow 30 days for them to issue a payment. If you are entitled to out-of-network benefits, we will make every effort to assist you in minimizing any out-of-pocket expenditure. We will contact your insurance company to pre-certify scheduled medically necessary procedures. However, pre-certification is not a guarantee of payment.

In addition to our office payment policy, please refer to the Patient Demographic Form for details, the following applies:

1. Deductible or portions thereof is to be paid at the time of your scheduled service. If your:

2. Co-insurance is part of your financial responsibility once the claim is paid by your insurance. Every effort will be made to work with you and your insurance company to reduce out-of-pocket expense. Feel free to contact our billing office at any time to discuss your insurance claim(s) reimbursement. deductible has been met at another physician's office, you may be asked for verification of this fact

3. I authorize John Paul Tutela, M.D., P.A. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits to be paid directly to be paid directly to John Paul Tutela M.D., P.A. In addition, I authorize John Paul Tutela M.D., P.A. or its designated representative to purse an appeal to my insurance company of any payment or non-payment of claims.

I have read, understand and agree to the above terms:

_____	_____	____/____/____.
Print Name	Patient Signature	Date

TUTELA PLASTIC SURGERY

PATIENT MEDICAL HISTORY

Medical/Surgical History (Past & Current):

_____

_____

Hospitalizations:

_____

_____

Family History:

_____

_____

Please check and, if applicable, circle, any of the following conditions you currently have or have had in the past.

•Do you: ____socially drink alcohol (____drinks/week) ____Use street drugs_____

•Do you: ____smoke or use (Any nicotine products)

If yes, How much daily?_____ If no, Have you ever?_____

•Please circle if you take any of the following on a regular basis:

☐ Coumadin ☐ Aspirin ☐ Vitamin E ☐ Garlic Tablets ☐ Ginkgo Biloba ☐ Ginseng ☐ Ginger ☐ Plavix

•Please circle if you have you ever had allergy or problem with any of the following and indicate your reaction if any allergies:

☐ Local Anesthetic ☐ Epinephrine (Adrenaline) ☐ Latex ☐ Adhesives/Bandaids ☐ Antibiotic Ointment (eg. Neosporin, Bacitracin)

•Please circle if you had or any family member had problems with anesthesia ☐ no ☐ yes:_____

FOR WOMEN ONLY: Do antibiotics cause you to have yeast vaginitis?_____ Are you pregnant or nursing?_____ Have you missed your last menstrual period?_____ Are you planning a pregnancy?_____ Date of last mammogram_____
**Please inform us if any of these become true during the course of your treatment at subsequent visits.*

•If a spouse, parent, child, sibling or friend were to ask questions regarding your care, do you authorize Tutela Plastic Surgery to discuss your care? If so, with whom? (please write names & relationship to you)

_____

•Do you allow us to leave medical information, such as laboratory results or answers to medical questions that were asked of us, on your voice mail or answering machine? ☐ yes ☐ no

•Is there anything else you think we should know about you in order to provide the best care possible?

TUTELA PLASTIC SURGERY

UNIVERSAL MEDICATION FORM

Patient Name: _____ Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

Do you have any Allergies to Medication? ☐ **NO** ☐ **YES** If yes, list allergies and reactions to medication:_____

_____

Do you currently take any Medications? ☐ **NO** ☐ **YES** If yes, **please list all medications that you are currently taking.**

INCLUDE ALL OF THE FOLLOWING MEDICATIONS: eye drops, inhalers, contraceptives, patches that contain medication, over-the-counter medications (e.g., aspirin, antacids) and dietary/herbal supplements (e.g., vitamins, gingko biloba). Also include medications taken as needed (e.g., nitroglycerin).

					FOR OFFICE USE ONLY	
Date	**Name of Medication & Dose (e.g., mg, drops)**	**Directions (e.g., am, pm)**	**Reason for taking/ Prescribing MD name**	**Date Stopped**	**Medication given in office**	**Contra-indicated?**
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N

Photo Consent For Your Medical Records

I hereby grant permission for the use of *my medical records* including illustrations, photographs or other imaging records created in my case for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. Dr.Tutela uses these photos to create your surgical plan.

Print Name _____ Signature _____ Date _____

Additional Photo/Video Consent

By allowing us the privilege of sharing your before and after photos, you are helping prospective patients visualize procedure enhancements. This gesture helps to ease the mind of those who need to see someone's results. It is extremely helpful to other patients.

By allowing us the privilege of sharing your photos, understand that YOUR NAME WILL NEVER BE USED and every attempt will be made to mask your identity.

Please circle yes/no if you give Dr.Tutela permission to use your photos for the following:

Dr.Tutela's Office Album: ☐ Yes ☐ No

Educational Presentation/Seminars: ☐ Yes ☐ No

Dr.Tutela's Social Media: ☐ Yes ☐ No

Dr. Tutela's Website: ☐ Yes ☐ No

Permission To Film Your Surgery: ☐ Yes ☐ No

Please check all that apply:

Cover my tattoo(s) ☐ Do not show my face ☐

Cover my scar ☐ Cover my birthmark ☐

Print Name _____ Signature _____ Date _____