Ryan Naffziger, MD
175 Mercado Street
Suite 111
Durango, CO 81301

PATIENT PERSONAL HISTORY
*Confidential Document

Last Name	First Name	Sex M F	Date of Birth / /	Age	Social Security #
Address		City	State, Zip		Marital Status Single / Married
Home Phone	Cell Phone	**Approx. Height:**		**Approx. Weight:**	
Insurance Company	Insurance #	Employer Name/Title/ Phone:			
Referring Doctor / Primary Care Doctor	Emergency Contact / Power of Attorney		Emergency Contact Phone #		
Email Address:		Preferred Pharmacy:			

How did you hear about our office?____

Person responsible for medical and insurance bills (Guarantor):

Name	Relationship	DOB	Social Security #
Address	City	State, Zip	Phone Number

Current Medications/Supplements	Doses	Frequency

Any Known Allergies to Medications	Reaction

List any medical illnesses you have or have had in the past:	Previous Surgeries with approximate dates:

Have you been diagnosed with any of the following:

Headaches	Heart attack	Blocked Leg Arteries
Thyroid Problems	Angina	Stomach Ulcer
Asthma	High Blood Pressure	Hepatitis
Emphysema	Stroke or TIA	Cirrhosis
COPD	Blood Clots	Skin Cancer
Diabetes	Abnormal Bleeding	HIV or AIDS/ARC
Breast Cancer	Tuberculosis	Problems with Anesthesia

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Family History:

Unknown family history Not known-adopted

Alive & Well: Natural Father Natural Mother Natural Brother Natural Sister Natural Daughter Natural Son

Deceased: Natural Father Natural Mother Natural Brother Natural Sister Natural Daughter Natural Son

Please check the box and write which family member & what side of your family they are on (maternal or paternal):

		Family Member(s)			Family Member(s)			Family Member(s)
Alcoholism			Cancer			Hyperlipidemia		
Arthritis			Cataracts			Hypertension		
Anemia			Diabetes, I			Kidney Disease		
Anxiety			Diabetes, II			Stroke		

Social History:

Smoking Status: ____Never _____Previous (quit:___________) ______Current How Much?__________

Smokeless Tobacco Use Y N

Do You Drink Alcohol? Y N How Much?________________

Do You Drink Caffeine? Y N How Much?________________

Do You Have Sleep Apnea? Y N Do you use a CPAP?________

Do You Have Clotting or Bleeding Disorders or Any Problems with Previous Anesthesia? Y N If Yes, Explain:____

Are you currently experiencing any of the following symptoms?

	Y	N
Weight Loss		
Fever		
Blurry Vision		
Loss of Hearing		
Sore Throat		
Chest Pain		
Difficulty Breathing		

	Y	N
Nausea/Vomiting		
Joint Pain		
Non healing skin sores		
Weakness in legs or arms		
Depression		
Enlarged lymph nodes		
Seasonal allergies		

Preferred Language: _________________________________
Ethnicity: Hispanic or Latino Not Hispanic or Latino
Race: American Indian/Native American/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White

*In order for you to obtain insurance benefits, we must supply the insurance companies with some of this information in addition to clinic notes, operative notes, hospital notes, and occasionally other information. By signing below, you provide authorization to allow Animas Plastic Surgery to provide your insurance company only with information they request that is required for payment of your benefits from your medical record.

Signature:____ Date:____________________

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Financial Policy

Payment for services rendered is due in full at the time service is provided.

We bill most insurance carriers for you if you provide us with the proper information. Co-payments, co-insurance, and deductibles **are due at the time of service**. **Co-payments are the patient's responsibility even if the patient has secondary coverage. Typically we do not bill secondary insurances for copays due to additional financial expense to the practice.** Your agreement with your insurance is a private one. If your insurance carrier has not paid us within 45 days of billing, the fees are due and payable in full from you. If you belong to a managed care plan, HMO, or PPO, and have not been referred by your primary care provider (PCP), you may have reduced benefits or no benefits at our facility. It is your responsibility to obtain any required referrals. We do not participate with Tri-Care, Tri-West, or SCI groups.

If your condition is work related, we will, after verification, bill your worker's compensation carrier for the treatment provided to you. It is your responsibility to provide us the correct billing information. If the information is not provided or if the claim is denied, you will be responsible for payment of service.

If you are involved with a personal liability situation (third party auto accident, personal injury, etc.) or have retained the services of an attorney, you will be responsible for your bill at the time of service. We will file insurance claims for you, but the insurance will pay you directly for those services. We will accept a "letter of protection" from your attorney, but you will be required to make reasonable payments until your claim has settled.

****Any additional paperwork requested by the patient concerning disability claims or work related issues will be assessed an additional fee of at least $25.00 per requested form.****

We accept cash, check, Visa, and Mastercard. In addition we are also contracted with the financing company CareCredit. A finance charge of 5% will be added with the use of a Visa, Mastercard, or financing company. If a financing company is used for payment, any additional merchant fees over 5% will also be the responsibility of the patient increasing the overall charges. There will be a **$20.00 fee** for all returned checks.

We recognize the unique and unanticipated nature of medical expenses and make available a flexible payment arrangement to assist special patient needs. Our Accounts Management Representative can assist you with these payment options. You may be contacted by a letter or by telephone if your account becomes past due. If you fail to respond to our requests for payment, your account may be referred to an outside collection organization. If that occurs, you may incur additional costs and you may be reported to a national credit-reporting agency.

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Some services such as specialist consultations, pathology, laboratory, interpretation of radiological studies, anesthesia, and hospital or surgery center operating room charges will result in billings from those specialists in addition to the bill from this office.

Disclosure Notice

Dr. Naffziger is a physician-owner of *Animas Surgical Hospital*, a private for-profit facility. As such, there is a financial incentive to order tests and perform surgeries and procedures at the hospital.

Any patient has the right to choose the provider and facility for their health care services. Thus we would like to inform you that *Animas Surgical Hospital* meets the definition of a physician-owned hospital under 42 CRF and Dr. Naffziger is an owner/shareholder of the hospital.

I have read, understood, and agree to this financial policy. I understand that I am ultimately responsible for my bill.

______________________________	______________
Signature of Patient/Responsible Party	**Date**

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Provider Notice of Privacy Practices

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.

Uses and disclosures of health information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of the treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for:

- Treatment
- Payment
- Health care operations and continuity of care
- Required by law
- To prevent serious threats to health or safety

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact our office.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative

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purposes, and other than when you explicitly authorized it. If you believe that information in your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Provider Notice of Privacy Practices

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our office. You also may send a written complaint to the US Department of Health and Human Services.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

If you have any questions or complaints, please contact:

Animas Plastic Surgery
175 Mercado Street
Suite 111
Durango, CO 81301
(970) 828-1199

Acknowledgement of receipt of notice of privacy practices

Please sign and print your name and date on this acknowledgment form. Please return this notice to the receptionist. A copy will be made for you and the original of the document will be placed in your chart.

Signature:____

Printed Name:____

Date:____

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Consent to the use and disclosure of health information for treatment, payment, or health care operations

I, _________________________________, understand that as part of my health care, Animas Plastic Surgery originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that Animas Plastic Surgery is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permitted by Section 164-506 of the Code of Federal Regulations.

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Consent to the use and disclosure of health information for treatment, payment, or health care operations

I further understand that Animas Plastic Surgery reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Animas Plastic Surgery change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:
____
____
____

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via FAX.

I fully understand and <u>accept</u> the terms of this consent.

____
Patient's Signature Date

I fully understand and <u>decline</u> the terms of this consent.

____
Patient's Signature Date

For office use only
____Consent received by_____________________________ on________________
____Consent refused by patient, and treatment refused as permitted
____Consent added to the patient's medical records on______________________

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Consent to Taking and Publication of Photographs

In connection with and in consideration of the plastic and reconstructive surgery and other medical services which I have been receiving or am about to receive from my physician Ryan Naffziger, MD and Animas Plastic Surgery, I consent that clinical photographs may be taken of me or parts of my body, under the following conditions:

The photographs shall be taken only with the consent of my physician and under such conditions and at such times as may be approved by my physician.

My physician shall take the photographs, or a photographer approved by my physician, and employed by Animas Plastic Surgery.

The photographs shall be used for medical record purposes and shall remain the property of my physician.

I may obtain a copy of these photographs with only a small fee to cover the cost of reproduction.

The American Board of Plastic Surgery may use these photographs for testing purposes during my physician's completion of the board certification process.

If in the judgment of my physician, medical research, education, or science will be benefited by their use, these photographs and information relating to my case may be published and republished, either separately or in connection with each other in professional journals or medical books, or used for other ethical professional medical educational purposes deemed proper by my physician. It is specifically understood however, that in any such publication or other use I shall **not** be identified by name.

Name:____

Signature:____

Parent or
Guardian:____