



WELCOME TO OUR PRACTICE!

PATIENT INFORMATION

Date: _____

Last Name _____ First Name: _____ MI: _____ SS #: _____

Sex: M F Age _____ Date of Birth _____ Marital Status: S M D W SEP

Parents' Names if Patient is a MINOR: Mother: _____ Father: _____

Spouse or Partner's Name: _____

Mailing Address _____ City: _____ State: _____ Zip: _____

Phone # home: () _____ cell: () _____ E-Mail: _____

Occupation _____ Employer Name: _____ work#: () _____

Notify in Case of Emergency: _____ Relation: _____ Phone #: () _____

Primary Care Doctor: _____ Phone #: () _____ Fax #: () _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

- Doctor _____ Friend _____ Patient _____ Staff _____
- Print Yellow Pages (Please Circle one) Pinellas/ West Pasco/Tampa www.AboutPlasticSurgery.com
- www.SuperPages.com www.YellowPages.com www.LoveYourLook.com www.BreastImplants411.com
- www.LookingYourBest.com www.Tummy-Tuck-Resource.com www.LocateADoc.com
- www.Breast-Augmentation-Resource.com www.ABoardCertifiedPlasticSurgeonResource.com Yahoo Google MSN
- EXPO Open House Other _____

CARRIER INFORMATION- Please provide a copy of your insurance card

Primary Insurance: _____ Policy #: _____ Group #: _____

Name of Policy Holder if other than Patient: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Name of Policy Holder if other than Patient: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____

PERMISSION FOR TREATMENT

I hereby voluntarily consent to and authorize medical care/diagnostic treatment and /or minor surgical treatment by **ISIDOROS MORAITIS, MD** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the use and disclosure of any of my past/current medical records for treatment and healthcare operations.

Signed: _____ Print Name: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

I hereby assign all medical/diagnostic/surgical benefits payable for the services rendered, to include major medical benefits to which I am entitled, including Medicare, Private Insurance and other health plans to **ISIDOROS MORAITIS, MD, PA**. I hereby authorize said assignee to release to CMS/Insurance Carriers and it agents all information needed to determine these benefits or benefits related to services. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/ procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services.

Signed: _____ Print Name: _____ Date: _____

Office Witness: _____ Print Name: _____ Date: _____



PATIENT HISTORY

Date: _____ Patient Name: _____ DOB: _____

Reason for your visit today: _____ Date of Injury, If Applicable: _____

Please list current medical conditions (Heart problems, diabetes, bleeding disorder, etc): _____

Medications currently taken as needed **or** on a regular basis (including over-the-counter and Herbals): _____

- Have you **EVER** had:
- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Pain in the Chest | <input type="checkbox"/> Diabetes/ Insulin Use |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pain in the Arms | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Breast Disease |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Glaucoma |

- Are you Allergic to:
- | | | |
|--|--|---|
| <input type="checkbox"/> Foods _____ | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Demerol |
| <input type="checkbox"/> Shellfish/ Iodine | <input type="checkbox"/> Other Antibiotics _____ | <input type="checkbox"/> Any anesthetic _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Novocaine/Lidocaine |
| <input type="checkbox"/> Sulfa | | |

Please list **any other allergies** not mentioned above: _____

Past Surgical History: (Please list any procedures or surgeries you have had, including cosmetic)

SURGERY	DATE	SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke? Yes No If yes, how many cigarettes per day? _____

If you are a former smoker, how many cigarettes per day did you smoke _____
and when did you quit? _____

Do you use any other tobacco products? Yes No If yes, how often? _____

Are you under the care of a physician at this time for any problem? Yes No

If yes, please explain: _____

Is there a chance you could be pregnant now? YES NO Not applicable



Date: _____ Patient Name: _____ DOB: _____

DESIGNATED RELATIVE

_____(Initial) I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with:

Name: _____ Relation: _____ Phone #: (____) _____
Name: _____ Relation: _____ Phone #: (____) _____

PRIVACY NOTICE

_____(Initial) I have been given a copy of ISIDOROS MORAITIS, MD, PA's office *privacy notice* as required by HIPAA that provides a complete description of *personal health information* uses and disclosures. I have been provided an opportunity to review it.

FINANCIAL POLICY

USUAL AND CUSTOMARY FEES: Our practice is committed to providing the best medical care for our patients. We charge what is usual and customary for our area. All patients are responsible for providing accurate and complete personal and insurance information prior to being seen by the doctor. The charges made, for your visit and care provided, depend on the nature and the complexity of your problem.

FORMS OF PAYMENT ACCEPTED: Payment may be in the form of cash, checks, Master Card, Visa and Discover. Returned checks are subject to a service charge as applicable by law. Elective Cosmetic Surgeries may also be paid in full with one of the various lending institutions we are contracted with (eg. CareCredit, SurgeryLoans, HealthOne Financial)

PAYMENT FOR SERVICES (SELF-PAY/NON-INSURED): Payment in full is expected before services are rendered unless prior financial arrangements have been made.

PAYMENT FOR SERVICES (PERSONAL HEALTH INSURANCE/MEDICARE): Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by your insurance company. In all cases, we require that the guarantor, the person who is financially responsible, is *personally* liable for all balances not covered by Medicare or other insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. All charges are your responsibility from the date services are rendered.

CO-PAYMENTS AND CO-INSURANCE: Co-payments and Co-insurances are due at the time of service.

WORKERS COMPENSATION: If you are seeking medical care as a result of a work-related injury, we will assist you in verifying your claim for the coverage of your medical bills. If for any reason your worker's compensation is not verified, the full responsibility for payment of services rendered will be that of the individual receiving treatment.

PAST DUE ACCOUNTS: Any balances on your account after 90 days may be referred to a collection agency unless other financial arrangements have been made in advance. Any fees that we pay to secure any past due balances may be added to your account. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

PAYMENT FOR ELECTIVE COSMETIC SURGERY: Payment in full is expected before services are rendered. Our office may require a minimum deposit of \$500 or 10% of the total surgeon's fee, whichever is greater, in order to schedule your surgery. This deposit will be applied to your "surgeon's fee" portion of the cost. Payment may be in the form of cash, checks, Master Card, Visa or Discover. If paying by credit card, the card must be presented in person by the authorized cardholder and a charge slip must be signed. Returned checks are subject to a service charge. Payment in full of the surgeon's fee must be received two (2) weeks prior to your scheduled procedure or we reserve the right to cancel or reschedule your surgery.

CANCELLATION OF ELECTIVE COSMETIC SURGERY: Should it become necessary for you to cancel or reschedule your surgery, we must receive notice of that change at least 10 days before your surgery date. If we receive notice of cancellation by that time, your deposit will be refunded in full. If you paid for your surgery with one of our financing companies offered, we will refund your financed portion of your payment minus 7% Administrative fee. If you should cancel your surgery two times, your deposit of \$500 or 10% paid will not be refunded and we will require a new deposit to reschedule your surgery. Exceptions will be made for documented emergency or medical disability.

REFUNDS FOR SKIN CARE SERVICES/PRODUCTS: Refunds will be made on pre-paid services that are not rendered, after regular prices are applied to those services already received. All SkinMedica home care products are 100% refundable within 30 days of purchase with receipt. Prescription products purchased at our office are non-refundable, non-returnable.

By signing this form, I fully understand and agree to the terms of the FINANCIAL POLICY.

Signed: _____ Print: _____ Date: _____

Office Witness: _____ Print: _____ Date: _____



Date: _____ Patient Name: _____ DOB: _____

CONSENT FOR TAKING AND/OR PUBLISHING PHOTOGRAPHS

I hereby grant authority to ISIDOROS MORAITIS, M.D. and/or his designated representatives to take photographs of me (your child, if you are consenting for a minor) with the understanding that such photographs are for confidential clinical purposes of evaluation and treatment, and that all photographs remain the property of ISIDOROS MORAITIS, M.D. I understand that the photographs are a permanent part of my medical record, and as such may be submitted to my insurance for the specific purpose of obtaining reimbursement for authorized services.

Signed: _____ Print: _____ Date: _____

Office Witness: _____ Print: _____ Date: _____

BOTTOM PORTION OF THIS CONSENT TO BE COMPLETED ONLY AFTER YOU HAVE RECEIVED TREATMENT/SURGERY FROM OUR OFFICE. YOUR ANSWER WILL NOT AFFECT THE CARE YOU RECEIVE

IN ADDITION to use of these photographs for the purposes as previously stated, I consent to their use as specifically indicated below provided however, that it is specifically understood that in such publication or use I shall not be identified by name. **(please check appropriate boxes to indicate approved choices):**

- YES** **NO** Office Patient Photo Before and After Album
- YES** **NO** Patient Educational Presentations (Power Point Presentations for Patient Seminars)
- YES** **NO** (Must sign separate consent for this)
Internet/Print Advertising Use

Signed: _____ Print: _____ Date: _____

Office Witness: _____ Print: _____ Date: _____

