REGISTRATION
(PLEASE PRINT)

DeCONTI

Plastic Surgery

Creating a more beautiful you.

DATE: _____

Last Name: _____ First: _____ Middle: _____
Age: _____ Birth Date: _____ Soc. Sec. #: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile Phone: _____ Work Phone: _____
Sex: M F Marital Status: _____

Email Address:

Guarantor/Patient's Name: _____ Soc. Sec. #: _____
Guarantor/Patient's Employer: _____ Birth Date: _____
Business Address: _____
Business Phone: _____
Occupation: _____

Spouse's Name: _____ Soc. Sec. #: _____
Spouse's Employer: _____ Birth Date: _____
Business Address: _____
Business Phone: _____
Occupation: _____

Person to Notify in Case of Emergency: _____ Relationship: _____
Home Phone: _____
Work Phone: _____

DO YOU HAVE INSURANCE? YES NO COSMETIC

Primary Insurance Company: _____

Secondary Insurance Company: _____

REASON FOR VISIT: _____

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How did you learn about us?

Patient _____

Physician _____

Friend _____

Internet Google Yahoo Bing LookingYourBest.com

Yellow Pages Large Book:

Large Display Ad: Physicians & Surgeons

Large Display Ad: Plastic Surgery

Newspaper

Magazine

TV

Radio

Seminar

Other _____

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FINANCIAL POLICIES

HMO/PPO and Commercial Insurance
THE PATIENT IS RESPONSIBLE FOR OBTAINING INSURANCE REFERRALS. IF PRIOR APPROVAL IS NOT OBTAINED, THE PATIENT WILL BE RESPONSIBLE FOR THE BILL. IF INSURANCE DENIES PAYMENT FOR A SERVICE, THE PATIENT IS RESPONSIBLE FOR THE BILL.

COPAYMENTS AND DEDUCTIBLES MUST BE COLLECTED AT THE TIME OF SERVICE, according to the contracts signed by the physicians.

Medicare
Robert W. DeConti, M.D. is a Medicare provider. If you do not have secondary and/or tertiary insurance that pays your deductible and co-payments, then you are responsible to pay this amount.

Medicaid
Robert W. DeConti, M.D. is a provider for Medicaid and Medicaid Medallion. According to the physician contract with the Commonwealth of Virginia, Medicaid patients are responsible for the $1.00 and $3.00 co-payments per service and hospital visit and are expected to pay at the time of service.

Cosmetic Surgery Fees
Fees may be paid with a personal check **two weeks** prior to the scheduled surgery date. If less than two weeks until surgery, payment must be in the form of cash or credit card. If payment is not received one week prior to surgery, then the surgery will be canceled. If the surgery is canceled and not rescheduled, a $500 administration fee will be retained. The remainder will be refunded.

THERE IS A $75.00 FEE FOR ANY CHECK RETURNED FOR NON-SUFFICIENT FUNDS.

FINANCIAL AGREEMENT

I hereby authorize, Robert W. DeConti, M.D., Inc. to furnish to my insurance company or companies, attorney, or legal representative, all information which said parties may request concerning my present illness or injury.

I hereby assign to Robert W. DeConti, M.D., Inc., all monies to which I am entitled under my insurance plan for medical and or surgical expenses relative to the services reported herein, including but not limited to, monies due me for allowable expenses covered under my insurance plan. Robert W. DeConti, M.D., Inc. will apply all monies received from my insurance company to my account. All overpayments will be refunded to me when my bill is paid in full. If the insurance company fails to make payments, or in the event that I received medical and/or surgical services that are not covered by my insurance plan, I understand and agree that I am personally responsible for such charges and for any other charges not covered by this assignment.

I agree to pay my account as it comes due and further agree that if I do not, I will pay all expenses incurred in collecting the same, including court costs, a thirty three and 1/3 percent (33 1/3%) attorney's fee of the outstanding balance, a one and 1/2 percent (1 1/2%) interest per month (18% annually) starting from the date of service, and $400.00 per hour physician's fee for court time and trial preparation.

I agree to provide Robert W. DeConti, M.D., Inc. with the address and other information changes so that said doctor can properly send current bills to me.

DATE: _____ SIGNED: _____
Patient/Insured/Guardian

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PATIENT NAME: _____

CONSENT TO TREATMENT

I hereby authorize Dr. Robert W. DeConti to examine and /or treat that which he deems necessary or advisable on me/patient.

In the event of any employee's exposure to my/patient blood and/or body fluids, I consent to laboratory testing of my/patient blood for Hepatitis and HIV antibody.

DATE: _____ SIGNED: _____
Patient/Insured/Guardian

CONSENT TO PHOTOGRAPH

I agree to allow Dr. Robert W. DeConti or his employees to take and/or release any photographs taken of me/patient for the purpose of publications, educational services, internet development or for the purpose of judicial cases or insurance review.

DATE: _____ SIGNED: _____
Patient/Insured/Guardian

WITNESS: _____

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HEALTH HISTORY
(PLEASE PRINT)

Date _____

Last Name _____ First _____ Middle_____

Birth Date _____ Age _____ Ht _____'_____" Wt _____lbs BP _____

Family Physician _____ Phone # _____

Address _____

Preferred Pharmacy _____ Phone # _____

Address_____

MEDICATIONS
(Name, Dose, and Frequency.
Include Herbal and Vitamin Supplements)

_____
_____
_____
_____
_____

ALLERGIES
(If no known allergies please specify below)

_____
_____
_____
_____
_____

DO YOU TAKE ASPIRIN REGULARLY? Yes No
DO YOU TAKE/OR HAVE YOU TAKEN STEROIDS? Yes No
HAVE YOU EVER HAD A BLOOD TRANSFUSION? Yes No

CONDITIONS (Circle all that apply)

AIDS
HIV Positive
Anemia
Emphysema
Anorexia
Arthritis
Bleeding disorder
Bronchitis
Psychiatric
Cancer
Congenital heart
Diabetes
Epilepsy
Liver Disease
Glaucoma
Goiter
Gout
Heart Attack
Bleeding Gums
Hepatitis
High Blood Pressure
High Cholesterol
Kidney Disease
Tuberculosis
Leukemia
Colitis
Pacemaker
Heart Disease
Nose bleeds
Pneumonia
Scarlet Fever
Stroke
Thyroid Disease
Typhoid Fever
Suicide Attempt
Ulcers
Venereal Disease
Rheumatic Heart
Polio

OTHER _____

FAMILY HISTORY (Circle and give relationship)

Arthritis _____
Asthma _____
Breast Cancer _____
Cancer _____
Colitis _____
Heart Disease _____
Kidney Disease _____
Epilepsy _____
Goiter _____
Heart Attack _____
High Blood Pressure _____
High Fever after Surgery _____
Suicide _____
Tuberculosis _____
Leukemia _____
Bleeding Disorder _____
Ulcers _____
Stroke _____
Thyroid Disease _____
Diabetes _____
Liver Disease _____

OTHER _____

SURGERIES & HOSPITALIZATIONS

YEAR HOSPITAL REASON FOR HOSPITALIZATION OUTCOME

_____
_____
_____
_____
_____
_____
_____
_____

SERIOUS ILLNESS/INJURIES

DATE TYPE OF ILLNESS/INJURY OUTCOME

_____
_____
_____
_____
_____

HEALTH HABITS (Circle substances you use and tell how much)

Alcohol _____ Drugs _____
Tobacco _____ Other _____

SYMPTOMS

WOMEN ONLY

Is there a chance you are Pregnant? Yes No
How many Pregnancies? _____ How many children born alive? _____
How many Miscarriages/Abortions? _____ How many premature births? _____
Any complications from Pregnancies? _____
Date of last Breast Exam: _____ Result: _____
Date of last Mammogram: _____ Result: _____

MEN ONLY

Treatment to genitals (private parts)? Yes No
Discharge from penis? Yes No
Prostate trouble? Yes No

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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient/Insured/Guardian Date

_____ _____
Reviewed By Date

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by *DeConti Plastic Surgery* for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of *DeConti Plastic Surgery*. I understand that diagnosis or treatment of me by Robert W. DeConti, M.D., F.A.C.S. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. *DeConti Plastic Surgery* is not required to agree to the restrictions that I may request. However, if *DeConti Plastic Surgery* agrees to a restriction that I request, the restriction is binding on *DeConti Plastic Surgery* and Robert W. DeConti, M.D., F.A.C.S.

I have the right to revoke this consent, in writing, at any time, except to the extent that Robert W. DeConti, M.D., F.A.C.S. or *DeConti Plastic Surgery* has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review *DeConti Plastic Surgery 's* Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the *DeConti Plastic Surgery*. This Notice of Privacy Practices also describes my rights and the *DeConti Plastic Surgery*'*s* duties with respect to my protected health information.

DeConti Plastic Surgery reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative