ORLANDO PLASTIC SURGERY ASSOCIATES

DR. DEAN JOHNSTON, M.D., F.A.C.S

4106 W Lake Mary Blvd #212, Lake Mary, FL 32746

PHONE: 321-247-7647

PERSONAL INFORMATION:

First Name: _____ Middle Name: _____

Last Name:_____ Nick Name: _____

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

DOB: _____ SSN#: _____ Gender: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Age: _____ New / Existing Patient: _____

Marital Status: _____ Primary Language: _____ Ethnicity: _____

SPOUSE OR EMERGENCY CONTACT INFORMATION:

Name: _____ DOB: _____ Relationship: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN#: _____ Age: _____ Gender: _____

Employer: _____ Occupation: _____

Employer Address: _____

IN CASE OF AN EMERGENCY I AUTHORIZE PROVIDER TO CONTACT:

Name: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Company: _____ Policy ID#: _____ Group#: _____

Insured Party Name: _____ Group Name: _____ DOB: _____

SSN#: _____ Relationship: _____ Employer: _____

SECONDARY INSURANCE INFORMATION

Company: _____ Policy ID#: _____ Group#: _____

Insured Party Name: _____ Group Name: _____ DOB: _____

SSN#: _____ Relationship: _____ Employer: _____

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HOW I WISH TO BE CONTACTED

PLEASE CONTACT ME ON MY:

☐ Home Phone

IF UNABLE TO REACH ME:

☐ Provider can leave their name and phone number only when they call ☐ Provider can leave a detailed message when they call

PLEASE CONTACT ME ON MY:

☐ Cellular Telephone

IF UNABLE TO REACH ME:

☐ Provider can leave their name and phone number only when they call ☐ Provider can leave a detailed message when they call

☐ Provider can Text their name and phone number only when they call ☐ Provider can Text a detailed message when they call

☐ Opt out for cellular voicemails or texts, (you do not want messages left on your cell phone).

PLEASE CONTACT ME AT WORK:

☐ Work Phone

IF UNABLE TO REACH ME:

☐ Provider can leave their name and phone number only when they call ☐ Provider can leave a detailed message when they call

PROVIDER CAN MAIL OR EMAIL ME INFORMATION SUCH AS APPOINTMENT REMINDERS, FORMS

☐ Mail or Email

IF UNABLE TO REACH ME:

☐ Provider can mail information to my home address ☐ Provider can mail information to my work address

☐ Provider cannot mail information to my home or work address, except statements of my accounts.

Provider can email information to: _____

THIS INFORMATION WILL ONLY BE USED BY OUR OFFICE FOR YOUR BENEFIT & NEVER RELEASED TO ANOTHER ENTITY.

I authorize disclosure of information regarding my billing, condition, treatment & prognosis to the following individual(s)

BY SIGNING THIS AUTHORIZATION FORM, I UNDERSTAND THAT :

- Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until revoked.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Office at the following address: Orlando Plastic Surgery Associates Attn: Health Information Management 4106 W. Lake Mary Blvd, Suite 212 Lake Mary, Florida 32746
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- "Please keep in mind that communications via email over the Internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.
- Please do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us. No one can diagnose your condition from email or other written communications, and communication via our website cannot replace the relationship you have with a physician or another healthcare practitioner.

PATIENT NAME: _____ DATE: _____

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YOUR MEDICAL HISTORY

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

REASON TO VISIT TODAY: _____

_____

PLEASE LIST ALL OF THE PHYSICIANS THAT YOU SEE CONSISTENTLY:

Physician's Name: _____ Speciality: _____ Phone: _____

Physician's Name: _____ Speciality: _____ Phone: _____

Physician's Name: _____ Speciality: _____ Phone: _____

Please list any and all prescription, non-prescription, and over the counter medications, home remedies, vitamins, birth control pills, inhalers, etc. that you currently take.

Medication: _____ Dose (e.g. mg/pill): _____ Frequency: _____ Purpose: _____

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Medication: _____ Dose (e.g. mg/pill): _____ Frequency: _____ Purpose: _____

Please list any medications with which you have had SEVERE SIDE AFFECTS OR REACTIONS, (If none write none)

Medication: _____ Adverse Reaction: _____

Medication: _____ Adverse Reaction: _____

ALLERGIES? If so, please list them and describe your reaction:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Please list all past surgical procedures, major or minor, that you have had: (If none write none)

Past Procedure: _____ Date: _____

Past Procedure: _____ Date: _____

Past Procedure: _____ Date: _____

Please list all major illnesses, accidents of injury, or hospitalizations you have had: (list, date)

Major Illness: _____

_____

_____

Accidents/Injuries: _____

_____

_____

Pregnancies/deliveries: _____

_____

_____

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DAILY ROUTINES

Tobacco Use

Smoke cigarettes: ☐ Never ☐ No ☐ Yes (If you do not use tobacco products, please skip to alcohol use)

Quit Date: _____ How many years did you smoke?: _____ Approx Packs / Day? _____

Current Smoker: Packs / Day _____ Current Smoker: Number of years _____ Other Tobacco Products: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use

Do you drink alcohol?: ☐ Daily ☐ Social ☐ Never Number of drinks per week: _____ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you drink caffeinated beverages? ☐ Yes ☐ No How many per day?: _____ Type: ☐ Coffee ☐ Tea ☐ Soda

Drug Use

Do you use marijuana or recreational drugs? ☐ Yes ☐ No Have you ever used needles to inject drugs? ☐ Yes ☐ No

Exercise

Do you exercise regularly? ☐ Yes ☐ No What is your typical exercise regimen? _____

_____

_____

Are you on any kind of special diet? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

SOCIAL HISTORY

Occupation: _____ Employer: _____ Children: _____

Ages if under 18 years: _____ Who lives at home with you: _____

WOMEN'S HEALTH HISTORY

Is there a chance that you are pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No Total number of pregnancies: _____ Total number of births: _____

Date (month/day if known) of last menstrual period: _____ Age when you began menstruation: _____

Age when you ended menstruation (menopause): _____

FAMILY HISTORY

DISEASE	FAMILY MEMBER(S)	DISEASE	FAMILY MEMBER(S)
☐ Bleeding / Clotting Disorder	_____	☐ Hepatitis	_____
☐ Endocrine Disease	_____	☐ High Blood Pressure	_____
☐ Cancer	_____	☐ Autoimmune Disorders	_____
☐ Anesthesia Problems	_____	☐ Lung Disease	_____
☐ Heart Disease	_____	☐ Liver Disease	_____
☐ Hemophilia	_____	☐ Stroke	_____
☐ Diabetes	_____	☐ Malignant Hypothermia	_____
☐ Kidney Disease	_____	☐ Von Willebrand's Disease	_____
☐ Heart Attack	_____		

GENERAL HEALTH FACTORS

Please make a mark next to any of the following persistent symptoms you have had in the past few months. Read through every section and check "No Problems" if none of the symptoms apply to you. If you have symptoms that are not listed, please list them on the space provided below.

GENERAL

☐ Unexplained weight loss or gain ☐ Unexplained fatigue or weakness ☐ Fever/Chills ☐ Falling asleep when sitting ☐ No Problems

HEAD/EYES/EARS/NOSE/THROAT

☐ Glaucoma ☐ Contact Lenses ☐ Blurred/Double Vision ☐ Ringing in Ears ☐ Hearing Aid ☐ Hoarseness for over 1 month ☐ Neck Stiffness

☐ Dentures or Partial Plates ☐ Capped Tooth ☐ Loose or Chipped Teeth ☐ Difficulty Swallowing

☐ Difficulty Opening Mouth Fully ☐ Frequent Headaches ☐ Arthritis ☐ Spinal Column Deformity ☐ Chronic Pain Problem ☐ NO PROBLEMS

NEUROLOGICAL

☐ Migraine Headache ☐ Seizures or Convulsions ☐ Chemical Imbalance ☐ Change in Memory ☐ Trouble with Balance ☐ Stroke

☐ Nerve injury or Numbness ☐ Psychiatric Care ☐ Nervous System Disorder ☐ Polio or Neuromuscular Disease ☐ NO PROBLEMS

CARDIOVASCULAR

☐ Heart Attack ☐ Shortness of Breath Lying Flat ☐ High Blood Pressure ☐ Abnormal Heart Beats ☐ Rheumatic Fever

☐ Heart Disease ☐ Swelling/Edema ☐ Heart Murmur ☐ Prolapsed Mitral Valve ☐ Pacemaker or Defibrillator ☐ Chest Pain

☐ Kidney Disease ☐ Heart Related Angina ☐ NO PROBLEMS

RESPIRATORY

☐ Frequent Colds ☐ Asthma ☐ Bronchitis or Emphysema ☐ Chronic cough/Wheezing ☐ Loud Snoring ☐ Altered Breathing During Sleep

☐ NO PROBLEMS ☐ Sleep Apnea (use of C-pap)

BLADDER/KIDNEY

☐ Prostate Problems ☐ Kidney Disease ☐ Blood in Urine ☐ Burning Urination ☐ NO PROBLEMS

DIGESTIVE

☐ Constipation ☐ Ulcers ☐ Hiatal Hernia ☐ Frequent Heartburn ☐ Vomiting Blood ☐ Liver Disease or Hepatitis ☐ Jaundice

☐ Black, Tarry Bowel Movements ☐ Blood in Bowel Movements ☐ NO PROBLEMS

HEMATOLOGICAL

☐ Abnormal Bleeding Tendencies ☐ Anemia or Low Blood Count ☐ Sickle Cell Anemia ☐ Cancer or Tumors ☐ Chemotherapy or Radiation Therapy

☐ Abnormal Chest X-Ray ☐ NO PROBLEMS

ENDOCRINE

☐ Diabetes ☐ Thyroid Problems ☐ NO PROBLEMS

Please list any other Symptoms or Medical Problems that are not covered by this form. _____

_____

_____

The above information is complete and correct to the best of my knowledge. I consent to consult with Dr. Johnston for his recommendations of treatment and/or surgical opinion for which I made this consultation. In addition, I consent to any photographs which may be taken and permit their use strictly for medical, educational and scientific purposes. Photographs will be property of Dean L. Johnston, M.D.

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Dean L. Johnston, M.D., Inc. all insurance benefits payable to me for services rendered. I understand that I am responsible for co-pays, deductibles, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize any physician or medical facility that has treated me in the past to release a copy of my record to Dean L. Johnston, M.D., Inc. I authorize use of this signature on all insurance benefits.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

ORLANDO PLASTIC SURGERY ASSOCIATES

DR. DEAN JOHNSTON, M.D., F.A.C.S

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your protected health information (PHI) and who we may use and disclose your PHI for treatment, payment, health care operations (TPO), and for other purposes that are permitted or required by law.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice: such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example of this would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or health information about treatment alternatives or other health related benefits and services that may be of interest to you.

We may release some or all of your health information when required by law.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, which we are required to honor and abide by, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
Dean L. Johnston M.D. FACS, 4106 W. LAKE MARY BLVD. SUITE 212, LAKE MARY, FL 32746 (407)333-2525.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect, copy, and amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices and to make new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you feel that your privacy protections have been violated, you have the right to file a written complaint with our office. You may also file complaints with the Department of Health and Human Services or Office of Civil Rights about violations of the provisions of this notice, or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information: The U.S. Department of Health and Human Services/Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C., 20201

PATIENT'S INITIALS: _____

ORLANDO PLASTIC SURGERY ASSOCIATES

DR. DEAN JOHNSTON, M.D., F.A.C.S

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Orlando Plastic Surgery Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). All matters concerning my medical care will be considered to be a health care treatment, and subject to the Medical Practices Act. (Orlando Plastic Surgery Associates Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Orlando Plastic Surgery Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Orlando Plastic Surgery Associates acting privacy officer, Kathy Johnston, R.N., at 4106 West Lake Mary Blvd., Suite 212, Lake Mary, FL 32746. With this consent, Orlando Plastic Surgery Associates may call my home or other alternative location and leave a message on a voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including
laboratory results among others.

With this consent, Orlando Plastic Surgery Associates may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential. With this consent, Orlando Plastic Surgery Associates may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Orlando Plastic Surgery Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Orlando Plastic Surgery Associates use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.
If I do not sign this consent, or later revoke it, Orlando Plastic Surgery Associates may decline to provide treatment to me.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

ORLANDO PLASTIC SURGERY ASSOCIATES

DR. DEAN JOHNSTON, M.D., F.A.C.S

PATIENT FINANCIAL POLICY

Thank you for choosing Dean L. Johnston, M.D., Inc. as your health care provider. We are committed to the success of your treatment. All matters concerning your medical care will be considered to be a health care treatment and subject to the Medical Practices Act of Florida. The medical services provided by our office are services you have elected to receive, which imply a financial responsibility on your part.

COSMETIC PROCEDURES/SELF PAY

Elective procedures must have financial arrangements made in advance of scheduling. Payment for services is due two weeks prior to the procedure.

The practice will accept cash, carrier's checks, personal checks, and the following major credit cards: VISA, MasterCard, and American Express.
We charge a $25 service fee for all returned checks. As a convenience to you, financing is also available. For those individuals who pay by credit card, debit card, or finance companies, you are not eligible for credit card challenge or "charge back" to the finance companies once the service is provided as per this agreement.

INSURANCE

We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date card, payment in full for each visit is required until we can verify coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage plan.

MEDICARE

We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

CO-PAYMENTS AND DEDUCTIBLES

All co-payments and deductibles must be paid in full at the time of service. This arrangement is part of your contract with your insurance company.

SELF-PAY

Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES

Please be aware that some services you receive may not be covered, or considered reasonable or medically necessary for coverage by Medicare or other insurance carriers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS

We are required to follow the guidelines of your managed care plan, which may require a referral from your primary care physician prior to your appointment when visiting a specialist's office. Therefore, if a referral is required and not presented at the time of your visit, your appointment will be rescheduled or you will be financially responsible for services received, paid in full upon completion of the visit.

CLAIM SUBMISSION

As a courtesy service to you, we will submit your insurance claims for the services rendered in our office, and assist you in anyway we reasonably can to help get your claims paid. Your insurance company may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim.

PATIENT'S INITIALS: _____

ORLANDO PLASTIC SURGERY ASSOCIATES

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PATIENT BILLING

You will receive a statement from us on the status of your claim and encourage your help in receiving payment after 30 days. You will be sent up to three statements for your financial responsibility after your insurance has processed Claims. After the third notice your account may be forwarded to a Collection Agency. If your account is assigned to an outside collection agency, additional fees will be added. Please let the billing departments know if you have difficulties resolving your bill. Payment arrangements may be considered on a case-to-case basis.

FORM COMPLETION

Completing Disability Forms, Family Leave Forms, or your third insurance forms require office staff time, copies to be made, and time out of Dr. Johnston's schedule which takes away from patient care. Therefore, our charge for this service is $15.00 and we request up to three business days for completion of this task.

PAYMENT POLICY

All balances will be due in full at the time of your office visit. We will provide you with a copy of your bill and the insurance credits upon request. We reserve the right to charge a $50.00 fee for missed appointments and an additional charge for surgical appointments. If you are unable to make your appointment, please cancel or reschedule by calling our office at least 24 hours in advance.

If I am paying by insurance, I the undersigned certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Dean L. Johnston, M.D., Inc. all insurance benefits payable to me for services rendered. I understand that I am responsible for co-pays, deductibles, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize any physician or medical facility that has treated me in the past to release a copy of my record to Dean L. Johnston, M.D., Inc. I authorize use of this signature on all insurance benefits.

I understand that it is my responsibility to inform the Doctor's office if there is a change in my health insurance information and/or contact information.
I understand and accept these terms.

Patient's Name: _____ Signature: _____

Responsible Party's Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____