Plastic Surgery, P.A.
& Surgery Center LLC.

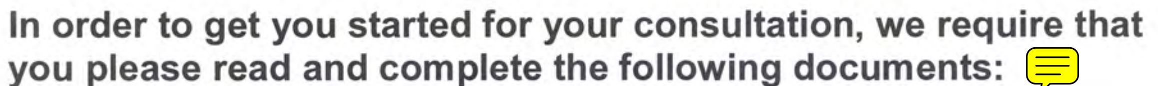
4161 N.W. 5th Street, Suite 100
Plantation, Florida 33317

Office: (954) 585-3800 Fax: (954) 585-6100
www.takeshape.info www.plasticsurgery.org

Russell F. Sassani, M.D.
Brian Olack, M.D.

Dear Patient:

In order to get you started for your consultation, we require that you please read and complete the following documents:



- Please print the next 8 pages. Read them and then complete the required 3 pages.
- Don't forget to read and sign the 4th and 5th page.
- Bring these 5 pages to the office.
- Please keep pages 6 through 8. They are for your information.

IMPORTANT: If you have an HMO and require a referral, please make sure to get this from your primary care physician. You will not be seen without the referral.

Please remember to bring your Driver's License and Insurance card and any pathology reports.

Thank you for your cooperation. This will ensure a quicker processing of paperwork at the office.

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# PATIENT INFORMATION SHEET

*PLEASE PRINT AND COMPLETE FORM:* *TODAY'S* DATE: ____________________

NAME: ______________________ AGE ______ DATE OF BIRTH ______________

STREET ADDRESS: ______________________________ APT# ______________

CITY ____________________ STATE __________ ZIP ______________

HOME PH# ______________ WORK# ______________ CELL# ______________

E-MAIL ADDRESS ______________________ FAX# ______________ SS# ______________

MARITAL STATUS: (*please circle one*): Single Married Divorced Widowed Partnered SEX: M F

EMPLOYER: ______________________ EMPLOYER PHONE# ______________

If patient is a minor or someone other than patient is financially responsible, please complete this section:

FULL NAME: ______________________ RELATIONSHIP: ______________

S.S# _____-____-______ PHONE: ______________

ADDRESS: ______________________ APT# __________ CITY __________ ZIP __________

EMPLOYER: ______________________ EMPLOYER PHONE: ______________

EMERGENCY CONTACT: ______________________________

ADDRESS ______________________ CITY ______________ STATE _____ ZIP _____

HOME# ______________ WORK # ______________ CELL# ______________

RELATIONSHIP: ______________________

****** *PLEASE PROVIDE INSURANCE CARD AND PICTURE ID FOR COPYING* ******

PRIMARY INSURANCE: ______________________ ID# ______________ GRP# __________

POLICY HOLDER NAME: ______________________ S.S# _______-_______-__________

SECONDARY INSURANCE ______________________ ID# ______________ GRP# __________

POLICY HOLDER NAME: ______________________ S.S# _______-_______-__________

REFERRING PHYSICIAN: ______________________ DERMATOLOGIST: ______________

PRIMARY CARE PHYSICIAN: ______________________ PHONE # ______________

REASON FOR VISIT: ______________________________________________

HOW DID YOU HEAR ABOUT US: INTERNET YELLOW PAGES PATIENT REFERRAL AD INSURANCE
OTHER: ______________________________

*AUTHORIZATION / RESPONSIBLE PARTY AGREEMENT:* I authorize Russell F. Sassani, M.D. / J. Brian Olack M.D. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I further authorize my insurance payments to be paid directly to TAKESHAPE PLASTIC SURGERY P.A. for all medical/surgical benefits due under the terms of my insurance. I understand and agree to arrange for prompt payment of the bill. Should my account become delinquent, I will be responsible for any interest, legal fees, and court cost.

______________________________ ______________________________
SIGNATURE OF PATIENT OR AUTHORIZED PERSON PLEASE PRINT NAME

NOTICE OF PRIVACY PRACTICE ACT RECEIVED: __________ DATE: ______________
INITIALS

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## MEDICAL HISTORY FORM

NAME ______________________________________ DATE ___________________

Primary Physician________________________ Phone Number__________________

What is your weight? _____________ What is your height? __________

**For the following questions please mark an "X" or write, whichever applies:**

| | YES | NO |
|---|---|---|
| 1. Are you in good health? | | |
| 2. Has there been any change in your general health within the last year? | | |
| If yes, please explain: | ← | |
| 3. The last time I saw my personal physician was : | ← | |
| 4. Have you had any serious illnesses, operation or been hospitalized in the past five years? | | |
| If yes, please list: | ← | |
| 5. Are you taking any medications including non-prescription medicine? | | |
| If yes, list medicine and strength | ← | |
| Are you taking any aspirin or aspirin product? (Ex: Aleve, Advil, Excedrin, etc) | | |
| 6. Do you have any of the following problems? | ← | |
| a. Any heart disease or Hypertension? | | |
| b. Do you need antibiotics before surgery? | | |
| c. Allergy or sinus problems? | | |
| d. Diabetes? | | |
| e. Do you take Insulin? | | |
| f. Hepatitis, jaundice, or liver disease? | | |
| g. AIDS or HIV infection? | | |
| h. Thyroid problem? | | |
| i. Respiratory problems ? If yes please list: | | |
| If yes, please list | ← | |
| i. Arthritis or painful swollen joints? | | |
| k. Stomach ulcer or Gerd? | | |
| 7. Have you had any abnormal bleeding or bruising? | | |
| 8. Have you ever required a blood transfusion? | | |
| 9. Have you ever had surgery? | | |
| If yes, please list | ← | |

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| | | |
|---|---|---|
| CONTINUES…… | YES | NO |
| 10. Have you seen a plastic surgeon before? | | |
| 11. Have you had plastic surgery before? | | |
| If yes, please list | ← | |
| 12. Please list allergies and reactions: | ← | |
| 13. Do you smoke? | | |
| 14. Do you consume alcohol? | | |
| 15. Do you consume illegal substances? | | |
| 16. Do you have any eye problems or wear contacts? | | |
| 17. If you are female, are you pregnant or do you think you could be? | | |
| 18. Do you have any disease, condition or problem not listed above that you think the doctor should know about? | | |
| If yes, please list | ← | |
| 19. Do you suffer from chronic pain? | | |
| If yes, please describe duration: | ← | |
| 20. Have you had a stroke, ministroke or seizures? | | |
| 21. Have you had contact with Tuberculosis? | | |
| 22. Are you on any special diet ? | | |

Emergency Contact________________________________ Phone Number________________

I certify that I have read and understand the above questions.

______________________________________________________________________

Patient Signature Date

______________________________________________________________________

Physician Signature Date

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# EXPLANATION OF PROFESSIONAL BILLING

The bill you receive from **Take Shape Surgery Center L.L.C.** is for the facility charges incurred from the procedure performed which includes the operating room, recovery room, and all sterile supplies used throughout the surgery and recovery period.

You may also receive a professional billing from one or more of the following physician services listed below for services provided during your procedure. This may include the pathologist, anesthesiologist and possibly radiologist. These bills will be a separate bill from the Center. The physician performing your surgery will also bill you for his professional services separately.

If you have any questions concerning the statements you have received, please call the appropriate billing office listed below:

**DOCTOR FEES:**
Chief: Russell F. Sassani, M.D.
J. Brian Olack, M.D.

Take Shape Plastic Surgery, P.A
(954)585-3800

**ANESTHESIOLOGY:**
Chief: Philip Jacobson, M.D.

South Florida Anesthesia, Inc.
(877)684-9114

**RADIOLOGY:**
Chief: Steve Markowitz

Reliable Radiographic Services
(954)733-5008

**LABORATORY/PATHOLOGY:**

Depending on your insurance
could be one if the following:

| | |
|---|---|
| Global Pathology | (954)971-1144 |
| Quest Diagnostics | (800)758-6047 |
| Ameri-Path | (866)836-7136 |
| Microbiology Associates | (954)771-8903 |
| Integrated Reg. Lab | (954)777-0018 EXT# 508 |
| CBL | (877) 225-7284 |

I acknowledge receipt of this information and understand the contents.

________________________________
Patient Signature

_________________________
Date Signed

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# Acknowledgement of Right to Receive Insurance Payment

Take Shape Surgery Center LLC (hereinafter referred to as TSSC) is responsible for billing its' patient (responsible party hereinafter) and any third party payers including insurance companies and any other health care benefit programs for the services provided at the facility. Responsible party having executed the document below agrees to cooperate with and assist TSSC by completing and executing any and every forms and documents necessary to entitle TSSC to receive payment for services rendered to the responsible party. If responsible party receives payment from their insurance provider or any other third party payer related to the services provided by TSSC, its affiliated physicians, staff and/or subcontractors, the responsible party will promptly contact TSSC (954)585-3800 x 31 advice the billing officer of the receipt of funds. The responsible party in full cooperation with TSSC staff will make every effort to forward said payment to the facility. Responsible party understands and hereby acknowledges that funds received by them in direct payment from any health insurance company or entity for services rendered by TSSC and its affiliates is the rightful property of TSSC. The responsible party further acknowledges that in the event funds are received in the above described manner, said funds are being held in trust by the responsible party and arrangements will be made expeditiously by him/her to forward said funds to TSSC for payment of services rendered. Responsible party understands that a check received for payment of services rendered by TSSC or any of its affiliates is not to be negotiated in any manner whatsoever by the patient him/her other than to render payment to TSSC and its affiliates. Responsible party agrees to endorse any such checks in favor of TSSC or its designated affiliates.

The responsible party does hereby acknowledge that any legal expense incurred by TSSC in an effort to collect funds from him/her shall be the responsibility of the responsible party. Responsible party further agrees that they have had sufficient time to ask any questions they might have related to this policy and that it has been explained to him/her to their full and complete understanding.

______________________________________________________________

**Responsible Party Signature** **Date**

______________________________________

**Print Name**

______________________________________

**Witness To Responsible Party Signature**

______________________________________

**Print Name**

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## PATIENT'S BILL OF RIGHTS

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources of his or her care.

A patient who is eligible for Medicare has the right to know, upon request, and in advance of treatment, whether the healthcare provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

## PATIENT'S RESPONSIBILITIES

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

*** Full text of this law and the address and phone number to file a complaint is available upon request.**
**** Si desea, por favor pregunte por este documento el cual está disponible en español.**
**Please contact Clinic Manager, Michael Schneider 954-494-9144 regarding questions or concerns.**

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## NOTICE OF PRIVACY PRACTICES

Effective Date: 4-13-03

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully. If you have any questions, please contact the Facility Privacy Official by calling the office.

Each time you visit a physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment and billing-related information. This notice applies to all of the records of your care generated by the physician.

We are required by law to maintain the privacy of your heath information and provide you a description of our privacy practices. We will abide by the terms of this notice.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide treatment of services to you. We may disclose medical information about you to your doctors, nurses, medical students or a hospital where you may be receiving care.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer.

We may also use and disclose medical information:
To physicians who have referred you to this office or whom we are referring you to
To business associates we have contracted with to perform the agreed upon services and billing for it
To remind you that you have an appointment for medical care
To tell you about possible treatment alternatives
To tell you about health related benefits or services
To tlie Food and Drug Administration
To Public Health or legal authorities charged with controlling disease, injury or disability
To Workers Compensation Agents
To Health Oversight Agencies
To National Security and Intelligence Agencies
To Law enforcement/Legal Authorities

You're Health Information Rights:
Although your health record is the physical property of the healthcare provider that compiled it, you have the right to:
Inspect and obtain a copy of the medical information that may be used to make a decision about your care. Usually, this includes medical and, billing records. We may

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deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional.

If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the facility.

You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your medical information for purposes other than treatment, payment or health care operations.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. This restriction must be made in writing. We are not required to agree to your request.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Please realize, we reserve the right to contact you by other means if you fail to respond to any communication from us that requires a response.

You have the right to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the privacy Official and submit your request in writing.

Changes to This Notice:
We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the office and include the effective date.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with the Facility Privacy Official. All complaints must be in writing.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing, at any time. If you revoke your permission we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are required to retain our records of the care that we provided to you.