SULLIVAN
SURGERY & SPA

PATIENT MEDICAL HISTORY

CONFIDENTIAL INFORMATION: information contained herein will not be released except when you have authorized us to do so. Please answer **all** questions to the best of your knowledge. The information that you provide will be used by your doctor in decisions regarding your care.

Patient Information

Name: _____ Date of Birth: _____ Age: ____

Physician Information

Referred By: _____

Primary Care Physician: _____

Medical Information

Reason for visit: _____

If this is for a medical reason, list date of onset: _____

Height: _____ Weight: _____

Do you currently have, or have you ever had any of the following? (Please circle – if "yes", give date of onset/occurrence)

AIDS or HIV+	No Yes _____	Heart Condition	No Yes _____
Anxiety	No Yes _____	Hepatitis	No Yes _____
High blood pressure	No Yes _____	Weight loss/gain	No Yes _____
Asthma	No Yes _____	Kidney disease	No Yes _____
Back Problems	No Yes _____	Migraines	No Yes _____
Bleeding disorder	No Yes _____	Seizure Disorder	No Yes _____
Blood clotting disorder	No Yes _____	Stomach ulcers	No Yes _____
Cancer	No Yes _____	Stroke	No Yes _____
Thyroid disorder	No Yes _____	Heart attack	No Yes _____
Depression	No Yes _____	Tuberculosis	No Yes _____
Diabetes	No Yes _____		

Other serious medical conditions or injury that you have or have had, not mentioned above:

_____

_____

Have you ever had surgery? (If "yes", please list the name of the operation and the date it was performed):

_____

_____

_____

Have you ever had any complications from anesthesia? (If "yes", please explain):

_____

_____

_____

Social History

Do you currently smoke? ____ If "yes": How much? _____ If "no": Have you ever smoked? ____ If "yes": When did you quit? _____
Do you currently Vape? _____ If "yes": How much? _____ If "no": Have you ever vaped? _____If "yes": When did you quit? _____
Do you currently use marijuana or cannabis products? _____ If "yes": How much? _____
If "no": Have you ever used marijuana or cannabis products? _____ If "yes": When did you quit? _____
Do you regularly drink alcohol? Yes / No If "yes": How much? _____ How often? _____

Allergies

Do you have any known allergies to medications, iodine/contrast dye, or LATEX? _____ If "yes", please list:

_____

_____

For women only:

Is there a chance you might be pregnant? _____ Are you still having regular monthly periods? _____Date of last period? _____
Date of last mammogram: _____ Results: _____ How many children do you have? _____
We recommend routine breast and pelvic exams by your physician for all adult females.

Are you presently taking any of the following medications? *(If "yes", please circle and list the name of the medication).*

Accutane (Isotretinoin)	_____	Hormones	_____
Antibiotics	_____	Insulin or diabetic pills	_____
Anxiety/Depression Meds	_____	Laxatives	_____
Arthritis medicine	_____	Retin-A	_____
Aspirin, Bufferin, Anacin	_____	Seizure Meds	_____
Birth control pills	_____	Sleeping pills	_____
Blood pressure pills	_____	Steroids	_____
Blood thinning pills	_____	St. Johns Wart	_____
Cough medicine	_____	Thyroid medicine	_____
Digitalis	_____	Water pills	_____
Headache meds	_____	Weight reducing pills	_____
Herbal Supplement	_____		

Other vitamins, supplements, or medications not listed above: _____

Family Medical History

If a blood relative has/had any of the following conditions, please circle and give relationship (blood relatives includes siblings, parents, grandparents, children):

Bleeding tendency	_____	Heart disease	_____
Blood clotting disorder	_____	Diabetes	_____
Breast cancer	_____	Stroke	_____

Please list anything about yourself or your health that you think would be important for the doctor to know: _____
_____

_____

_____

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PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____
Address: _____
Sex: Female Male Social Security Number: _____-_____-_____ Marital Status: _____
Home No.: _____Cell No.: _____
E-Mail: _____
Emergency Contact Name: _____ Phone Number: _____
*** If patient is a minor:** Name of person financially responsible: _____
Relationship to Patient: _____
How Did You Hear About Sullivan Surgery & Spa? _____
****

Insurance Carrier (PRIMARY): _____
Group #: _____Member/ID #: _____ Employer: _____
Date Effective: _____
Policy Holder's Name: _____ Date of Birth: _____
Social Security Number: _____-_____-_____ Sex: Female Male Relationship: _____
Secondary Insurance Carrier: _____
Group #: _____Member/ID #: _____ Employer: _____
Specialist Co-pay amount: _____ Date Effective: _____
Policy Holder's Name: _____ Date of Birth: _____
Social Security Number: _____-_____-_____ Sex: Female Male Relationship: _____
****

_____ * I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-pays, or coinsurances. *I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. *I authorize my provider's office to contact me by telephone to remind me of my appointments.

Patient/Guardian Signature: _____Date: _____

Photograph Consent and Release

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery or a procedure. The photographs will be taken by one of the members of the Sullivan Surgery & Spa medical staff. Any photographs taken will become part of my medical records. My photographs are to be used for the purposes of insurance pre-authorization, office and hospital medical charts, and any necessary medical treatment.

I hereby give my consent for Sullivan Surgery & Spa to use the photographs under the following conditions:
Please choose one of the following options and initial

(Please initial) _____ I authorize my photographs to be used for the purposes of: Medical Seminars, website publication, social media and/or office photo albums. All efforts will be made to ensure patient anonymity and confidentiality. No names or identifying references will be made in conjunction with published photography.

(Please initial) _____ I authorize my photographs to be used only for my medical record, my surgery record and insurance purposes of my surgery with Surgeon. I understand these photos *will not* be used on the office website or in any publications.

Patient/Guardian Signature: _____Date: _____

Financial Policy

Cosmetic/Self-Pay:
When scheduling with our Surgeons, there will be a $100 consultation fee that will be collected at the time of your initial appointment. This fee covers the cost of the time and advice that you receive from her. This fee is non-refundable. At the end of your consultation, a member of our billing team will discuss surgical fees and payment options available to you. If you decide to book surgery with us, **a non-refundable** deposit of a $1,000 is required to reserve a surgery date. We understand that a situation may arise that could force you to postpone or cancel your surgery, Sullivan Surgery & Spa does incur costs associated with scheduling your surgery; therefore the $1,000 deposit is non-refundable once surgery is booked. Final surgical payment will be due at your scheduled pre-operative visit or no later than two weeks prior to your scheduled surgery date. Your surgery will be cancelled if payment is not received by the due date. Surgeries cancelled within two weeks of your surgical date are not eligible for a refund of surgical fees. If paying by credit card there is a 2.5% credit card processing fee.

Insurance:
If your surgery could be considered "Medically Necessary", we would be more than happy to help you submit to your insurance company to receive benefits that you may be entitled to receive. The benefits paid by insurance companies for plastic surgery vary greatly from carrier to carrier and plan to plan. Therefore, we make every effort to determine in advance if insurance coverage exists, and what amount of "out of pocket" expense you may be responsible for paying. After you have been seen by the surgeon, a member of our billing team will discuss the surgical fees and payment options available for your procedures. If procedures are billed to your insurance company by our Surgeons, the Anesthesiologist and the Surgery Center of Annapolis, the procedures will all be billed by each separately. You will be responsible for any co-pay, deductible or co-insurance for each biller as per your insurance benefits. All EOB's and insurance payments that are mailed to you must be mailed to the office within one week of receiving them.

General information:
There will be a $50 returned check fee for any returned checks. It may become necessary to release your protected health information to financial parties, credit card entities, banks and financial companies when requested, to facilitate your payment. Services performed that are paid for with a credit card, debit card or financing third –party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Sullivan Surgery & Spa to use and disclose my protected health information to any Credit Card entity, Bank or Financing Company when they request such information to process an account & assist with payment. I will not challenge such credit, debit or financing card payments once services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this non-credit card challenge agreement is irrevocable.

Skin Care Products are Non-Refundable unless you have an allergic reaction to the product. Dr. Sullivan and our Medical Spa Aestheticians will need to document the reaction with photographs in order to return the product back to the company. Med-Spa Memberships are Non-Refundable or transferable.

Cancellation Policy: Should you need to cancel, please do so at least 24 hours in advance of your scheduled appointment. We understand emergencies and unforeseen circumstances may arise, please contact our office as soon as you can. If you cancel with less than 24 hours' notice more than twice, your credit card on file will be charged the cancellation fee. Appointments scheduled for Monday must be canceled/rescheduled by 3pm on Friday in order to avoid cancellation fees. Should you arrive late for a scheduled appointment and time does not allow us to perform some or all of your treatment, the full amount of the scheduled service will be charged to you. **The cancellation fee for all services is $50.**

If you would like a copy of our financial policy, we would be happy to provide you with one. By signing this document, I acknowledge and accept the terms of the financial policy.

Patient/Guardian Signature: _____ **Date:** _____

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Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed. The practice has implemented policies and procedures so that the confidentiality of your personal and medical information remains confidential.

So that we may provide you or your dependent with appropriate medical care, for general practice operations and/or for the purpose of obtaining payment, we will, at our discretion, provide information regarding the treatment you or your dependent received in this practice, the charges for this treatment and related information regarding the treatment and charges to other health related entities such as; Physician/Non-Physician Providers who work outside of this practice, Medical Facilities, Laboratories for the purposes of running medical tests, other health care providers such as pharmacies, durable equipment suppliers, and ambulance services, insurance companies (or third party administrators) for the purpose of obtaining payments, reviewing medical necessity and/or general case management, State or Federal agencies that require the submission of specific health related information. This information will be submitted by means of the U.S. Postal Service, fax, Internet, voicemail, and/or personal communications.

We may need to contact you by telephone to discuss your appointments, test results, treatment, referrals, an account balance, and/or to return your phone call. We will first attempt to contact you on your cell phone; however, if you are not available and you provide us with a work or home phone number, we may attempt to contact you on those numbers

In the event that you do not pay all of your charges at the time of your visit, we will mail a statement to your home. We may mail other correspondences to your home noting that we are trying to contact you regarding and appointment, test result information and/or information that you may have requested, or information regarding your account in order to collect a debt. We may contact your insurance company to determine your coverage, eligibility, unmet deductible and/or your co-insurance and co-pay requirement.

If you would like information sent to another physician or medical facility, you must sign an authorization to release your information. We will provide this form for you. You may have to fill out a separate form to have your records and documentation send to us from another facility.

You have the right to inspect and copy your protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. This may not include psychotherapy notes. You must submit your request in writing to the Practice Manager in order to inspect and/or obtain a copy of your PHI. Requests for PHI will be processed and completed within 30days; if an extension is needed to process the documents it will not exceed an additional 30 days. Our practice may charge a fee for the costs of emailing encrypted PHI, use of a USB memory stick, CD, copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of any denial. Another licensed health care professional chosen by us will conduct reviews.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care, or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request if the procedures have been submitted to your insurance company. At your request the physician may not disclose information about care that you have paid for out-of- pocket, unless for treatment purposes or in the rare event disclosure is required by law. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, unless it is for information you have paid out-of-pocket for. If your physician agrees to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by providing a written request to the practice at any time. Your physician is also not allowed to sell any of your PHI without your written authorization. Breach Notification: We will notify you if there has been a breach of your PHI.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, for example, if we think the information is correct, or was not created by our practice, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Practice Manager to determine if you have questions about amending your medical record. To file an amendment, your request must be in writing and must be submitted to the Practice Manager.

When necessary, these policies will be modified to ensure compliance with the practice operations and with State and Federal privacy regulations. If you have any questions or concerns with the policies and/or procedures noted above, please contact the Practice Manager to discuss them. We trust that you are comfortable with our efforts to maintain confidentiality or the information related to you or your dependent's medical care.

I have read & understand the Privacy Policies (HIPPA) for Sullivan Surgery & Spa.

Patient/Guardian Signature _____ Date: _____

SULLIVAN
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Discrimination is Against the Law

Sullivan Surgery and Spa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **Sullivan Surgery and Spa** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Sullivan Surgery and Spa: Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters - Written information in other formats (large print, audio, accessible electronic formats, other formats) - Provides free language services to people whose primary language is not English, such as: Qualified interpreters information written in other languages

If you need these services, contact Sullivan Surgery and Spa's Compliance Officer.

- Name: **Erica Hale**
- Mailing Address: **130 Admiral Cochrane Drive, Suite 300, Annapolis, Md. 21401**
- Telephone number: **410-571-1280**
- Fax number: (410) 571-1288
- Email: Erica@sullivansurgery.com

If you believe that **Sullivan Surgery and Spa** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Sullivan Surgery and Spa's Compliance Officer. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Sullivan Surgery and Spa's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: **U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)** Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

I have read & understand the Discrimination Policies for Sullivan Surgery & Spa.

Patient/Guardian Signature _____ Date: _____