JAY B. FINE, MD
PATIENT INFORMATION

DATE_____

Name_____SS#_____

Address_____

City/State_____Zip Code_____

Home Phone_____Cell Phone_____

E-mail address_____

Birthdate_____Age_____Sex M/F_____Marital Status_____

Employer_____Work Phone_____

Spouse_____

Spouse
Employer_____Phone#_____

Emergency
Contact_____Phone#_____

FamilyPhysician_____Phone#_____

Referred
by_____

Reason for
visit_____

Person Responsible for
Payment_____

MEDICAL HISTORY

1. Please list any previous surgery, cosmetic or otherwise.

_____

_____

2. Do you have or have you been treated for any medical problems?

High Blood Pressure____ Palpitations____ Heart Attack____ Chest pains____

Heart Murmur_____

Bleeding Problems_____ Easy bruising_____

Hepatitis_____ Acid Reflux_____ Ulcer problems____ Bowel problems_____

Anxiety____Migraines____Depression____Dizziness/Fainting____Stroke____Back pain____

Asthma____ Pneumonia____ TB____ Shortness of breath____ Bronchitis_____

Diabetes_____ Thyroid problem____ Other medical conditions_____

Kidney problems_____ Eye/Vision problems eg: glaucoma, cataracts_____

3. Are you taking any medications?

_____

_____

4. Do you have any allergies?_____

4. Do you smoke?_____ **Alcohol?**_____ **Recreational Drugs?**_____

_____

Jay B. Fine, MD

KNOW YOUR INSURANCE POLICY

Dear Patient,

Please read and sign this form. It contains general information regarding your health insurance policy which can affect insurance payments to this office and your financial responsibility.

It is our pleasure to assist you in contacting your insurance company in advance of surgery to ask whether a visit or procedure is "covered". However, due to the many insurance policies available, the frequency of changes within those policies and the difficulty in contacting some companies, it is no longer possible for us to interpret each patient's individual policy and determine with absolute accuracy whether a particular procedure is covered or even if a patient is insured. In addition, we cannot guarantee that we are in the "network" of your policy since that is not within our control. Although we can advise you and we try to stay aware of changes, it remains your responsiblity to know your individual policy coverages and it's limitations and to obtain all required referral and authorization forms.

We are here to assist you in any way we can but please remember that your insurance policy will work for you only if you are responsible for and adhere to it's provisions.

*Print Name*_____

*Signature*_____ *Date*_____

PAYMENT INFORMATION

Insurance Company_____

Address_____

_____

Phone #_____

Policy ID#/Group #_____Medicare Number_____

Insured
Person_____DOB_____SS#____

Office Financial Policy and Patient Financial Responsibility

Jay B. Fine, MD will provide medical services and in turn the patient or guarantor will be held liable for that portion of the costs of medical care for which they are responsible. For Medicare and contracted insurance companies, the patient will be liable for any deductibles and co-payments for covered services and the full amount for any non-covered services, due at the time of service.

Patient account balances are due within 30 days of the receipt of the billing statement unless otherwise agreed to in writing. Patients may contact us to make payment arrangements. After 60 days, if no contact or arrangements have been made for payment or no payment received, the account may be referred for collection proceedings. Delinquent accounts will be assigned to a collection agency. The patient or guarantor acknowledges that if the account is referred to a collection agency or reported to a credit agency that the fact of treatment at our office may become a matter of public record. All costs of collection will be added to the outstanding balance. Any attorney fees required for collection will be added in addition. The patient or guarantor agrees to these terms by accepting medical care.

Patient Name_____ Responsible Party_____

Signature_____ Date_____

Authorizations

I authorize payment of the insurance medical expense benefits, otherwise payable to me, directly to Jay B. Fine, MD. I understand that I am financially responsible to the physician for the charges incurred and that such obligation is not contingent on any expected settlement, judgment or anticipated insurance payment.

I authorize release of information to my insurance company.

I authorize release of any requested medical records to Jay B. Fine, MD.

I permit a copy of this authorization to be used in place of the original.

I authorize Jay B. Fine, MD to disclose complete and inclusive information concerning medical findings and treatment to any individual who, in Dr. Fine's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Notice: This office operates under regulations pursuant to the rules of the Board of Medicine as set forth in Rule Chapter 64B8, F.A.C.

Signature_____Date_____

Jay B. Fine, MD

Receipt of Notice of Private Practices Written Acknowledgement Form

I, [name]_____

Have received and reviewed a copy of the HIPPA Notice of Privacy Practices of Jay B. Fine, MD

Signature_____

Date_____

Office Use Only

I have attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so for reasons documented below.

Signature _____ Date _____

JAY B. FINE, MD, FACS

MALPRACTICE INSURANCE NOTIFICATION

UNDER FLORIDA LAW, PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MALPRACTICE INSURANCE OR OTHERWISE DEMONSTRATE FINANCIAL RESPONSIBILITY TO COVER POTENTIAL CLAIMS FOR MEDICAL MALPRACTICE. HOWEVER, CERTAIN PHYSICIANS WHO MEET STATE REQUIREMENTS ARE EXEMPT FROM THE FINANCIAL RESPONSIBILITY LAW. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. THIS NOTICE IS PROVIDED PURSUANT TO FLORIDA LAW.

We welcome any questions that you may have regarding this matter. In over 30 years of practicing plastic surgery, Dr. Fine has a clean malpractice record. We choose to maintain a low volume practice allowing maximum patient care and safety. Skyrocketing malpractice insurance rates have forced us to take this action. We hope that you will understand.

I,_____ acknowledge receipt of the above notification.

DATE_____ Signed_____