URBANIAK PLASTIC SURGERY & MEDICAL SPA

Roderick M. Urbaniak, MD

BOARD CERTIFIED PLASTIC SURGEON

PATIENT HISTORY FORM

NAME: _____ SEX: ____ DOB: _____ AGE: _____

PHONE: _____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ SOCIAL SEC #: _____

MARITAL STATUS: (Please Circle One) Married Single Divorced Separated Widowed

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT & RELATION: _____ PHONE: _____

NAME OF INSURANCE CO: _____ MEMBER ID: _____

NAME OF INSURED: _____ INSURED DOB: _____

PRIMARY PHYSICIAN: _____

LAST LAB WORK: _____ EKG: _____

HEIGHT: _____ WEIGHT: _____ BMI: _____

REASON FOR TODAY'S CONSULTATION: _____

HAVE YOU CONSULTED ANOTHER DOCTOR ABOUT THIS: _____

PLEASE LIST ANY MEDICAL PROBLEMS: _____

_____

HAVE YOU EVER HAD (PLEASE CHECK - IF YES):

HEART DISEASE: _____ HEPATITIS/LIVER PROBLEMS:_____ KIDNEY DISEASE:_____ MRSA: _____

CANCER: _____ DIABETES: _____ BLEEDING/BRUISING PROBLEMS: _____ EPILEPSY: _____

BLOOD CLOTS: _____ HIGH BLOOD PRESSURE: _____ STROKE: _____ POOR SCARRING: _____

MEDICATIONS YOU ARE **ALLERGIC** TO: _____

*PHARMACY NAME AND PHONE NUMBER: _____

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LIST **ALL** SURGERIES AND DATES:

_____

_____

DO YOU SMOKE/VAPE: _____ IF YES, HOW MUCH: _____ HOW MANY YEARS: _____

DO YOU TAKE ASPIRIN ? YES or NO DO YOU TAKE ANY BLOOD THINNERS: _____

DAILY CONSUMTION OF ALCOHOL: _____ COFFEE/CAFFEINE: _____

HOW MUCH DAILY EXERCISE DO YOU GET? _____

LIST ALL DISEASES THAT RUN IN YOUR FAMILY (HEART DISEASE, STROKE, DIABETES, HYPERTENSION, etc.)

_____

_____

Please answer YES or NO to the following questions:

Have you or relative ever had a bad reaction of a general or local anesthetic (gas, Pentothal, etc)? _____

Have you ever had a bad reaction to a local anesthetic (Novacaine, Xylocaine, etc)? _____

Are you allergic to adhesive tape? _____

Do you bleed unusually from cuts, surgery, etc? _____

Do you have any skin disease, hives, eczema or rashes, frequent infections or boils? _____

Have you ever taken cortisone or "cortisone-like" medications by mouth? _____

Do you have shortness of breath or chest pains while walking? _____

Have you ever had a history of facial pain, frequent headaches or TMJ? _____

Have you ever been advised to see a counselor or therapist for emotional problems? _____

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN FURTHER:

_____

How did choose our practice? Physician Friend Internet Hospital Other Social Media

Would you like to receive a monthly email with our specials? Yes or No

In compliance with HIPAA regulations all records are kept confidential. I authorize the release of any medical records or other protected healthcare information that the office may need in order to carry out my treatment or to receive payment for my treatment. You may request to inspect, amend, obtain copies of, or restrict access to your medical records and communications.

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SIGNATURE: _____ DATE: _____

Name:_____ Date:_____

NAME OF MEDICATION	STRENGTH /FREQUENCY	CONDITION MEDICATION TAKEN FOR	PHYSICIAN WHO PRESCRIBES THE MEDICATION

List of Current Prescription Medication(s):

Supplements and Over-the Counter Medications:

_____

_____

ANY KNOWN ALLERGIES:

_____

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HIPAA NOTICE OF PRIVACY PRACTICES
Effective Date: March 01, 2014.

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.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

l. **Your Rights**.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means. You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us. You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization. You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial. You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few. You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 727447-4536.

ll. **We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here Is One Example of Each:**
We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care. Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you. We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

lll. **We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization.** However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to: To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form. As Required By Law. For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings. In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding. To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply

with a court order or grand jury subpoena and other law enforcement purposes. For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.
For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time. Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice. Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will require a separate written authorization.

- Use or Disclosure of Psychotherapy Notes. Written authorization is required if our practice intends to use or disclose psychotherapy notes.
- Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. **You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes**:

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you. Change of Ownership. In fhe event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner. Electronic Exchange. Your information may be shared with other providers, labs and radiology groups through our EMR/EHR system: Eclinical works

VI. **Our Duties.**
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice. We are also required to abide by the terms of this Notice. We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially char-vs this Notice, we will send you another copy.

VII. **Complaints to our Practice and the Government**.
You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and we will review all complaints in a professional manner and keep you informed of your rights as our patient. We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. **Contact Information**
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: Ginger L Wiersma, MD at 727-447-4536. You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-61 Toll Free: 1-877-696-6775

I _____ hereby acknowledge that I have reviewed and received a copy of this practice's Notice of Privacy Practices, which has been updated for the new Omnibus Rule and has an effective date of May 2019

URBANIAK
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The notice describes: The ways that the Privacy Rule allows our practice to use and disclose protected health information. How our practice will get your permission, or authorization, before using your health records for any other reason. The practice's duties to protect health information privacy. The patient's privacy rights, including the right to complain to HHS and to the covered entity if you believe your privacy rights have been violated. How to contact our practice for more information and to make a complaint. I understand that the Notice of Privacy Practices may be revised from time to time and that t have a right to receive an updated copy upon request.

PATIENT SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS

l, irrevocably assign to Roderick M. Urbaniak, M.D., Urbaniak Plastic Surgery & Med Spa, and each of its affiliates (collectively, "Provider") all of my rights and interests to any benefits or other recovery of any type whatsoever receivable by me or on my behalf that may be due and payable to me by any governmental payor, insurance company, health maintenance organization, managed care company, self-funded plan, plan sponsor, plan fiduciary, automobile liability, personal injury protection, medical payments, uninsured or underinsured mother vehicle benefits, settlement/judgements/verdicts, or any other third party payor (collectively, Health Plan") for healthcare goods and services I received from Provider.

I authorize direct payment to Provider of all such benefits or recovery from Health Plan, which payment shall be sent to:

13201 Walsingham Rd. Suite 200 Largo, FL 33774

I hereby authorize and designate Provider as my authorized representative to act on my behalf with respect to all matters related to the appeal of my claim for denials or reductions in payments, improper claims practices and administration, or any other misconduct by my Health Plan, including but not limited to, receiving all information, documentation, and or notifications related to by claim (s).

I further authorize and fully assign to Provider the right to pursue all legal and equitable claims and causes of action including claims for attorneys' fee and costs that I may have against my Health Plan arising or related to any denial or reduction in payment, improper claims practices and administration, or other misconduct by my Health Plan for healthcare goods and services furnished by Provider. Moreover, I authorize Provider to initiate a complaint to the insurance commissioner or any other governmental agency for any reason on my behalf in my name or in Provider's name. Additionally, I authorize Provider as my agent and authorized representative to pursue any and all appeals, legal and equitable claims, and causes of action in Providers' name or in my name. In the event Provider is required to pursue any such appeals, claims, or causes of action, I agree to fully cooperate with Provider and their attorneys and other professionals whom Provider hires to pursue such appeals, claims, or causes of action.

Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment, under Title XVIII or XIX of the Social Security Act, is correct and request that payment of authorized benefits are made to Provider on my behalf.

I agree to be financially responsible for charges not paid according to this assignment, to the extent permitted by applicable law. I also agree that any delay in paying the full amount of any and all amounts for which I am legally liable and any partial payments received by Provider towards my charges, shall not (a) constitute acceptance of any installment payment plan (unless expressly agreed to by Provider in writing), (b) constitute a waiver of the right to receive payment-in-full promptly upon demand, (c) constitute an "accord and satisfaction" of my charges, regardless of any such terms or restrictions indicated on, or included with, any payments, or (d) effect a settlement or resolve an existing dispute as to amounts due and owing by me to Provider. I further acknowledge that Provider does not accept reference-based pricing by Health Plans and, to the extent permitted by applicable law. Provider may elect to deny providing services to my or bill me directly for the balance of by bill, should it be determined that my Health Plant uses reference -based pricing to bill for non-network services. We fight your insurance claims on your behalf for up to three years.

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

l, the undersigned, as the patient or patient representative, or, for a minor/incapacitated patient, as the legal guardian, hereby certify that I have read, and fully and completely understand this Assignment of Benefits and knowingly, freely and voluntarily agree to be bound by its terms.

URBANIAK PLASTIC SURGERY & MEDICAL SPA

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Signature: _____ Date: _____

Print name: _____ Relationship to Patient: _____

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Dr. Roderick Urbaniak and his experienced team appreciate the confidence you have shown in choosing us to provide for your healthcare needs. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf including secondary (if commercial payer). However, you are ultimately responsible for payment of your bill. We are dedicated to minimizing your out-of-pocket costs and in some cases if necessitated we may file appeals or reconsiderations on your behalf; although not industry standard. We fight hard on your behalf in addition to having the ability to set a realistic expectation of costs by estimating the cost of your treatment, care, and or surgical care/procedures.

The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees for what your insurance carrier deems as Patient Responsibility or if the insurance denies payment, then you are legally liable for the uncovered portion of the bill. Please review your patient estimates prior to your services.

_____ You are responsible for payment of any deductible and payment/insurance as determined by your contract with your insurance carrier. We expect these payments, or you will require an appointment with our Billing Specialist to discuss and arrange payment prior to your procedure/surgery. Many insurance companies have additional stipulations that may affect your coverage. You also acknowledge Dr. Roderick M. Urbaniak M.D. is Out of Network provider for all carriers except Medicare. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

_____ I have read the above policy regarding my financial insurance to Roderick M. Urbaniak M.D. P.A., for providing services to me or the above-named patient. I certify that the information provided is true and accurate. If I provided inaccurate insurance information I may be billed for all charges and given paperwork to submit to my correct insurance. I authorize my insurer to pay any benefits directly to Roderick M. Urbaniak M.D. P.A., the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier(s). If I receive any payments from insurance for services provided by Dr. Roderick Urbaniak, I will bring them to the office within 7 days.

Patient Signature: _____ Date: _____

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Guarantor Signature: _____ Date: _____

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT unless other arrangements have been set up prior to Date of Service. Thank you for your cooperation in this matter.

Patient/Guarantor Signature: _____ Date: _____

Consent for Treatment and Authorization to Release Information

I hereby authorize, Dr. Roderick M. Urbaniak M.D., through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize, Dr. Roderick M. Urbaniak M.D., to release to appropriate agencies, any information acquired during my or the above-named patient's examination and treatment. I understand there may be a fee for doing so.

Patient/Guarantor Signature: _____ Date: _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

We will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature: _____ Date: _____

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Self-Pay

I do not have health insurance and will be responsible for services rendered here at Urbaniak Plastic Surgery Dr. Roderick M. Urbaniak M.D. P.A. I agree to pay, Roderick M. Urbaniak M.D. or Urbaniak Plastic Surgery & Med Spa the full and entire amount of treatment given to me or to the above-named patient at each visit.

Patient/Guarantor Signature: _____ Date: _____

HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's Social Security Number**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific persons is authorized to use or disclose information about me:

   _____

2. The following persons person may receive disclosure of protected health information about me:

   Name

   Name

   Name

3. The specific information that should be disclosed is (FINANCIAL AND OR HEALTH): _____

UNLESS YOU SIGN, NO INFORMATION ABOUT YOUR HEALTH/ FINANCIAL WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION * _____ **NO**, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person receiving it, and would then no longer be protected by federal privacy regulations.

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5. I may revoke this authorization by notifying **Roderick M. Urbaniak M.D, PA** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING *

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator