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: _____

*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:_____

List of Current Prescription Medication(s):

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

Supplements and Over-the Counter Medications:

_____

_____

ANY KNOWN ALLERGIES:

_____

_____

13201 Walsingham Rd. Ste 200
Largo, FL 33774
Fax: 727-442-1600

P: (727) 447-4536
UrbaniakPlasticSurgery.com

2111 Drew St. Suite 200
Clearwater, FL 33765
Fax: 727- 441-3927

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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

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

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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: _____

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.

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 –

_____ | _____ | _____

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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

OFFICE POLICIES

Thank you for choosing Dr. Roderick Urbaniak or Dr. Samuel Sohn as your physician. We recognize that you have a choice in your health care providers and we appreciate the trust that you have placed in us. Our office policies allow us to provide excellent health care to all of our patients based on mutual respect. Please review and **initial next to each** office policy acknowledging that you have read and understand the policy.

_____ We respect your time. We try our very best to stay on schedule, but occasionally a patient requires more than the allotted amount of time due to an urgent or complicated problem. Thank you for understanding that we will provide this same level of attention to you in the event that you should ever have the same need.

_____ In the event that you have an urgent health care problem that requires Immediate attention, please try to contact the once as soon as possible to reschedule your appointment. If possible, we will still see you in the once that day. Appointment cancellations require 24-hour advanced notice. Appointments not cancelled within 24 hours of the appointment time will be coded "no-show". Three "no-shows" appointments may be reason to release you from care. If you need to cancel an appointment after our once is closed, please leave a message on our answering service. We realize that in rare cases you will be unable to provide the required 24-hour notice.

_____ If you are going to be more than 15 minutes late for a scheduled appointment, it may be necessary to reschedule your appointment. We will make every effort to see you on the day of your appointment, however if the wait time exceeds the time needed for your appointment it will need to be rescheduled, unless your appointment is urgent.

NOTICE: In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, please note the following: PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE. For your convenience, we accept CASH, VISA, MASTERCARD. DISCOVER AND PERSONAL CHECKS. Your signature below indicates that you understand and accept this policy. **A convenience fee of 3% will be made to all credit card transactions, except for Care Credit.**

We look forward to the opportunity to work with you to meet your plastic surgery needs.

I have read, understand and agree to abide by the office policies described above.

Print Patient Name or Legal Guardian	Signature of Patient or Legal Guardian	Date