ROBERT Feins

Patient Health History

Name_____ Today's Date _____

Date of Birth:_____ Age:_____ Height :_____ Weight:_____

Pharmacy Name, Phone Number_____

Primary Care Physician_____

Reason for Today's Visit:_____

How did you here of Dr.Feins:_____

Insurance: _____

Please Circle any conditions you may have:

Anxiety
Arthritis
Blood Transfusion
Bleeding Problems
Blood Pressure Issues
COPD
Cancer
Depression
Diabetes
Dizziness
Dentures
Emphysema
Eye Problems
Glaucoma
Hearing Loss
Headaches
Herpes or Viral Infection
Heart Attack
Implant Placed in the Body
Kidney Disease
Liver Disease
Lung Disease
Migraines
Mouth Sores
MRSA
Nervous Disorders
Pancreatitis
Radiation Therapy
Sinus or Nasal Problem
Seizures
Stomach Ulcers
Stroke
Thyroid Disease
Wear Glasses or Contact
Weight Loss

Any other Medical Problems?_____

Please List Any Surgeries that you have had:_____

Anything else the doctor should know about:_____

Do you take any blood thinning products such as Vitamin E, Plavix, Coumadin, or Aspirin? _____

Have you ever had any significant weight loss?_____

Please explain:_____

ROBERT Feins

Do you Smoke?_____ How Much?_____ How Long?_____

Do you Drink Alcohol?_____ If yes how many drinks per week_____

Do you use any recreational Drugs?_____ Have you ever used needles to inject drugs?_____

Allergies:

Food: _____
Enviromental:_____
Anesthesia:_____
Tape or Latex:_____
Other:_____

Medications: Please list all prescriptions, non prescriptions, herbal remedies, vitamins, over the counter medication, street drugs, etc

_____
_____
_____
_____
_____
_____
_____
_____
_____

I understand the importance of a truthful health history to assist Dr.Feins's and staff in providing the best care possible. I have the opportunity to discuss my health history with my doctor. If I am a surgical candidate this information with be shared with the surgical facility for pre-operative purposes.
I verify that the above information is true and accurate to the best of my knowledge as of today's date.

_____

Signature of Patient or Parent/Guardian if patient is a minor Date

ROBERT Feins

Informed Consent for Opioid Analgesic Therapy for Pain

Pain Relief is an important goal for your care. For the reasons discussed during your office visit, opioid medication is being prescribed, which may increase your pain control, ability to carry out activities of daily living, and quality of life. However it is important for you to recognize that opioid medications (often referred to as "narcotic medications") can lead to serious and even fatal consequences. This agreement that addresses these concerns and your signature constitutes your understanding and accepting of these concerns.

1. **Potential Side Effects:** mood changes, drowsiness, nausea, constipation, urination, difficulties, itching, depressed breathing, sexual difficulties, addiction tolerance, irregular heartbeat, cessation in breathing leading to coma, brain damage and death.

PLEASE BE AWARE: Opioids can slow down your reaction time, cause downiness, or cloud judgment. It may be unsafe for you to drive or operate machinery while taking these medications.

2. **Physical dependence and tolerance:** suddenly stopping an opioid may lead to withdrawal symptoms including abdominal cramping, pain, and diarrhea, sweating anxiety, irritability, and aching. A dose opioids may become less effective over time and there is no change in your physical condition which may require adjustment or discontinuation.

3. **Overdose:** the risk of overdose is increased if you take more medication than is prescribed or take the opioid along with sedation medications or alcohol. Do not use alcohol or other illegal drugs while taking opioids.

4. **Pregnancy:** serious risk to your unborn child can occur if you are taking opioids. Notify your provider immediately if you are pregnant or plan on becoming pregnant.

5. **Victimization:** you may at risk of becoming a subject of deceit, assault or abuse by someone seeking to get access to your medications. It is important that you keep the opioid medications in a secure locations at all times and consider vary carefully who you choose to tell that you are taking medication.

6. **Diversion:** by signing below, you agree that you will not sell, trade, share, or in any way provide your medication to someone else.

7. **Disposal:** used medication should be disposed of by taking it to a designed drop off site or mix it with a small amount of water and an undesirable waste substance such as used coffee grounds or cat litter.

By signing below, I agree that I understand the risks as delineated above and I will use the prescribed opioids medication responsibility and as directed.

Patient Name:_____ Date: _____

Patient Signature:_____

If Applicable Signature of Parent/Guardian:_____

ROBERT Feins

INFORMED CONSENT FOR TREATMENT

Patient Name: _____

I, knowing that I am experiencing a condition requiring diagnostic, medical or surgical treatment, do hereby request that a consultation with Robert S. Feins, M.D., F.A.C.S., a Board Certified Plastic Surgeon, and do voluntarily consent to examination and evaluation of my condition by Dr. Feins. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Dr. Feins.

_____ _____

Patient Signature Date

OR

_____ _____

Legal Guardian Signature Date

Consent for Clinical Personnel: I am aware that patients at this office may be attended by a nurse or other health care personnel, whom may be present during patient care as part of their duties.

Consent for Photos: I consent to the taking of photographs or video for medical record documentation and treatment purposes only provided that my identity is not disclosed to any outside party without my prior written consent.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider involved with my current treatment. I understand that office personnel may release the fact that I am presently a patient here, without disclosing confidential information, so that I may receive phone calls.

Insurance Consent: I request that payment of authorized benefits be made to Dr. Robert Feins, for any covered services furnished to me. I authorize Dr. Feins's office to release to my third party payor, Medicare, or Medicaid, as applicable, medical or financial information as needed for claims processing, fraud investigation, or quality of care review, and studies.

Pre-certification/prior authorization agreement: I understand that I am responsible to comply with the rules and requirements of my insurance company reading pre-certification and prior authorization requirements.

Guarantee of account: I agree to pay Dr. Feins for all charges not covered by any third party payer.

_____ _____ _____

Patient Signature (or Legal Representative) Relationship to Patient Date

Reason patient is unable to sign consent: __(minor) __(physical or mental disability) __(other)

ROBERT Feins

OUR FINANCIAL POLICIES

BASIC POLICY: Payment for services is due in full at the time service is provided.

For Patients with Insurance: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than an anticipated for your care. If an insurance carrier has not paid within 45 days of billing, professional fees are due and payable in full from you.

Deductibles and Co-Pays: It is your responsibility to check your insurance for your deductible and co-pays for office visits and surgeries. If your deductible has not been met, you will be responsible for the unpaid portion.

Medicare Patients: We will bill Medicare for you. We will also bill secondary insurance for you. All co-payments or deductibles are due and payable at the time service is provided.

Medicaid Patients: All Medicaid Patients must provide a current, valid certified before being seen.

Surgery Fees: All co-pays, deductibles and payments for non-covered surgical procedures are due in full prior to surgery. Prior authorization may be required by your carrier.

Non-Covered Services: Any care not paid by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Cosmetic Services: If you elect to pursue cosmetic surgery, you will meet with our surgical coordinator who will have more detailed information on policies, pricing, scheduling, informed consents and forms to be completed.

Payment and HIPPA: I understand that HIPPA authorizes you to disclose my protected health information to third party payers (including health/life insurance companies, banks, credit card companies, the issuing bank or payment processors) for payment purposes.

Delinquent Accounts: Should your account become delinquent and be referred to an attorney or collection agency for collection, you shall pay actual attorney's fees and collection expenses. All delinquent accounts may be charged interest at the maximum rate allowed by law.

I have read, understood, and agreed to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all professional fees.

_____ _____

Signature of patient (or parent/legal guardian) Date

ROBERT Feins

WAIVER/NON-COVERED DISCLOSURE

Provider Name: Robert S. Feins, M.D., F.A.C.S.
Practice Name: Robert S. Feins, M.D., Prof. Ass'n
Phone: 603.647.4430

You are hereby informed that the patient receiving service(s) today that payment of their service may be denied by their health insurance plan(s) for the following reasons.

Non-referred:

- The patient is not being treated by their primary care physician (PCP) and has not obtained a referral.
- The PCP's name is not on the insurance card or the PCP's name on the insurance card does not match the name of the provider treating the patient today.
- The patient has not contacted their insurance company to advise they have selected the provider they are seeing today and have not obtained a referral.

Not Covered:

- The service provided today is not a covered benefit under the patient's insurance plan.
- The service provided today is considered "not medically necessary" under the patients insurance plan.

Other:

- The patient has provided correct insurance information.
- The patient no longer has health insurance.

I have been informed by the provider indicated above in advance that the service(s) provided today may not covered by my health insurance plan.

Should these services be denied by my insurance, I understand that I will be responsible for the full payment of these charges to Dr. Feins.

_____ _____

Patient/Responsible Party Signature Date

ROBERT Feins

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, _____, have

reviewed a copy of Dr. Feins's Notice of Privacy Practices

_____ _____

Signature of Patient Date

ROBERT Feins

New Patient Consent to use and Disclosure of Health Information For Treatment, Payment or HealthCare Options

I, _____, understand that as part of my health care, ROBERT S. FEINS, M.D., PROF. ASS'N., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means for communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means of which a third-party payer can verify that services billed were actually provided and,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided or have reviewed a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that ROBERT S. FEINS, M.D., PROF. ASS'N is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization my refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ROBERT S. FEINS, M.D., PROF. ASS'N reserves the right to change their notice and practices and that prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should ROBERT S. FEINS, M.D., PROF. ASS'N change their notice, they will send a copy of any revised notice to the address I've provided (whether by U.S. Mail or, if I agree, by email.)

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of the organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for the permitted uses, including disclosures via fax.

_____ _____

Patient/Responsible Party Signature Date

ROBERT Feins

HIPAA
REQUEST TO DISCLOSE PROTECTED HEALTH INFORMATION

Before ROBERT S. FEINS, M.D., PROF. ASS'N., can discuss Protected Health Information, we must first verify and document your identity, the information you would like to use or disclose, and your purpose for requesting this information.

Please fill out the information below. Be as accurate and specific as possible.

Date: _____ Time:_____

Do you give our office permission to discuss medical information with family members?

Name: _____
Business: _____ Home Tel: _____
Address:_____ Work Tel: _____

Relationship to patient (check one):

☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Grandchild
☐ Aunt or Uncle ☐ Attorney (or representative of patient) ☐ Legal Guardian

Information Requested:

Name of Patient:_____

I am requesting the following Protected Health Information:

_____
_____
_____

The purpose of my obtaining this information is (*check all that apply*):
☐ Treatment of the Patient ☐ Payment ☐ Health Care Operations ☐ Other

Please explain:

_____
_____
_____

ROBERT S. FEINS, M.D., PROF. ASS'N. is hereby authorized to discuss my Protected Health Information with _____
As provided herein.

_____ _____
Signature of Patient Date: