Dr. Aryeh L. Herrera M.D., F.A.C.S.

Patient Information

Last Name: _____ First Name: _____ MI: ____

Address: _____
Street P.O. Box/ Apartment #

_____
City State Zip Code

Phone (Home):_____ (Cell Phone):_____ Email Address _____

Birth Date: _____ Sex: Female / Male **Social Security No**. _____

Race:_____ Ethnicity:_____ Language:_____

Marital status: single married widowed divorced Legally separated

Contact person in case of an emergency: _____ Relationship: _____

Contact Phone _____ **Other Phone** _____

Employment Information:

Employer: _____

Address: _____
Street P.O. Box/ Apartment #

_____
City State Zip Code

Work Phone: _____ Ext. _____ Status: ___ Full-Time ___ Part-Time

Guarantor (Person signing patient agreements/consenting to treatment):

Name: _____ **Date of Birth**: _____

Social Security No. _____ Phone (Home): _____ (Other): _____

Address: _____
Street P.O. Box/ Apartment #

_____
City State Zip Code

Employer:_____ Phone:_____

Employer's Address: _____
Street P.O. Box/ Apartment #

_____
City State Zip Code

Referring Provider: _____ **Primary Doctor**: _____

Insurance Information (Policy #1 – Primary) HMO ___ Yes ___ No

Insurance Co. Name: _____Phone No. _____

Address: _____
Street P.O. Box/ Apartment #

_____
City State Zip Code

Policy Holder: _____ Relationship to Insured: ___Self ___ Spouse ___ Child ___ Other

Policy Holder's Address:

_____
Street P.O. Box/ Apartment #

_____
City State Zip Code

Policy Number: _____ Group Number: _____ Policy Holder's Birth Date: _____

Policy Holder's SS #.: _____ Policy Holder's Employer: _____

Policy Start Date: _____ Policy End Date: _____

Insurance Information (Policy #2 – Secondary) HMO ___ Yes ___ No

Insurance Co. Name: _____Phone No. _____

Street: _____City:_____ State: ____ Zip Code: _____

Policy Holder: _____ Relationship to Insured: ___Self ___ Spouse ___ Child ___ Other

Policy Number: _____ Group Number: _____ Policy Holder's Birth Date: _____

Policy Holder's SS #.: _____ Policy Holder's Employer: _____

Policy Start Date: _____ Policy End Date: _____

Worker's Comp

Employer Name _____ Contact Person: _____Phone_____ Ext#___

Compensation Insurance: _____ Date of Injury: _____

Street: _____City:_____ State: ____ Zip Code: _____

Claim Number: _____ Policy Number: _____

Claim Representative: _____ Phone: _____ Fax: _____

MEDICAL HISTORY

NAME:_____ Age: _____ Date: _____

REASON FOR VISIT:_____

History of:	You	Relative(Who)
Heart Disease:	( )	_____
Diabetes:	( )	_____
Arthritis:	( )	_____
Hypertension:	( )	_____
Thyroid Disease:	( )	_____
Seizures:	( )	_____
Asthma:	( )	_____
Emphysema:	( )	_____
Chest Pain:	( )	_____
Swelling:	( )	_____
Bleeding:	( )	_____

History of:	You	Relative(Who)
Heart Attack:	( )	_____
Stroke:	( )	_____
Rheumatic Fever:	( )	_____
Kidney Disease:	( )	_____
Cancer:	( )	_____
Blood Clot:	( )	_____
Hepatitis:	( )	_____

Date last period:_____Last mammogram:____
Last PAP:_____Number of living children:____
Pregnancies:Full:___Preterm:____Abort/Miscarriage:___

Any other medical problems? _____
Do you or did you Smoke? _____How much? _____How long?_____When Did You Stop?_____
Do you or did you drink alcohol?_____What type?_____How often?_____When Did You Stop?_____
Do you use drugs? _____What type?_____How often?_____When Did You Stop?_____
Do you or have you ever taken steroids?_____

Family History: Age(current or at time of death)
Mother:_____Cause of death:_____
Father: _____Cause of death:_____
Brother:_____Cause of death:_____
Sister: _____Cause of death:_____
List additional siblings or relatives on back

Allergies To Medications		
	Medication:	Reaction:
1.		
2.		
3.		

Current Medications			
	Medication:	Dosage:	How Often:
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Past Surgeries		
	Date:	Procedure:
1.		
2.		
3.		
4.		
5.		

Dr. Aryeh L. Herrera M.D., F.A.C.S.

Patient Agreement

"The undersigned hereby consents to be treated by Dr. Aryeh L. Herrera M.D., F.A.C.S. "The undersigned authorizes payment of any worker's compensation or other insurance benefits otherwise due for services, directly to Allegheny Plastic Surgery. The undersigned hereby acknowledges that he/she is financially responsible for any health insurance deductible, coinsurance, or failure for any reason of any insurance carrier to pay the physician's charges in full when rendered. The undersigned also agrees, whether signing as an agent or patient, that he/she is obligated for the payment for all outstanding medical services rendered to the patient, due when rendered. A charge of $50.00 will be assessed for missed appointments if notice is not received and acknowledged by this office at least 24 hours prior to a scheduled appointment. With regards to self-pay discounts agreements, discounts will be revoked and original charges reinstated, due and payable in full in the event of default. The undersigned understands that any balance outstanding over 30 days may be subject to late charges at the rate of 1.5% monthly or 18% annually. The undersigned further accepts responsibility: (1) for payment of all outstanding charges and balances due for medical services rendered to the patient, together with all accrued late charges, and, (2) in the event the patient's account is referred to an attorney or agency for collection, for payment of all court costs, processing fees, collection costs and attorney's fees in the amount of thirty percent (30%) of the balance due, which attorney's fees the undersigned expressly agrees are reasonable."

The undersigned hereby authorizes this office to release any and all medical information concerning this patient's care to any agencies and/or insurance carrier for the payment of any medical charges and/or the determination of any benefits to which either the undersigned or the patient may be entitled from any other party."

Date: _____

Patient: _____

Patient and/or Guarantor Signature _____(SEAL)

Witness_____

Consent to Taking of Photographs

In connection with the medical services which I am receiving from Allegheny Plastic Surgery, I consent that photographs may be taken of me or parts of my body, under the following condition:

> ***These photographs shall be used for medical records only, unless, in the judgment of my physician, medical research, education, or science will be benefited by their use. In that event, I agree that they may be used for such purpose, provided that my identity is not revealed by descriptive texts accompanying them.***

Patient and/or Guarantor Signature _____(SEAL)

Witness_____

Dr. Aryeh L. Herrera M.D., F.A.C.S.
FORM: Acknowledgement Notice of Privacy Practices and Consent

The Patient hereby consents to the use or disclosure of his/her individually protected health information by **Allegheny Plastic Surgery** in order to carry out treatment, payment, or health care operations. The Patient should review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, we will post a summary of the current notice in our office with the effective date. You are entitled to a paper copy upon request.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to Patient's requested restriction(s), such restrictions are then binding on the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already taken action in reliance on the Consent

As required by law **Allegheny Plastic Surgery** has provided you with Notice of Privacy Practices. This notice describes information about privacy practices followed by our health care providers, employees, staff and other office personnel. It also describes your rights and obligations in which information and records that we may have about your health, health status and the healthcare and services you receive at this office may be used or disclosed**.**

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO THE ABOVE STATED TERMS.

_____ _____ _____
Patient Signature Date Please print name

_____ _____ _____
Parent/ Guarantor Signature Date Please print name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

_____
_____
_____

Witness signature: _____ Date_____

Patient chart # _____

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STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS*

For this authorization, "My Health Information" is any and all information relating to my course of examination and treatment. I authorize Allegheny Plastic Surgery to discuss My Health Information with:

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Phone #: _____ Phone #: _____

For general information and inquiries, arranging appointments, identifying medications, discussing billing and payment, and any other related matter.

This authorization is valid for one year from date signed, unless I revoke this authorization, Allegheny Plastic Surgery may contact me to extend this authorization, but I do not have to do so.

Allegheny Plastic Surgery's medical and administrative staff are pledged to maintain strict patient confidentiality in keeping with high ethical standards and in accordance with state and federal laws. Allegheny Plastic Surgery has procedures in place to support this policy. These procedures make it very unlikely that my health information will be improperly disclosed. However, if this happens, my health information may no longer be covered by these privacy protections.

I am not required to sign this authorization. Allegheny Plastic Surgery does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. However, if I do not sign this authorization, Allegheny Plastic Surgery may disclose "My Health Information" as requested. I will receive a copy of this authorization upon signature.

I may revoke this authorization at any time in writing by following the guidelines on the back page of this form.

Patient Name: _____
(first) (m.i.) (last)
Signature: _____ **Date:** _____

Address: _____
_____

Phone: _____ **Birth Date:** _____

For Healthcare agent/guardian/surrogate/parent, I, _____, represent that I am the representative for the patient as circled above.
Representative's Signature: _____ **Phone:** _____
Address: _____

If you are the healthcare agent or guardian, please attach proof of your authority to act on behalf of the patient.

*Not to be used in connection with health information from substance abuse treatment programs.
By signing this authorization, I understand that health information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the clinic or department where my authorization was made.

If I am unable to provide a copy of the original authorization with my request to revoke, I will provide the following information.

- **Date of authorization,**
- **Name,**
- **Address,**
- **Phone number,**
- **Medical Record number,**
- **Date of birth,**
- **Purpose of authorization,**
- **A description of the health information covered by the authorization,**
- **The person or entity authorized to use the data.**

If the form was signed by my representative, the request will also include:

- **The representative's name,**
- **Relationship,**
- **Address and**
- **Phone number.**

I understand that if I am unable to provide all of the above information, Allegheny Plastic Surgery may not be able to honor my revocation request.