DeRosa Plastic Surgery

Dear Patient,

Thank you for contacting us regarding our services and for scheduling an appointment at DeRosa Plastic Surgery. You can feel confident that our staff is committed to meeting your needs. Please be assured that Dr. DeRosa and her staff will work with you to prepare the best plan and take the time to address all of your specific needs.

At DeRosa Plastic Surgery, we strive to provide the most current, safe, and effective procedures available today. By applying the newest technologies and cutting edge procedures, our office is able to provide you with the best options available.

In order to minimize your wait time, **please complete the enclosed New Patient forms prior to your visit and bring them with you to your appointment.** If you have any questions at all, please feel free to call our office.

All cosmetic consultations will be charged $50.00 due upon check-in for your consultation. If for any reason you are unable to keep your appointment, please contact us within 48 hours of your scheduled appointment to cancel or reschedule. Appointments that are not cancelled 48 hours prior to your consult may be billed the basic consult fee of $50. We understand that some delays are unavoidable but please try and arrive at least 15 minutes before your scheduled appointment.

Thank you for choosing DeRosa Plastic Surgery!

Sincerely,
Amy P. DeRosa, D.O. and Staff
www.derosaplasticsurgery.com
248-688-7597
22401 Foster Winter Dr.
Southfield, MI 48075

Name: [First] _____ [M.I.] ____ [Last] _____ ☐ Male | ☐ Female
Address: _____ [Apt.] _____ Age: _____ D.O.B: ____/_____/_____
City: _____ State: ____ Zip: _____ Home Tel: _____
Social Security #: _____Drivers License #: _____
Marital Status:☐Single |☐Married |☐Other
E-mail: _____ Mobile Tel: _____ Other Tel:_____

SPOUSE CONTACT *[If applicable]*

Name: [First] _____ [Last] _____ Spouse's Mobile Tel: _____
Spouse's Employer: _____ Spouse's Work Tel: _____

EMPLOYMENT INFORMATION

☐FullTime |☐PartTime |☐Student |☐Retired |☐Other Occupation:_____
Employer/School: _____ Work Tel: _____
Work/School Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT *[not in your household]*

Name: [First] _____ [Last] _____ Home Tel: _____
Relationship to Patient: _____ Work Tel: _____
Address: _____ City: _____ Mobile Tel: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____ Telephone: _____
Name of Insured: [First] _____ [Last] _____
Policy#:_____ Group#:_____ Co-pay?☐Yes|☐No
If Yes, Amount:$_____ Secondary Insurance Company Name: _____
Telephone: _____ Name of Insured: [First] _____ [Last] _____

Policy#:_____ Group#:_____ Co-pay?☐Yes|☐No If Yes, Amount:$_____

I understand that office visit charges are payable on the day service is rendered. I authorize DeRosa Plastic Surgery to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

Signature: (Patient, Parent or Guardian)_____ Date: _____

DeRosa Plastic Surgery

REFERRAL INFORMATION

Referring Physician or Patient: _____
How did you hear about DeRosa Plastic Surgery? _____
Have you been to our website [www.derosaplasticsurgery.com]? ☐ Yes | ☐ No
If yes, was our website helpful? ☐ Yes | ☐ No

PROCEDURE INFORMATION

What is the reason for your visit today? *[Check all applicable procedures below]*

FACE	BREAST	BODY	SKIN
☐Facelift ☐Cheek Lift ☐Brow Lift ☐Neck Lift ☐Facial Fat Transfer ☐Facial Implants ☐Lip Augmentation ☐Chin Augmentation ☐Ear Reshaping ☐Upper Eyelids ☐Lower Eyelids ☐Rhinoplasty Other_____	☐Breast Augmentation ☐Breast Lift (Mastopexy) ☐Breast Revision / Repair ☐Breast Implant Exchange ☐Breast Capsulectomy ☐Breast Reduction ☐Breast Asymmetry ☐Breast Reconstruction ☐Male Breast Other_____	☐Liposuction ☐Tummy Tuck ☐Mommy Makeover ☐Body Lift ☐Buttock Augmentation ☐Arm Lift (Brachioplasty) ☐Thigh Lift ☐Fat Transfer ☐Cellulite Reduction Other_____	☐Botox Cosmetic ☐Facial Fillers ☐Juvederm ☐Fat Injections ☐Skin Resurfacing ☐Skin Tightening Laser ☐Hand Rejuvenation ☐Hyperhidrosis ☐Skin Care ☐Latisse

Is this procedure a revision from a previous surgery? ☐ Yes | ☐ No
If Yes, how many previous surgeries? _____

SURGERY SCHEDULING

To help us understand your particular needs and time preferences for your surgery, please provide us with the following information:

When would you like the procedure done: ☐Month |☐3Months|☐6Months|☐1Year

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HEALTH INFORMATION

PATIENT INFORMATION

Name: [First] _____ [M.I.] _____ [Last] _____ D.O.B___/____/___
Home Tel: _____ Mobile Tel: _____
Primary Care Physician: _____ Internist: _____ Cardiologist: _____
Age:_____ Weight:_____ Height:_____ B/P: *[To be taken in office]* _____

Personal Past History

Please check (√) if you have had any of the following medical problems

	High Blood Pressure		Cancer		HIV/AIDS
	Heart Disease		Kidney Disease		Stroke
	Heart Failure		Liver Diesease		Psychiatric Diagnosis
	Seizures		Diabetes		Depression/anxiety
	Bleeding/clotting problem		High cholesterol		Stomach Problems
	Chest Pain		Thyroid problem		OBGYN Problem
	Pacemaker		Hepatitis		Other_____

Is there a personal or family history of anesthetic complications or malignant hyperthermia?
☐Yes | ☐No
If yes, please explain? _____

Family History

Do you have a family history of any medical problems? *[Fill in box for those that apply]*

	Heart disease/ Heart attack		Diabetes		Depression/anxiety
	Bleeding/clotting problem		High cholesterol		Seizures
	Cancer (Malignancy)		Thyroid problem		Breast Cancer
	High blood pressure		Hepatitis		Allergies/Asthma

Women only: **Are You Pregnant?** YES NO

Pregnancies: ____ # deliveries:___ # abortions: ___

miscarriages:____ Age at 1st period: _____ cycle of periods: _____day, Length of each: ____

Birth control method _____

Date of last mammogram_____ Normal vs Not normal_____
Date of last PAP and pelvic exam _____ Normal vs Not normal_____

DeRosa Plastic Surgery

To your knowledge, do you now or have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Fever/chills			Excessive thirst or hunger			Lose of balance/paralysis		
Cough/wheeze			Dizziness/light-headedness			Memory loss		
Headaches			No energy/weakness/tired			Numbness/Tingling		
Belching/ gassy			Difficulty hearing/ringing in ears			Cold limbs / hands / toes		
Nausea/vomiting/diarrhea			Insomnia/sleep problem			Change in vision/burry		
Constipation			Difficulty Breathing			Head Injury		
Blood in stool			Vision Problems			Day /Night time sweating		
Epigastric/ Abdominal pain			Chest pain/discomfort			Muscle/joint pain		
Depression/Anger control			Breast lump/nipple discharge			UTI/ Urinary problem		
Anxiety/stress			Unexplained weight loss/gain			TMJ/Jaw problem		
High Blood Pressure			Heart Attack			Chronic Back Problems		
History of Asthma or Wheezing			Heart Failure			Scoliosis (Curvature of Spine)		
Tuberculosis or Silicosis			Rheumatic Fever			Epilepsy/Seizures		
Sleep Apnea			Mitral Valve Prolapse			History of Anemia		
Shortness of breath at rest or with limited exercise			Do you take Prenatal Antibiotics			Excessive Bleeding from Surgery		
Chronic Cough or Lung Problems			Chronic Heartburn			History of Bleeding or Bruising		
HIV/AIDS			Hiatal Hernia			Blood Transfusion		
Irregular Heart Beat, Palpitations			Stomach Ulcer			Phlebitis/Blood Clots		

SOCIAL HISTORY Please check (√) if you have had any of the following

1. ( ) Nicotine/Smoke How many pack a day? _____Since when_____
2. ( ) Alcohol How many glass a day/Week?_____
3. ( ) Caffeine How many cup a day?_____
4. ( ) Soda How many cans a day?_____

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Surgeries and Hospitalizations with Dates

_____

_____

_____

Allergies (drugs, food, environmental) List any allergies and the reactions they cause, including foods:

_____

_____

_____

Please List All Medications you are presently taking, including dosage and frequency.

Please include all non-prescription medications such as iron, aspirin, laxative, etc.

_____

_____

_____

Do you have any special concerns?

_____

_____

_____

Patient's Signature: _____ Date:_____

DeRosa Plastic Surgery

PAYMENT POLICY

For all cosmetic patients - During your visit you will be given a fee estimate for your proposed aesthetic procedure(s). This quote will include fees for the Surgery Center and fees for the Anesthesiologist, as well as any special equipment fees or Assistant fees. Please note this quote is good for 90 days only. If you choose to schedule the procedure more than 90 days in the future, it is possible that the fee will be different than the original quote. The Surgery Centers control their own fee schedules, and may increase their fees at any time. Payment for surgery may be made by cash, major credit card, or personal check. We also offer patient financing through M-Lend. Payment of non-surgical treatments such as Botox® Cosmetic and fillers are made at the time of service by cash or credit card; we are unable to accept personal checks for these treatments. At times, a surgical revision or "touch up" procedure may be desired. Should that be the situation, you the patient will be responsible for additional fees including but not limited to Operating Room or Anesthesia.

In regards to procedures that may or may not be covered by medical insurance, there may be situations in which part of your surgery would be considered functional or medically necessary. In that case, your insurance may pay part of the surgery fee. As a courtesy to you, our office will pursue prior authorization for this procedure. You will be responsible for the Surgeons fee, deductible and/or co-payments prior to the procedure. If the surgery center is a Preferred Provider, you will be responsible for your deductible and co-payments for the operating room & anesthesia, as well as payments for the cosmetic portion of your procedure. **Purely cosmetic services will not be billed to any third party insurer.**

Dr. DeRosa is not responsible for refunding any surgical fees or rescheduling fees that result from a patient's non-compliance. The failure to follow pre-surgical instructions includes: nicotine, alcohol, or drug use, failure to avoid or to take specific medications as instructed, and failure to follow day of surgery instructions. Any surgical procedure rescheduled by the patient less than fourteen days prior to surgery or as the result of patient non-compliance, will incur a surgeon's rescheduling fee; this does not include fees that may be charged by the surgical facility. All fees must be paid prior to confirming any new surgical date.

Should you pay for your procedure with a credit card and then for any reason receive a credit, this credit will reflect a usage fee of 5% of the initial amount charged, due to usage fees that have been assessed to our account by the credit card company to process the initial transaction. Our office requires a non-refundable $1,000.00 scheduling fee to guarantee your surgery date & time. Surgery fees are due in full 20 days before your surgery date. There will be a $1,000.00 fee if you cancel or reschedule your procedure up to 14 days of your procedure. This fee increases to 50% of your surgery fee if you cancel between 10 and 14 days of your procedure. If you cancel within one week (7 days) of your procedure, you will forfeit 100% of your surgery fee. These penalties do not apply to illness related cancellations where a Doctor's note is provided. If a check is returned from the bank, the patient will be responsible for the amount of the check plus a $30.00 processing fee.

We encourage you to contact our office staff for any questions that you may have, so that this policy may be clarified for you prior to scheduling any procedures. We have found that most patients are pleased to have all details known prior to scheduling.

Statement of Financial Responsibility

"I, the undersigned, have read the above & understand that I am responsible for all medical & surgical charges incurred by myself or my dependents. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by the office of Dr. Amy DeRosa. I understand that my medical insurance contract is between my insurance company and myself and that the failure of the insurance company to pay my claim does not absolve my financial responsibility to Dr. DeRosa. All court and attorney fees or other fees associated with the collection of my account are my financial responsibility."

Signature: (Patient, Parent or Guardian)_____ Date: _____/_____/_____

DeRosa Plastic Surgery

PHOTOGRAPHIC AUTHORIZATION

I consent to the taking of photographs or videotapes of myself or parts of my body by Dr. Amy DeRosa, or her designee, in connection with any and/or all plastic surgery procedure(s) to be performed by Dr. Amy DeRosa.

I understand that photographs may be required by my insurance company for the purpose of prior authorization and consent to the release of any requested images for this purpose

I understand that such photographs, videotapes or case histories may be published by Dr. Amy DeRosa and/or any party acting under her license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Amy DeRosa.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge Dr. Amy DeRosa, DeRosa Plastic Surgery, PLLC, and all parties acting under his license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

_____ ____/____/____ _____

Patient Signature Date Physician/Witness Signature

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

_____ ____/____/____ _____

Parent, Guardian or Conservator Signature Date Physician/Witness Signature

DeRosa Plastic Surgery

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0% APR for at least 12 months for qualified applicants. No required payoff or back accrued interest charges.
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Financing up to $50,000
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Call us at: 888-474-6231

DeRosa Plastic Surgery

LATEX ALLERGIES

Latex allergies can be deadly. Latex has been known to cause anaphylactic shock and subsequently death. If someone has experienced itching and burning after coming in contact with any rubber substances, they would be well advised to tell their doctor that they might be allergic to latex and have Dr. Amy DeRosa take appropriate precautions. Allergic reactions to latex can include difficulty breathing, wheezing, bronchospasm, tachycardia, cardiovascular collapse, vomiting, swelling, puffiness, rash, blisters, itchiness and hives. If you know you have an allergy to latex we advise you to wear a Medical Alert Bracelet.

Please mark the appropriate box below indicating whether you **DO** or **DO NOT** have a latex allergy.

_____ I **DO** have a latex allergy.

_____ I **DO NOT** have any know allergies to latex.

Patient Signature:_____ Date:_____

HIPAA PRIVACY NOTICE

I, _____(patient) do hereby authorize the Physicians and staff of DeRosa Plastic Surgery, P.L.L.C. to discuss and release the results of any testing, or procedure(s) that I have had done, or thinking of doing after a consultation, with the following people:

Name:_____(Relationship)_____

Name:_____(Relationship)_____

Patient Signature:_____ **Date**:_____

Please request a copy of the HIPAA privacy policy if you are not familiar with this policy

HIPAA PRIVACY NOTICE RECEIVED

ACKNOWLEDGEMENT:

I acknowledge that I have received the Notice of Privacy Practice given upon request.

Patient/Personal Representative
Signature:_____ Date:_____

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:
Print
Name:_____Relationship:_____

Patient Email_____@_____

DeRosa Plastic Surgery Notice of Patient Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Why Do We Publish this Notice?

As medical professionals, we understand that information about you and your health is sensitive and personal. We are also required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and copy our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information about You?

- *Treatment*. We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.

  These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- *Payment*. We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

  For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in connection with payment for your care.

DeRosa Plastic Surgery

- *Health care operations*. We may use or disclose information about you for operation as in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- To health oversight authorities, for regulatory, licensing and other legal purposes.
- In litigation, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- Worker's Compensation: In such cases that your treatment is a result of an injury on the job, we may release your information to the appropriate carrier/employer.
- To Funeral Directors/Medical Examiners/Coroners in the event of your death.
- When required by Federal, State or Local law.
- For medical research purposes, subject to your authorization or approval by an institutional review board.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone or e-mail at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise us in writing at our Contact address given above.

We may not use or disclose information about you for any other purpose without your written authorization.

<u>What Legal Rights Do You Have In Connection With Your Information?</u>

The Law entitles you to:

- Ask us to further restrict our use and disclosure of information about you. We are not required to grant such a request, but if we do we must make sure the restrictions are implemented.
- Receive confidential communications from us, at an alternative address you provide to us.
- Review our records of your information.
- Obtain a copy of all or any part of our records of your information. You will be charged a copying charge for your records of a $60 base fee, $0.00 for pages 1-20, then $.25 for any pages over 20.
- Ask us to amend your records, if you believe that they are incorrect or incomplete. We are not required to make such an amendment. If you request an amendment and we determine we will not make it, you are entitled to have a statement of your disagreement included in your records. If you do include a statement of disagreement in your records, we may include a statement of explanation or response in your records as well.
- Obtain an accounting of all persons to which we have disclosed information about you, for any purpose except your treatment, payment for your treatment, or our health care operations.
- If you believe we have violated your privacy rights, you may forward us a written complaint to our Contact address given above. You may also file a complaint with the Secretary of the United States Department of Health and Human Services. If you do file a complaint we are legally prohibited from retaliating against you.

DeRosa Plastic Surgery, PLLC Receipt of Notice of Privacy Practices Acknowledgement

I, _____, acknowledge receiving on
(Print patient name)

_____/_____/20_____, a copy of DeRosa Plastic Surgery's Notice of Privacy Practices.

(Print date)

_____

Patient signature or initials