LEWIS PLASTIC SURGERY

New Patient Forms

■ Name _____
Last First Middle Nickname

Reason for Visit _____

Referred by _____ Family Physician _____

Home Address _____ Apt No. _____

City _____ State _____ Zip _____

Home Phone _____ Mobile _____ Work _____

Email Address _____ May we email you about promotional items or sales? ◯Yes ◯No

How did you hear about our office? ◯Physician ◯Online Search ◯Our Website ◯Other

Age _____ Birthdate _____ Social Security Number _____ ◯Female ◯Male

Race/Ethnicity _____ Language _____

Marital Status _____

■ Employer and Occupation _____

Work Phone _____ Ext _____ Is it okay to contact you at work? ◯Yes ◯No

■ Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Mobile Phone _____ Other Phone _____

■ Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone # _____

Insured Name _____ Date of Birth _____ Employer _____

■ Secondary Health Insurance _____

Policy # _____ Group # _____ Ins. Phone # _____

I understand that the office visit charges are payable on the day service is rendered. I authorize Gordon Lewis, M.D. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Gordon Lewis, M.D. and myself.

Signature _____ Date _____

2331-A Robious Station Circle Richmond, VA 23113 804.267.6009 www.lewisplasticsurgery.com
Dr. Gordon Lewis is Board Certified by the American Board of Plastic Surgery

ASPS Member Surgeon®

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Current Medications (dose and frequency- continue on back as necessary)

1.	5.
2.	6.
3.	7.
4.	8.

Do you take any aspirin or blood thinners? ◯ Yes ◯ No

Medical Problems (Check ALL that apply)

Breast

◯ Cancer ◯ Lumps ◯ Pain ◯ Tenderness ◯ Asymmetry ◯ Nipple Discharge ◯ None

◯ Other _____

Respiratory

◯ Lung ◯ Blood Clots ◯ Shortness of Breath ◯ Use of Home Oxygen ◯ Bronchitis ◯ Asthma ◯ Chronic Cough ◯ None

◯ Other _____

Cardiovascular

◯ Chest Pain ◯ Heart Murmur ◯ Heart Failure ◯ Heart Attack ◯ Pacemaker or Defibrillator ◯ Atrial Fibrillation ◯ None

◯ Other _____

Hematologic / Lymphatic

◯ Blood Clots ◯ Anemia ◯ Bleeding Disorder ◯ Easy Bruising ◯ Previous Transfusions ◯ Enlarged Lymph Node ◯ None

◯ Other _____

Psychiatric

◯ Depression ◯ Anxiety Disorder ◯ Schizophrenia ◯ Bipolar Disorder ◯ None

◯ Other _____

Skin

◯ New Lesion ◯ Changing Lesion ◯ Bleeding Lesion ◯ Melanoma ◯ Skin Cancer ◯ None

◯ Other _____

Other

◯ Diabetes ◯ Seizures ◯ Problems with Anesthesia ◯ Other (please describe below)

_____

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List Of All Medication Allergies

_____

_____

_____

_____

Previous Surgical Procedures

Previous Surgical Procedures	Surgeon	Month/Year

Family Medical History

◯ Breast Cancer ◯ Melanoma ◯ Blood clots or pulmonary embolism

Social History

Tobacco / Nicotine: ◯ Never ◯ Currently ◯ Previously How Much?_____ Quit: When?_____

Alcohol: Number of drinks per day / week: _____

Do you or have you used illicit drugs? ◯ Yes ◯ No Which drugs? _____

Female Patients

Mammogram (date) _____ Location _____ Results _____

Number of Pregnancies _____ Number of Births _____ Method of Birth Control _____

Could you be pregnant now? ◯ Yes ◯ No Are you attempting pregnancy? ◯ Yes ◯ No

Medical Staff Use Only

BP _____ **Height** _____ **Weight** _____

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CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, do hereby present myself (or the patient) for care or treatment at the office of GordonLewis, M.D., and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/or surgical procedures. I understand that I amunder the care and supervision of my physician and it is the responsibility of the practice and it's staff to carry out the instructions of such physician. All physicians expectpayment in full upon receipt of a bill and I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results, treatments or examination in the office. I understand that Iam responsible for the outcomes of care or treatment if I do not follow the care, service or treatment plan.

PATIENT IMAGING: I certify my understanding that there is NO WARRANTY, expressed or suggested, as to my own final appearance after elective surgery based on the results of any photographs that I am shown in demonstration of any procedure.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Gordon Lewis, M.D., the physician accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Gordon Lewis, M.D. for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent, or legal guardian, do hereby authorize Gordon Lewis, M.D., the practice's officers andhis employees, to release to any third party payor (such as an insurance company or government agency). Concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. If there is a dispute about payment with any third party payor, i.e. credit card or credit company, I authorize Dr. Lewis to release my information to any involved party as needed to justify these charges or payments.I do hereby release Gordon Lewis, M.D. from all liability that may arise for any health insurance deductibles and coinsurance.

FOR MEDICARE AND MEDICAID PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given to me in applying for payment under Title XVIII or/or the Title XIX of the Social Security Act is correct. I authorize any holder ofmedical or other information about me to release to the Social Security Administration or it's intermediary-carriers, any information needed for this or a related Medicareor Medicaid claim. I request that payment of authorized benefits to be made on my behalf. I assign the benefits payable to Gordon Lewis, M.D. I understand that I amresponsible for any health insurance deductibles and coinsurance.

MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES: Medicare does not cover some inpatient, outpatient, and emergency services. Items not covered include, but are not limited to, medications typically self-administered, annual testing and physicals.

ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY): My signature only acknowledges my receipt of this message from Gordon Lewis, M.D. as dated below and does not waive any of my right to request a review or make me liable for any payment.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to pay the account of Gordon Lewis, M.D. in accordance with the regular rates and terms of the physicians. The undersignedwill pay all costs and expenses including reasonable collection fees (which may include agency, attorney, interest or court fees) incurred or paid by the hospital or Gordon Lewis, M.D. in the collection of this obligation by suit or otherwise.

Patient's Signature _____ Date _____

Patient's Representative / Policy Holder or Spouse _____ Relationship _____

Patient Unable To Sign Due To: _____

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PATIENT'S CONSENT FOR PROVIDER TO DISCLOSE PHI TO AUTHORIZED PERSONS

1. Authorization to Disclose PHI (Protected Heallth Information). I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medicaland protected health information ("PHI") to the persons indicated below.

2. Persons to Whom Disclosure May be Made. Provider may disclose my PHI to the following persons:

Name _____ Relationship, If Any _____

Name _____ Relationship, If Any _____

Name _____ Relationship, If Any _____

3. Purpose of Disclosure. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

4. Expiration of Authorization. This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

5. Conditioning of Treatment. Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

6. Redisclosure by Recipient. I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.

7. Acknowledgement of Reading and Agreement. I have read and understand this authorization.

8. Acknowledgment of Receipt of Notice of Patient Privacy Practices: I acknowledge that I have received from Lewis Plastic Surgery a copy of a separate document, entitled. "Notice of Privacy Practices" which sets forth Lewis Plastic Surgery's privacy practices and my rights regarding privacy of my protected health information.

Signature of Patient or Representative _____ **Date** _____

If a Representative Signs, State the Representative's Authority _____