David A. Femovich, M.D.

Cosmetic, Plastic &
Reconstructive Surgery

PATIENT INFORMATION

PATIENT'S LAST NAME ______ FIRST NAME ______ MIDDLE INITIAL ______ SEX M____ F____

STREET ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

DATE OF BIRTH ______ SOCIAL SECURITY NUMBER ______ HOME PHONE ______ WORK PHONE ______

CAN WE LEAVE A MESSAGE: YES____ NO____ CELL PHONE NUMBER____________

E-MAIL ADDRESS______________________________

RESPONSIBLE PARTY INFORMATION

LAST NAME ______ FIRST NAME ______ MIDDLE INITIAL ______ SEX M______F______

STREET ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

SOCIAL SECURITY ______ BIRTHDATE ______ HOME PHONE ______ WORK PHONE ______ CELL PHONE ______

EMPLOYER'S NAME ______ EMPLOYER'S ADDRESS ______ PHONE NUMBER ______

FAMILY PHYSICIAN______________________________

BILLING INFORMATION

COSMETIC________ COMMERCIAL INS.________ WORKER'S COMPENSATION________

MEDICARE________ CASH____________ MOTOR VEHICLE ACCIDENT__________

PRIMARY INSURANCE COMPANY ______ POLICY #/CLAIM # ______ GROUP NUMBER ______

INSURANCE COMPANY ADDRESS______________________________

SECONDARY INSURANCE COMPANY ______ POLICY #/CLAIM # ______ GROUP NUMBER ______

DATE OF INJURY____________________ REFERRED BY____________________

AUTHORIZATION FOR MEDICAL CARE

I hereby authorize Dr. Femovich to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of myself or members of my family, as listed above, who are minors. This authorization shall continue and be in full force and effect until revoked in writing.

RESPONSIBLE PARTY SIGNATURE______________________________DATE________

DR. DAVID A. FEMOVICH
NEW PATIENT HISTORY & PHYSICAL

PATIENT NAME: ______________________________ DATE: __________
D.O.B.: ______________ AGE: __________ RACE: ______________ RELIGION: ______________
REASON FOR VISIT: ______________________________
CHIEF COMPLAINT OF PRESENT ILLNESS: ______________________________
____

RIGHT / LEFT HAND DOMINANT Family Physician: ______________ Referring Physician: ______________

REVIEW OF SYSTEMS: Are you having difficulty with the following?

Nausea	Yes	No
Vomiting	Yes	No
Chills	Yes	No
Fever	Yes	No
Anorexia	Yes	No
Diplopia (double vision)	Yes	No
Tinnitus (ringing in the ear)	Yes	No
Headaches	Yes	No
Parethesisa (tingling or prickling sensation)	Yes	No
Leg Pain	Yes	No
Dysphagia (difficulty swallowing)	Yes	No
Hemoptysis (coughing up blood)	Yes	No
Chest Pain	Yes	No
Changes in bowel or bladder	Yes	No
Shortness of Breath	Yes	No
PND DOE (Difficulty breathing at night or on exertion)	Yes	No
Blurred Vision	Yes	No
Blindness	Yes	No
Confusion	Yes	No
Ataxia (unsteady gait)	Yes	No
Vertigo	Yes	No
Syncope (fainting)	Yes	No
HIV	Yes	No
Hepatitis	Yes	No
Blood Clot or Embolus	Yes	No
Allergy to Eggs	Yes	No
Allergy to Soy	Yes	No
Allergy to Latex	Yes	No
Lactose Intolerant	Yes	No

Height: __________ Bra Size: __________
Weight: __________ Measurements: ______________

PAST MEDICAL HISTORY:
Medication Allergies: ______________________________
OTC/Vitamins/Herbs: ______________________________
Medications: ______________________________
____
Past Medical History: (asthma, diabetes, hypertension, etc.) ______________
Past Surgical History: ______________________________
Anesthesia Complications: (self or family history) ______________
Immunizations: Yes No Hepatitis Vaccine: Yes No

FAMILY HISTORY:

Tuberculosis	Yes	No	Who: __________
Asthma	Yes	No	Who: __________
Heart Disease	Yes	No	Who: __________
Diabetes	Yes	No	Who: __________
Hypertension	Yes	No	Who: __________
Cancer	Yes	No	Who: __________
Stroke	Yes	No	Who: __________
Epilepsy	Yes	No	Who: __________
Kidney Disease	Yes	No	Who: __________
Blood Clot	Yes	No	Who: __________
Embolus	Yes	No	Who: __________

Other ______________________________

SOCIAL HISTORY:
Tobacco Yes No How much per day __________ How many years __________
Alcohol Yes No How much per day __________ What kind __________

Occupation: ______________________ Employer: ______________
Single / Married / Divorced / Widowed
Husband / Wife Occupation: ______________ Children: Yes / No How many ______ Ages ______
Reviewed by

PHYSICIAN SIGNATURE ______________ **DATE** __________ **STAFF INITIALS** __________ **DATE** __________
PHYSICIAN SIGNATURE ______________ **DATE** __________ **STAFF INITIALS** __________ **DATE** __________
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PATIENT AUTHORIZATION

INSURANCE ASSIGNMENT:

In consideration of services rendered or to be rendered, I hereby assign and transfer to David A. Femovich, M.D., any benefits payable to or for my benefit under hospitalization or sickness insurance, and any other insurance coverage to include major medical for the payment of such services rendered. I agree to cooperate, aid and assist David A. Femovich, M.D. A photocopy of this assignment of benefits is to be considered as valid as the original.

INITIAL: ___________

RELEASE OF INFORMATION:

I authorize David A. Femovich, M.D. to release any medical information requested by representative of local, state and federal agencies, insurance companies, or other organizations or entities as may be required by said representatives for payment of claims arising out of these medical services as are due to David A. Femovich, M.D.

INITIAL: ___________

HEALTH INFORMATION RELEASE:

I agree to share my health information with the following individual(s):

____

INITIAL: ___________

PHOTOGRAPH RELEASE:

I authorize the use of all photographs taken of me for any medical purpose deemed appropriate by my physician. I authorize the release of pre and post-operative photographs to referring physicians.

INITIAL: ___________

Such photographs and/or details regarding medical services that I have received may be shown, printed or broadcast by David A. Femovich, M.D. in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, television, and Dr. Femovich's website and other Internet communications in order to inform the public about plastic surgery methods and results. I grant this consent as a voluntary contribution in the interest of education and scientific purposes, and my consent is subject only to the condition that I not be identified by name at any time during any use of publication by David A. Femovich, M.D.

PATIENT SIGNATURE: ______________________________ **DATE:** __________

WITNESS: ______________________________

Member

AMERICAN SOCIETY OF PLASTIC SURGEONS

American Board of Plastic Surgery
ABMS Maintenance of Certification*
Certification Matters

COMMITTED TO EXCELLENCE

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FINANCIAL POLICY

HEALTH INSURANCE:
Please realize that your health insurance is YOUR insurance, not ours. We will do everything possible to help you get reimbursed from your insurance carrier, but the ultimate obligation for payments rests with you, the patient, not with the insurance company.

HMO'S (Alliance, Select Blue, Keystone...):
If you are self referred to our office or if the referral can not be verified, you will be financially responsible for today's visit. We prefer to have the referral for each visit present at the time of service or you will need to reschedule your appointment. If any services provided at the time of visit require pre-authorization you will need to reschedule or be responsible for payment. At times, services are provided that the insurance does not cover, you will then be responsible for payment.

SURGERY CHARGES:
Cosmetic surgery is paid-in-full at least 2 weeks in advance. If you cancel your surgery less than 3 days before your surgery, 1/3 of your pre-payment will be kept as a deposit towards rescheduling of your surgery.
For in-hospital surgery, we will bill your insurance company directly for their portion of your charges. For us to do this, you must assign benefits to be paid directly to us. You will be responsible for what your insurance does not cover. We will pre-certify your surgery with your insurance company if necessary. You are responsible for checking benefits. If the procedure is not covered by your benefits, you will be responsible for payment.

HMO SURGERY:
We will pre-certify your procedure with your insurance and your PCP. You are responsible for checking benefits. If the procedure is not a covered benefit with your insurance company, you will be responsible for payment.

MEDICARE:
We will file directly with Medicare for you, but you are responsible for the 20% they do not pay or what Medicare does not cover.

WORKER'S COMPENSATION:
If you are here because of a work related injury, we must verify the coverage of your medical bills from your employer and we need exact information from you on the time, location and nature of your injury. Please bring this information with you and notify the receptionist that you are covered under worker's compensation. If for some reason the worker's compensation is not verified, then you (the patient) is responsible for the charges.

THIRD PARTY:
We can only bill a third party (other than a primary company) if we have written verification that the other party will be responsible for the patient's charges.

SELF PAY:
Payment is expected at the time of service.

GUARANTOR/PATIENT SIGNATURE: ______________________________ **DATE:** ________

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NOTICE OF PRIVACY PRACTICES

David A. Femovich, M.D.
P.O. Box 235
Seneca, PA 16346
1-888-780-4200
1-814-676-8000

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name ______________________________ Birthdate ____________________

Signature ____

Date ____