SILVIA ROTEMBERG, M.D.

DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY
MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS
7500 SW 87 Avenue* Suite: 201* Miami, Fl. 33173
Tel: (305) 274-5170* Fax: (305) 274-5172

PATIENT INFORMATION

LAST NAME: ______________________________________ FIRST NAME: _______________________________

ADDRESS: ____

CITY: ________________________ STATE: ________________ ZIP CODE: _____________

HOME TELEPHONE: (   ) _________________________________

WORK TELEPHONE: (   ) _________________________ CELL PHONE: (   ) __________________________

PREFERRED METHOD OF CONTACT: ________________ **EMAIL:** _____________________________________

D.O.B: ___________________ SEX: ___________ SOCIAL SECURITY: __________________

HEIGHT: _________________________ **WEIGHT:** ___________ MARITAL STATUS: _________

REASON FOR CONSULTATION: ____

EMPLOYER: ____ OCCUPATION: _____________________

EMERGENCY CONTACT: _______________________________ TELEPHONE: (   ) ________________________

RELATIONSHIP TO PATIENT: _______________

WHO IS YOUR FAMILY DOCTOR: __________________________ TELEPHONE: (   ) ________________________

PHARMACY NAME: _____________________ **TELEPHONE: (   )** __________________ **ADDRESS:** _____________________

WHO REFERRED YOU TO OUR OFFICE: ____

PHYSICIAN'S RELEASE AND ASSIGMENTS

I understand that I am financially responsible for all charges incurred by me, and I agree that in the event that this account is referred to collections, to pay all collection expenses.
SIGNATURE REQUIRED:

PATIENT/ PARENT/ GUARDIAN: ____ **DATE:** ___________________

CHECK THE APPROPRIATE ANSWER IF YOU DO NOT KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE PROVIDED

Are you currently under a physician's care? YES ___ NO ___ **If so, why?**
____

Are you taking any medications? YES __ NO __ **if so, Please list**
____

Are you allergic to any medications/foods? YES ___ NO ___ **if so, please list**
____

Are you allergic to any metals or latex? YES ___ NO ___

Are you pregnant of suspect you might be? YES ____ NO ____

Do you use any birth control? YES ___ NO ___

Have you ever been treated or been told you might have a heart disease? YES ___ NO ___ **if so, please list**

____

Do you have high or low blood pressure? YES ___ NO ___

Do you have a pacemaker? YES __ NO ___

Have you used ACUTANE? YES__ NO ____ **if so, list when**:

____

Have you taken diet pills? YES ____ NO ____

Have you had a serious illness or previous surgery? YES ___ NO ___ **if so, please list**

____

Have you had previous PLASTIC SURGERY? YES ___ NO ____ **if so, please list**

____

Are you diabetic? YES ___ NO ___

Do you have asthma? YES ___ NO ___

Do you have kidney or liver problems? YES ___ NO ___

Do you have a history of sleep apnea? YES ___ NO ___

Are you HIV positive? YES ___ NO ___

Do you bleed excessively after being cut or injured? YES ___ NO ___

Do you have any blood disorders? YES ___ NO __ **if so, please list:**

____

Have you had or test positive for hepatitis? YES ___ NO ___

Do you smoke? YES ___ NO ___

Do you consume alcoholic beverages? YES ___ NO ___ **if so, how often?**

____

Would you accept blood in an emergency? YES ___ NO ___

Do you habitually use marijuana or any other illegal substances? YES ___ NO ___

Do you have any disease, condition or illness not listed? YES ___ NO ____ **if so, please list**

____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/GUARDIAN SIGNATURE: ______________________________________ **DATE:** ____________________

ROTEMBERG PLASTIC SURGERY/MIAMI CENTER FOR ADVANCED PLASTIC SURGERY MUTUAL PRIVACY AGREEMENT

Dr. Rotemberg and Miami Center for Advanced Plastic Surgery/Rotemberg Plastic Surgery agree to provide treatment to: ____. The physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling list of patients or medical information to companies to market their products or services directly to patient without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, physician agrees not to provide medical information for the purpose of marketing directly to patient. Regardless of legal privacy loopholes, physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician- his practice, expertise, and/or treatment- on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if patient prepares such commentary for publication on web pages, blogs and/or mass correspondence about physician, the patient exclusively assigns all intellectual property rights, including copyrights, to physician for any written, pictorial, and/or electronic commentary. The assignment shall be operative and effective at the time of creation.

The Agreement shall be in force and enforceable for a period of five years from physician's last date of service to patient. As a matter of office policy, physician is requiring all patients in its practice sign the mutual agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all physician's patients. Further, this agreement will survive for a minimum of three years beyond any termination of the physician-patient relationship.

Patient and Physician acknowledge that breach of this agreement may result in serious, irreparable harm. Patient and physician agree to the right of equitable relief. Should a breach of this agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

Dr. Silvia Rotemberg; Rotemberg Plastic Surgery/ Miami Center for Advanced Plastic Surgery

Patient Signature: ___________________________________ Date: _______________________

NOTICE TO ALL PATIENTS

Your health plan has specific regulations you must follow in order for you to avoid liability from full payment on services rendered by our physician.

REFERRALS: We participate with many health plans. It is your responsibility as a patient to provide us with an updated referral on the day of your scheduled appointment. Our office cannot be held responsible for obtaining referrals. If we do not have a referral on file on the date of your scheduled appointment, we will reschedule you for a later date. To avoid this problem, we suggest you contact your primary care physician in advance.

PAYMENT METHODS: We accept cash, Visa, MasterCard, Discover, American Express, and personal checks.

NON-CANCELLATION POLICY: Please be courteous and call us if you cannot make your scheduled appointment 24 hours in advance. This allows us to see other patients who may be in need of our services. A $35 non-cancellation fee will be charged for missed appointments at the discretion of the office manager.

FORMS: There is a charge of $20 to complete any non-insurance related disability, jury duty or school forms.

BILLING FEE: Co-payments, co-insurance, and deductibles are payable at the time services are rendered. There will be a $10 billing fee for each statement that needs to be generated when your account has become 60 days delinquent. **All Cosmetic Consultations have a fee of $50 due at the time of service.**

TEST RESULTS: Dr. Rotemberg may require a follow-up visit to review and discuss any diagnostic testing or pathology results.

HIPPA: Upon request, a copy of the privacy policy will be provided to you.

Finally, this is your insurance plan. Please familiarize yourself with every rule of the health plan you are enrolled in. Your insurance company will mail a summary of charges, payments, denials or requests for further information. Please review all insurance correspondence.

Please sign and return this form to the front desk after reading it. If you have any questions, feel free to speak to one of our office personnel.

I have read and understand the above information.

Patient Name: ____

Signature: ____ Date: _______________

Notice of Privacy Acknowledgement

Dr. Silvia Rotemberg

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _______________ Attempt: ____

Staff Name: ____

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

____ _____________________

Patient Name or Legal Guardian (print) Date

____

Signature

ROTEMBERG PLASTIC SURGERY/MIAMI CENTER FOR ADVANCED PLASTIC SURGERY

Patient Consent for Use of Credit Cards, Debit Card, and Financing -
Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow **ROTEMBERG PLASTIC SURGERY/MIAMI CENTER FOR ADVANCED PLASTIC SURGERY** to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

______I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

______I agree that this non credit card challenge agreement is irrevocable.

____
Print Patient's Name

____ ____________________
Signature of Patient or Legal Guardian Date

CONSENT FOR PHOTOGRAPHY, VIDEOTAPING OR PUBLICATION

I, ___________________________________do hereby voluntarily participate and give authorization to appear in filming, photographs, videotaping and/or interviews for **Miami Center for Advanced Plastic Surgery/Rotemberg Plastic Surgery** public relations and advertising. I do hereby consent to the unlimited use of such product or interview in MCAPS/Rotemberg Plastic Surgery publications and/or website, social

media, news media reports, newspapers, magazine, television or radio, billboard or any type of advertising. I do hereby release Miami Center for Advanced Plastic Surgery, its agents and employees from all liability in connection with the above. I waive any right to inspect or approve the finished product or the advertising or other copy that may be used in connection with the above. I hereby consent to the above, without expectation of remuneration to me now or in the future, and this shall be binding upon my heirs, personal representative and assigns. I agree to allow my records to be reviewed by other physicians of Miami Center for Advanced Plastic Surgery for the purpose of peer reviews.

____
Print Name of Patient

____
Signature of Patient or Subject

____
Date