# 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:** _____

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**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, personal checks, and all major credit cards (Visa, MasterCard, Discover, and American Express).

**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: <u>There is a charge of $25 to complete any forms including FMLA, work, disability, jury duty or school.</u>**

**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 $55 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.

**HIPAA:** 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: _____

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

**HIPAA AUTHORIZATION FORM**

| **Patient's Full Name** | **Patient's Social Security Number/Medical Record Number** |
|---|---|
| **Address** | **Patient's Date of Birth** |
| **City, State Zip Code** | **Patient's Telephone Number** |

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   _____
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   **His/her/its Name**

   **Address**

   **City, State Zip Code**

3. The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

_____

**UNLESS YOU SIGN HERE**, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
**YES**, DISCLOSE THIS INFORMATION *_____
**NO**, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____ .
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

**FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.***

| _____ | _____ | _____ |
|---|---|---|
| **Signature of Individual*** (The person about whom the information relates) | **Date of Individual's Signature** | **Date of Birth or Social Security Number** |

*OR, if applicable –*

| _____ | _____ | _____ |
|---|---|---|

| Signature of Guardian* or Personal Representative of Patient's Estate | Date of Guardian's/Personal Representative's Signature | Description of Authority to Act for the Individual |
|---|---|---|

***A copy of this completed, signed and dated form must be given to the Individual or other signator.***

| Official Use Only | | |
|---|---|---|
| Received | Processed By | Log # |

**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

# Email Consent Form

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

## 1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

## 2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a) All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patients medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b) Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c) The patient is responsible for protecting his/her password or other means of access to email Consent Form mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
d) Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
e) It is the patient's responsibility to follow-up and/or schedule an appointment.

## 3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.
b. Inform Provider of changes in his/her e-mail address.
c. Confirm that he/she has received and read the e-mail from the Provider.
d. Put the patient's name in the body of the e-mail.
e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).
f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
g. Withdraw consent only by e-mail or written communication to Provider.

## 4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you, if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

## PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print) _____

Patient Signature _____ Date _____

## HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____ Date _____