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

**** IF YOUR INSURANCE REQUIRES A REFERRAL FOR YOU TO SEE DR. ROTEMBERG, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT – DUE TO NO REFERRAL – YOU THE PATIENT AGREE TO PAY DR. ROTEMBERG IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT. ****

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: _____ **DATE:** _____

INSURANCE RELEASE INFORMATION

I HEREBY AUTHORIZE THE OFFICE OF DR. ROTEMBERG TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO DR. ROTEMBERGI UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

PATIENT: _____ **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 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.

PAYMENT METHODS: We accept cash, 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 48 hours in advance. This allows us to see other patients who may be in need of our services.

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.

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

HIPAA AUTHORIZATION FORM

I acknowledge that due to HIPAA laws, my doctor is required to obtain a written consent to disclose any Private Health Information in the presence of anyone other than myself. **Please check the corresponding line:**

- _____ **I ALLOW** Rotemberg, MD to discuss details of my medical records/financial records with

  _____**. (Please print name of authorized family member of friend).**

- **Relation (of authorized person) to patient** _____**.**
- _____ **I DO NOT ALLOW** Rotemberg, MD to discuss details of my medical records/financial records with anyone else but me.

_____ _____

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 by Dr. Rotemberg 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 a payment.

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

_____
Print Patient's Name

_____ _____
Signature of Patient Date

CONSENT FOR PHOTOGRAPHY

I _____ acknowledge that Dr. Rotemberg will photograph me for medical purposes.

_____**I ALLOW** Dr. Rotemberg to use my photographs to appear in filming, photographs, videotaping and/or interviews for public relations and advertising. I consent to the unlimited use in publications and/or website, social media, news media reports, newspapers, magazine, television or radio, billboard or any type of advertising.

_____**I DO NOT ALLOW** Dr. Rotemberg to use my photographs to appear in filming, photographs, videotaping and/or interviews for public relations and advertising

_____ _____
Signature of Patient 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 _____