Virginia Center for Plastic Surgery

Eric Desman, M.D.
Board Certified Plastic Surgeon

# PATIENT DEMOGRAPHICS & REGISTRATION FORM

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change ☐ Yearly Update

**Please PRINT and answer all questions: Date:_____ Reason(s) for Visit today:_____**

**Patient Name**: LAST _____ FIRST _____ MI_____ Sex ____ **DOB** ___/____/____

SSN: _____ **How did you hear about us**? _____

Person Responsible For Bill (If other than patient)_____Relationship:_____

Patient Address: _____ City: _____ST: ____ ZIP:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address:_____ *Would you like to receive specials, offers, news and events via email?* ☐Yes ☐No

Race: *(Check one) White, Black/African American, Asian, Native Hawaiian, Other Pacific Islander, Hispanic, American Indian/Alaska Native, Unknown*

Ethnicity: *(Circle one) Latino or Hispanic Identity, Not Hispanic or Latino, Unknown*

Marital Status: *(Circle one) Married, Divorced, Single, Widowed, Separated* Language: _____

Employer: _____Occupation:_____

**Referring Physician (*If applicable; Please include first name*):** _____ Phone: _____

**Primary Care Physician (*Please include first name*):** _____Phone: _____

**Name of Emergency Contact**: _____Relationship: _____ Phone: _____

***(BOXED INSURANCE SECTION NOT REQUIRED IF YOUR APPOINTMENTS ARE FOR ELECTIVE/COSMETIC REASONS)***

PRIMARY INSURANCE COVERAGE:_____ Policy holder's SS#: _____

Policy holders (subscriber's) name: _____ DOB ____/____/____ Sex: M F

Your relationship to policy holder: _____ Policy #: _____ GRP# _____

Policy holder's employer: _____Phone #: _____

SECONDARY INSURANCE COVERAGE: _____ Policy holder's SS#: _____

Policy holders (subscriber's) name: _____ DOB ____/____/____ Sex: M F

Your relationship to policy holder: _____ Policy #: _____ GRP# _____

Policy holder's employer: _____Phone #: _____

ASSIGNMENT & RELEASE: I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed company/companies and assign directly to VCPS/Dr. Eric Desman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize VCPS/Dr. Eric Desman to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

*Signature of Insured/Responsible Party* *Date* *Printed Name of Insured/Responsible Party*

_____ *(initial)* **A copy of the Privacy Practice for Virginia Center for Plastic Surgery has been provided to me**. I understand that it will be updated every three years and will be made available to me upon request.

**Health Care Status Authorization**

_____ *(initial)* I hereby give authorization to Virginia Center for Plastic Surgery for the release of information concerning the status of my health care, including test results and discussing my plan of treatment, billing or claims payment, or other purposes as I may direct, with the names listed below and I understand that I may revoke this authorization at any time.

Name:_____ Relationship:_____ Name:_____ Relationship:_____

**Authorization for use of Answering Machines**

_____ *(initial)* I authorize Virginia Center for Plastic Surgery to provide detailed information to me via my home, work, and/or cell voicemail concerning appointment, referral and test information. I understand that I may revoke this authorization at any time.

I certify that, to the best of my knowledge, the above information is complete and accurate.

**Patient/Guarantor's Signature**: _____ **Date**: _____

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# PATIENT MEDICAL HISTORY FORM

**Patient Legal Name**:_____ **Age:**_____ **Height**:_____ **Weight**: _____

**Today's Date**: _____/_____/_____ **Reason for today's visit**:_____

Primary Care Physician:_____ Other Treating Physician(s):_____

Have you seen another physician for the same reason you are here today? ☐No ☐Yes

**Current Medications** (include vitamins and herbal supplements, insulin, steroids, inhalers, oxygen, eye-drops, etc.)

| *Drug* | *Dose* | *Frequency* | *Drug* | *Dose* | *Frequency* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Allergies and Adverse Reactions** (Include allergies to antibiotics, Latex, X-ray, dye, skin preps, pain medications if applicable)

Do you have any drug allergies? ☐NO ☐YES (if yes, please list) _____

Please check any item to which you have had an allergic reaction: ☐ Iodine ☐ Latex rubber ☐ Local anesthetics (e.g. Novocaine)

**Alcohol:** ☐YES *(if yes, how much?)* ☐*Minimal* ☐*Moderate* ☐*Heavy* ☐*Previously Heavy* _____ ☐NO

**Tobacco**: ☐ YES - I smoke ___packs/day and have for ___ years ☐Smokeless tobacco/Vaping ☐NO ☐Stopped in year _____

☐Previously smoked ____ packs/day for ___ years. **Do you use recreational drugs** (*Marijuana, Cocaine, Heroin, etc*)?☐Yes ☐No

**Please check any of the following conditions you currently have or have had in the past:**

| | | | | |
|---|---|---|---|---|
| ☐AIDS or HIV Infection | ☐Cold sores | ☐Glaucoma | ☐Kidney Disease | ☐Respiratory or Breathing Problems |
| ☐Anemia | ☐Concussion | ☐Heart Attack | ☐Leukemia | |
| ☐Angina | ☐Depression | ☐Heart Disease | ☐Liver Disease | ☐Rheumatic Fever |
| ☐Arthritis | ☐Diabetes | ☐Heart Murmur | ☐Low Blood Pressure | ☐Seizure |
| ☐Asthma | ☐Emphysema | ☐Hepatitis/Jaundice | ☐Mental Illness | ☐Stroke |
| ☐Cancer | ☐Epilepsy/Convulsions | ☐High Blood Pressure | ☐Mitral Valve Prolapse | ☐Substance Abuse |
| ☐Cardiac Pacemaker | ☐Fainting/Seizures | ☐Joint Replacement or Joint Implant | ☐Psychological Problems | ☐Suicide Attempts |
| ☐Chest Pain | ☐Fever blisters | | ☐Radiation Therapy | ☐Thyroid Problems |

**Have you had other cosmetic surgery procedures in the past?** ☐No ☐Yes (If Yes, Please list procedures & dates):

_____

**Past Medical and Surgical History** *(List all operations & major injuries, all hospitalizations and illnesses for which you have been treated)*

_____

**Please check any of the following conditions that have occurred in your family**:

| | | | | |
|---|---|---|---|---|
| ☐Anesthesia reaction | ☐Asthma | ☐Diabetes | ☐High blood pressure | ☐Melanoma |
| ☐Heart disease | ☐Cancer | ☐Eczema | ☐Lung disease | ☐Skin cancer |

**The following questions help assess your risk for developing a blood clot/deep vein thrombosis (DVT) with surgery:**

Have you had a previous DVT? ☐No ☐Yes

Has anyone in your family ever had a DVT? ☐No ☐Yes

Will you need to travel more than 30 minutes to this office for appointments? ☐No ☐Yes

***For women only*:**

Are you pregnant or think you may be pregnant? ☐No ☐Yes

Are you nursing? ☐No ☐Yes

Are you taking oral contraceptives? ☐No ☐Yes

Do you perform self-breast exams? ☐No ☐Yes

*I have fully completed, reviewed, and verified that all of the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.*

_____ _____

*Patient/Responsible Party Signature* *Date*

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# PATIENT – VCPS FINANCIAL POLICY

**Patient Legal Name**:_____ **DOB**____/____/_____

VCPS believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to understand our financial policy completely.

PLEASE READ AND INITIAL EACH ITEM BELOW:

_____PAYMENT is due at the time of your cosmetic or insurance related visit. We accept cash, checks, and credit (Visa, MC, AMEX) Photo ID is required. Payment will include an unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing clause, payment in full is due at the time of visit.

_____INSURANCE: We are participating providers with several insurance plans. As a courtesy, we will file all medical claims to your insurance company for any non-cosmetic services, provided that you have supplied us with all the correct, appropriate information. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for the payment in full. If your insurance company does not pay the practice within a reasonable period, you will be responsible for the bill for services received. If we later receive payments from your insurer, we will refund any overpayment to you. Not all insurance plans cover all services. If your insurance plan determines a service "Not Covered" for any reason, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. Understand that, in the event of collection activity, the Responsible Party will b e held liable for interest charges, late charges, collection fees, reasonable attorney's fees, and court fees.

_____BANK FEES It is not our practice to accept personal checks as a form of payment. However, please understand that if you submit payment for a bill through the US mail and that check is returned by your bank, a $30.00 returned check fee will automatically add to your account balance. This balance is required paid prior to receiving services from our staff or the physician. At that point, your account will require payments for services in the form of cash, money order, or certified funds. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Fairfax County.

_____BILLING OFFICE: If you have questions in regards to any our billing statements, our accounts receivable staff is available to assist you. Please let our office know, and we will direct you to the appropriate person.

_____CANCELLATIONS OR MISSED APPOINTMENTS: If you must cancel or reschedule your appointment, please do so by giving our office at least 36 hours notice. If you do not cancel your appointment at least 36 hours before, of if you no-show, your account will accrue a $50 missed appointment fee.

_____COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance; This includes (but not limited to) late fees, collections, agency fees, court costs, and/or interest fines. I understand that these additional charges will be my responsibility to pay in full.

PLEASE NOTE:

- If you are a MEDICARE patient, we will file a claim for payment at time of service. Balance due at time of service including but not limited to: Deductibles, co-insurance, and non-covered services.
- WORKERS COMPENSATION: Authorization for treatment and financial responsibility, provided in writing by your employer is required to avoid payment due in full at time of service.
- CREDIT CARD TRANSACTIONS: By signing below, I give permission for Virginia Center for Plastic Surgery to communicate with my credit card company regarding any issues or discrepancies on my bill.
- PATHOLOGY FEES are billed separately from VCPS fees, and I acknowledge that I will be responsible for any pathology fees not covered by insurance.

MEDICAL RECORDS/FORMS/REPORTS:
MEDICAL RECORDS: No charge for the first report. Our office has up to 30 days to complete your request. If your request is to have your records mailed, an additional processing fee may be charged.
DISABILITY FORMS: There will be a $15.00 charge for each request for disability forms and a 7-10 day business day's process time.
FMLA (Family Medical Leave Forms): No charge, and a 7-10 day business day's process time.
NARRATIVE REPORTS: $350.00

I have read and understand Virginia Center for Plastic Surgery's financial policy as stated above and I agree to abide by the terms. I also understand and agree that the practice may amend such terms at any time.

Patient/Guarantor's Signature: _____ Date: _____ Time:_____

Patient/Guarantor's Printed Name:_____

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# PHOTOGRAPHS & VIDEOS RELEASE AND AUTHORIZATION

**Patient Legal Name**:_____ **DOB**____/____/_____

*ABOUT THIS FORM: Dr. Desman and our team are privileged to be trusted with your health, care, and healing. As you know, taking the step to visit a plastic surgery office about your surgical or non-surgical journey can be a difficult and nervous decision. If you would like to help VCPS in educating other potential patients through visual aides such as photos/videos, you can assist them in their decision-making process by selecting Options 1 or 2 in the Photo Consent below. If you prefer to keep your photos strictly within your medical record, you may select Option 3.*

**PHOTOGRAPHS & VIDEOS RELEASE AND AUTHORIZATION CONSENT**

I hereby acknowledge that one of the members of Virginia Center for Plastic Surgery (VCPS) medical staff will take photographs or videos of me or parts of my body before and after surgery. My signature and selection below provide my consent to use and reproduce any and all photographs, electronic images or video footage of me taken by VCPS, or that VCPS has in its possession, provided either by me or by a third party (collectively, "Images"), for the selected purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques. I acknowledge that VCPS will not compensate me for their use. My consent to the use of the Images includes a waiver of any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter or manner in which that the Images may be used.

I understand that my treatment, payment, enrollment, or eligibility for service/benefits will not be conditioned on my choice indicated below, or whether I sign this authorization. Accordingly, my initials below provide VCPS, and its affiliates, or anyone authorized by any of them (including but not limited to designers, publishers, or printers) my consent and authority to utilize my images in:

## (Please initial **one** of the following)

_____ 1. **All Media Sources**: Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the VCPS website and social media sites such as YouTube, Real Self, Facebook, Instagram and Twitter. The Images (including any photographic negatives) shall be the sole property of VCPS. I give my consent as voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party. I understand that in some circumstances, (i.e. photos taken for face or nasal patients), the photographs may portray features that shall/may make my identity recognizable.

_____ 2. **Only VCPS Website**: Photographs or video taken of me or parts of my body as well as details regarding medical services that I have received at Virginia Center for Plastic Surgery, can be used on the company's website in order to inform the public about plastic surgery methods. The Images (including any photographic negatives) shall be the sole property of VCPS. I give my consent as voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party. I understand that in some circumstances, (i.e. photos taken for face or nasal patients), the photographs may portray features that shall/may make my identity recognizable.

_____ 3. **For Office Use/Medical Care Only**: Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Virginia Center for Plastic Surgery. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Virginia Center for Plastic Surgery, including my profile with the practice.

I hereby release, discharge and agree to hold harmless VCPS and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the photographs and/or videos.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily. I further recognize that this consent form will revoke any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

Patient/Guarantor's Signature: _____ Date: _____

Patient/Guarantor's Printed Name:_____

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# NOTICE OF PRIVACY DISCLOSURES AND PRACTICES
# For
# VIRGINIA CENTER FOR PLASTIC SURGERY, PC

**Implemented April 1, 2003**
**Last revised May 1, 2017**

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.***

***PLEASE REVIEW IT CAREFULLY.***

***Understanding Your Health Records Information:*** Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and plan for future care or treatment. This information, often referred to as your health or medical records, serves as a basis for planning your care and treatment and serves as a means of communication among the many healthcare professionals who contribute to your care. Understanding what is in your records and how your health information is used helps you to ensure it's accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

***Your Health Information Rights:*** Unless otherwise required by law your health records are the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right t o request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the information practices upon request, inspect, and obtain a copy of your health records. Obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

***Our Responsibility:*** The Virginia Center for Plastic Surgery is required to maintain the privacy of your health information. In addition, we are required to provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. The Virginia Center for Plastic Surgery must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. Should our information practices change, we will post our new notice on our Web site. We will not use or disclose your health information without your authorization, except as described in this notice.

***For More Information or to Report a Problem:*** If you have questions and would like additional information, you may contact Sam McCarthy at (703) 924-3144. If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.



ERIC DESMAN, MD – BOARD CERTIFIED PLASTIC SURGEON | www.vcps.com | 6355 Walker Ln, #510 | Alexandria, VA 22310 | PH: 703.924.3144 | Fax: 703.924.9644

## *EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:*

***We will use your health information for treatment:*** For example: information obtained by a healthcare practitioner will be recorded in your records and used to determine the course of treatment that should work best for you. By way of example, Dr. Desman will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record actions they took and their observations (example varies by practitioner type). We will also provide your other practitioners with copies of various reports that should assist them in treating you.

***We will use your health information for payment:*** For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

***We will use your health information for regular health operations:*** For example: members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health records to access the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare service we provide.

***Business Associates:*** There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests and a copy service we use when making copies of your health records. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

***Notification.*** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

***Communication with Family:*** Dr. Desman, using his best judgment, may disclose to a family member, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

***Funeral Directors:*** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

***Organ Procurement Organizations:*** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

***Food and Drug Administration (FDA):*** As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

***Workers' Compensation:*** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

***Public Health:*** As required by law, we may disclose your health information to public health or legal authorities charged with tracking births and deaths, as well as with preventing or controlling disease, injury, or disability.

***Law Enforcement:*** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

***Notice of Privacy Practices Availability:*** This notice will be prominently posted in the office where registration occurs. Patients will be provided a hard copy and the notice will be maintained on our Web Site (www.vcps.com) for downloading.



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