Daniela Rodriguez, M.D., P.L C.

Patient Health History

(Please Print)

Patient Name: _____, **Today's Date:** _____

Date of Birth: _____/_____/_____/ **Current Age:** _____, **Phone :( )**_____

Reason for today's visit? _____

Person who referred you to Dr. Rodriguez? _____

Do you smoke? N Y ; If so, how much? _____

Below, please mark any current or past illness/disease that may pertain to you:

Diabetes ___
High Cholesterol___
Thyroid Disease____
High Blood Pressure___
Heart Attack_____
Congestive Heart Failure__
Other Heart disease_____
_____
Chronic Bronchitis_____
Stomach Disease_____
Bleeding/clot disorder___
Broken Bones_____
Cancer: (please specify); _____

Kidney Disease___
Bladder Problems___
Prostate Problems___
Osteoporosis____
Angina/Chest Pain__
Pneumonia_____
Other Lung Disease___
_____
Diseases of Colon_____
Hemorrhoids_____

Head Injury_____

Depression____
Anxiety_____
Arthritis_____
Gout_____
Stroke_____
Allergies_____
_____
Asthma_____
Emphysema___
Anemia_____
Seizure/epilepsy_

Medication allergies: _____

Current Medication List

_____

_____

Are you taking any over the counter medications? If so, please list here: _____

_____

Local Pharmacy Information:
Name: _____ **Phone Number:** _____

Patients Signature/ Date

_____

Physician Signature/ Date

_____

Name: _____ Date: _____

Weight_____ Height___ Primary Care Physician _____

Personal Medical and Surgical History: (Please list any medical conditions that you have and past surgeries and indicate year you had the surgery) _____

_____

_____

_____

_____

_____

Family Medical History: (Please list your immediate family members (parents, grandparents, siblings & children), their relationship to you, along with their health status (living or deceased) and any serious medical condition) _____

_____

_____

Social History: Do you smoke? Yes___ No___ Illicit Drug Use? Yes___ No___

Do you drink alcohol? Yes___ No___ How Often? _____ Do you have children? How many? ____

Physician Notes:

ROS:

PE:/HEENT:

HEART:

LUNGS:

ABD:

EXTREMITIES:

NEURO:

PROBLEM focused PE:

ASSESSMENT/PLAN: **Time:**

PRE-OPERATIVE PATIENT INFORMATION

Please complete the following information prior to surgery.

Drug Reactions / Allergies / Latex Sensitivity

Some patients cannot take certain medications such as penicillin because of allergic reactions. Other patients experience reactions such as nausea / vomiting from narcotic pain medications (Codeine, Morphine, Demerol, Vicodin, Percocet, etc.). Please list below regarding any known drug allergies or reactions, or sensitivities.

Medication Name Type of Drug Reaction / Allergy

1.
2.
3.
4.

_____I do not have known drug allergies, drug reactions, or latex sensitivity.

Prescription Medications

Please list all prescription medications you currently take:

1.
2.
3.
4.

_____I am not currently taking any prescription medications.

Non-Prescription Medications / Dietary Supplements / Vitamins / "Herbs" / Minerals

Many patients take non-prescription medications such as aspirin, anti-inflammatories (Advil, Motrin, Alleve) and other preparations that can be purchased without a prescription (dietary supplements, vitamins, "herbs", and minerals). Many of these can have profound effects on increased risk of bleeding during and after surgery or react with prescription medications. If you currently take items in this category, please list below. Please discontinue taking all non-prescription medications, dietary supplements, vitamins, herbs, and minerals for a minimum of 10 days before and after surgery.

1.
2.
3.
4.

_____I am not currently taking non-prescription medications, dietary supplements, vitamins, herbs, or minerals.

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray)-

Patients who are currently smoking, use tobacco products, or nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of skin dying and delayed healing. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication. Please indicate your current status regarding these items below:

_____I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

_____I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

Date: _____ Signature:_____

05-09-09 version

PATIENT INFORMATION SHEET

TODAYS DATE: __/__/__

Name of Patient: _____Soc. Sec. #_____

Date of birth:____/____/____; Sex: Male/ Female Single/ Married/ Other_____

Home Address: _____City, State, Zip_____

Home phone: (___) _____Cell or alternate phone (___) _____

Name and phone of emergency contact: _____

Employer:_____Emp. Ph #_____

AUTHORIZATION FOR TREATMENT

I authorize Daniela Rodriguez, M.D., to provide medical treatment for myself

@@@Signature: _____

We will copy your cards. BUT, please, we need you to fill in the information of the actual policy holder. Spouse, parent, etc…

Primary Insurance : _____Policy holder : _____
Policy ID # _____ Group # _____
Policy holders Date of Birth: _____ Policy holders SS # _____
Relationship to you: _____Employer:_____
Employer phone: _____O.V. Copay?_____

Secondary Insurance:_____Policy Holder:_____
Policy holders date of birth_____Policy holders SS #_____
Relationship to you: _____Employer:_____
Employer phone:_____CoPay:_____Deductible:_____

PLEASE READ ASSIGNMENT OF INSURANCE BENEFITS AND SIGN BELOW.@@@@@

I request that payment of authorized insurance benefits be made to me or on my behalf to Daniela Rodriguez, M.D. PLC, for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my insurance company, and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it. Signed: _____Date:____/_____/_____

MEDICARE PATIENTS MUST READ AND SIGN BELOW.

I request that payment of authorized Medicare Benefits be made to me or on my behalf to Daniela Rodriguez, M.D., PLC, for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it. Signed: _____Date____/_____/_____

DANIELA RODRIGUEZ, M.D., PLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT:

Name:_____

Address:_____

Telephone:_____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent and Acknowledgement: By signing this form, you acknowledge that you have received a copy of this office's Notice of Privacy Practices and you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Acknowledgement and Consent. Our Notice Provides a description of our treatment, payment activities and healthcare operations, of uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Acknowledgement and Consent. We encourage you to read it carefully and completely before signing this Acknowledgement and Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Privacy Officer: Daniela Rodriguez, M.D., P.L.C.
21727 Mack Avenue
St. Clair Shores, MI 48080
Telephone (586) 777-7260
Fax (586) 777-7265

Right to Revoke: You will have the right to revoke this Acknowledgement and Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Acknowledgement and consent will not affect any action we took in reliance on this Acknowledgement and Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Acknowledgement and Consent.

I, _____ have had full opportunity to read and consider the contents of this Acknowledgement and consent form and the DANIELA RODRIGUEZ, M.D., PLC Notice of Privacy Practices. I understand that by signing this form, I am acknowledging receiving a copy of the Notice of Privacy Practices and am also giving my consent for DANIELA RODRIGUEZ, M.D., PLC to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date:_____

If a personal representative on behalf of the patient signs this Acknowledgement and Consent, complete the following:
Personal Representative's Name:_____Relationship to the Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS ACKNOWLEDGEMENT AND CONSENT AFTER YOU SIGN IT

Daniela Rodriguez, M.D., P.L.C.
21727 Mack Avenue, St. Clair Shores, MI 48080
Consent Agreement

CONSENT FOR EXAMINATION: I understand that medical treatment may be necessary for the patient by Daniela Rodriguez, M.D., P.L.C. or her associates or assistants.

I understand the examination procedures will be explained to me and I shall consent to the examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with Daniela Rodriguez, M.D., P.L.C. I hereby release my examiner from all responsibility in connection with this examination.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by Daniela Rodriguez, M.D., P.L.C. or her associates or assistants. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgement of Daniela Rodriguez, M.D., P.L.C. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

I have read the above Acknowledgments and Agreements and fully understand the same.

Patients Name (print) _____

Signature of Patient or Guardian _____ Date _____

Relationship to Patient _____ Witness _____

Daniela Rodriguez, M.D., P.L.C.
Plastic & Reconstructive Surgery
Certified by the American Board of Plastic Surgery

21727 Mack Avenue • St. Clair Shores, MI 48080 • 586.777.7260 • Fax: 586.777.7265

Financial Policy

Thank you for choosing Daniela Rodriguez, M.D. as your plastic surgeon. Although billing is not always a comfortable topic, we want to keep you aware of our current office financial policies. We ask that you please read, initial, and sign this policy before any treatment.

Payment for medical care is different for everyone because there are many insurance companies and different types of coverages. Since you are the person that is seeking care, please know that you are responsible for the payment of the bills related to your care. To help you, we will bill your insurance carrier(s) for you, when you have given us a copy of your current insurance information.

Financial Terms:

Payment Types Accepted: Cash, personal check, VISA, MasterCard, American Express, Health Care savings card, or Care Credit for cosmetic surgery patients only.

Co-Payment: The fixed dollars amount that is **set by your insurance plan** that **MUST** be paid by you at the time of your visit. The co-pay cannot be "waived" by our practice because it is a rule set by your insurance carrier.

Deductible: The annual dollar amount that is **set by your insurance plan** is deducted from your insurance benefits and **MUST** be paid by you. The deductible cannot be "waived" by our practice because it is a rule set by your insurance carrier. This fee is due prior to any surgery.

Co-Insurance: The percentage that is **set by your insurance plan** is deducted from your insurance benefits and **MUST** be paid by you. The co-insurance cannot be "waived" by our practice, because it is a rule from your insurance carrier. This fee is due prior to any surgery.

Self-Pay: The dollar amount to be paid by patients who have no insurance benefits or for cosmetic surgery. The consultation fee is due at the time of the visit.

Payments Due

You, the patient, are responsible for annual deductibles, co-payments, co-insurances, percentages, and any services that are not covered prior to the time the service is rendered. If you do not know what your insurance coverage is, please contact your insurance company to find out. It is up to you, the patient, to know your own insurance plan and the benefits that it provides. Your benefit plan is between you and your insurance carrier, NOT between our physicians and your insurance carrier.

"No Show" for Appointments and Procedures:

We understand that emergencies happen for our patients, just as they do for us. However, when a patient cancels an appointment without enough notice, or does not show up, we cannot use that time to service the needs of our other patients. We ask that you please call at least 24 business hours in advance to cancel any

appointment. Patients who do not show, may be charged a $50.00 "No Show" fee for a regular appointment and a $50.00 "No Show" fee for an appointment for a procedure. **This fee will be charged to the patient, not to your insurance carrier.**

Referrals:

If your insurance has referral requirements, you **MUST** have prior authorization or a referral from your Primary Care Physician (PCP) before you can be seen in our office. If this authorization of referral is not available at the time of your visit, you will be asked to reschedule your appointment or you will be required to pay for all services rendered.

If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating lab. Please make us aware of plan requirements.

Your doctor is here to manage your medical care. The physician is not an expert on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial arrangements with the business office staff.

Returned Checks/Rejected ACH Withdrawals:

A $35.00 fee will be added to your account for any checks returned or ACH withdrawals rejected by your financial institution. This is an addition to any fees that your financial institution may charge you.

Authorization to Release Information/Pay Benefits

I authorize Daniela Rodriguez, M.D., to release information contained in my medical record, to any third party payer, insurance agencies, or carriers which are responsible in whole, or in part for services rendered.

I assign and authorize direct payment of all health care benefits and other forms of payment which relate to the care provided by me by Daniela Rodriguez, M.D., for application to my bill. I assume FULL FINANCIAL RESPONSIBILITY FOR PAYMENT of all expenses associated with my care and treatment, including any portion of hospital or physician charges that are not covered/paid for by my insurance, worker's compensation, or social agencies.

I, the undersigned, have read, clearly understand, and agree to the provisions of this financial policy. I also understand and agree that the terms of the financial policy may be amended by the practice at any time without prior notification to the patient.

Signature of the patient or Guardian

Printed name of the patient

Date

COSMETIC INTEREST QUESTIONNAIRE

Please check any of the following procedures that you would like to receive more information on, either a brochure or consultation. (Check all that apply).

Face/Necklift _____

Eyelift _____

Browlift _____

Laser Skin Resurfacing _____

Otoplasty (Ears) _____

Breast Augmentation, Lift, or Reduction _____

Abdominoplasty (Tummy tuck) _____

Lower Bodylift _____

Thighlift _____

Liposuction _____

Fat Transfer _____

Labialplasty _____

PRP Treatments _____

Cosmetic Injectable (Botox, Restylane, or Juvederm Products) _____

Would you like to receive announcements via an email address?

Email Address _____

Thank you!