PLASTIC SURGERY OF HOLLYWOOD
DR. JEFFREY CAPLAN, MD, PA
954-924-9525

4330 SHERIDAN STREET
SUITE 102
HOLLYWOOD, FL 33021

## PATIENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

DOB: __/__/____ AGE _____ Home Phone : (___) ___ - ____ Mobile Phone: (___) ___ - ____

Address: _____ Apt/Suite: _____ City: _____ State: ____

Zip code: _____ Social Security Number: _____-____-_____ Marital Status: _____

Race: _____ Ethnicity: _____ Gender: _____ Primary Language: _____

Preferred method of contact: Email / Phone / Mail Email: _____

### Employer Information

Employer Name: _____ Phone: (___) _____ - _____

Address: _____

### Emergency Contact

Name: _____ Phone: (___) ___ - ____ Relation: _____

## PHARMACY INFORMATION

Pharmacy Name: _____ Phone/ Fax # (___) ___ - ____ Zip code: _____

## INSURANCE INFORMATION

### Primary Insurance

Name: _____ Policy # :_____ Group #: _____

Subscriber Name: _____ Relationship to Insured: _____

DOB: _____ Gender: _____

Address: _____ City: _____ State: ____ Zip code: _____

**Secondary Insurance**

Name: _____ Policy # :_____ Group #: _____

Subscriber Name: _____ Relationship to Insured: _____

DOB: _____ Gender: _____

Address: _____ City: _____ State: ____ Zip code: _____

**Workers Compensation**

Carrier: _____ Claim #_____

D.O.I. _____ Adjuster name & phone # _____

Insurance address for claims:_____

Address: _____ City: _____ State: ____ Zip code: _____

**REFERRING/PCP PHYSICIAN INFORMATION**

Referring Physician Name: _____

Primary Care Physician Name: _____

☐ I certify that the above information is true and current to the best of my knowledge. If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the Physicians in this office for medical or surgical treatment received by me. I understand I am financially responsible for any charges not covered by insurance. I also authorize the physicians to release my information acquired in the course of my examination/treatment to my insurance company for the purpose of processing insurance claims.

**Signature:** _____ **Date:** _____

Plastic Surgery of Hollywood

# JEFFREY CAPLAN MD

**Today's Date:**

## HEALTH HISTORY QUESTIONNAIRE

**All questions contained in this questionnaire are strictly confidential and will become part of your medical record.**

| **Name:** *(Last, First, M.I.)* | ☐ M ☐ F | **DOB** |
|---|---|---|
| **Previous or Referring Doctor:** | | **Date of Last Physical Exam:** |

## PERSONAL HEALTH HISTORY

**Past Medical History: (Please indicate if (self) or (family) to any of the following):**

| | |
|---|---|
| Heart Problems: | Lung Cancer: |
| Diabetes: | Kidney Problems: |
| Vascular: | Other: |

**History of Cancer in Family:**

| Type: | Relationship: |
|---|---|
| | |
| | |

**Surgeries:**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

**Other Hospitalizations:**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

**List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:**

| Name of Drug | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

*Continued on Back Side*

| **Allergies to Medications:** | |
|---|---|
| Name of Drug | Reaction You Had |
| | |
| | |
| | |

## HEALTH HABITS AND PERSONAL SAFETY

| | |
|---|---|
| **Exercise:** | ☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)<br>☐ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)<br>☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes) |
| **Diet:** | Are you dieting? ..... ☐ Yes ☐ No<br>If yes, are you on a physician prescribed medical diet? ..... ☐ Yes ☐ No<br># of meals you eat in an average day?_____<br>Rank Salt Intake ☐ Hi ☐ Med ☐ Low Rank Fat Intake ☐ Hi ☐ Med ☐ Low |
| **Substance Abuse:** | History of Substance Abuse? ..... ☐ Yes ☐ No |
| **Alcohol:** | Do you drink alcohol? ..... ☐ Yes ☐ No |
| **Tobacco:** | Do you use tobacco? ..... ☐ Yes ☐ No<br>☐ Cigarettes - Pks/day ☐ Chew - #/day ☐ Pipe - #/day<br>☐ Cigars - #/day ☐ # of Years ☐ or Year Quit |

X _____

PATIENT/GUARDIAN SIGNATURE DATE

# Dr. Jeffrey Caplan, MD, PA

## Financial Policy

Thank you for choosing us as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our billing department if you have any questions. They may be reached at 954-924-9525.

- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**
- **ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECK, VISA/MASTERCARD, AND DISCOVER.**
- **ALL PATIENTS MUST COMPLETE OUR "PATIENT REGISTRATION FORM" AND OTHER RELATED FORMS.**
- **FOR CASES WHICH WILL BE INSURANCE DIRECTLY, WE MUST HAVE A COPY OF THE INSURANCE IDCARD.**
- **PLEASE NOTIFY US IMMEDIATLEY OF ANY CHANGES IN YOUR INSURANCE OR COVERAGE.**
- **24-HOUR NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS AND THERE MAY BE A NOMINAL FEE.**

***IF PAYMENT IS NOT REQUIRED FROM THE INSURANCE CARRIER OR OTHER RESPONSIBLE THIRD PARTY IN 90 DAYS, WE HAVE THE RIGHT TO BILL YOU DIRECTLY.***

### UCR (USUAL AND CUSTOMARY RATES)

We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area.

### SELF PAY

We expect payment at time of service unless prior arrangements have been made.

### MEDICARE

We accept Medicare assignment. As a Medicare patient you are responsible only for the difference between the approved charge and the amount Medicare pays and, of course, you're deductible.

### HMO/PPO

**ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF YOU DO NOT KNOW YOUR CO-PAY YOU MAY USE OUR PHONE TO FIND OUT.** We are members of most, but not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member you will not be billed as long as we have the necessary referrals. Please refer to our HMO information sheet for details. PPO patients will only be responsible for their co-payments and co-insurance as long as they have verified with their insurance that our physician is in their plan.

### WORKERS' COMPENSATION

If you are here as a result of work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. We will also need to verify that your employer assumes responsibility for charges incurred. If we cannot verify responsibility or we are unable to obtain information on your employer's Workers' Compensation insurance, as a courtesy we will bill your health insurance carrier. If payment is not received from these third parties within 90 days, we have the right to bill you directly.

### ACCIDENT CLAIMS

If you are here as a result of an accident claim, we will require information regarding both health insurance and accident insurance. In addition, we will need the name, address, and phone number of your attorney. In the case of a lawsuit we may need to file liens for payment. If payment is not received from these third parties within 90 days, we have the right to bill you directly.

**I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment for all services.**

_____

*Name of Patient* (please print) Signature of Patient or Responsible Party Date

# Plastic Surgery of Hollywood

954-924-9525

**Acknowledgement of receipt of "Notice of Privacy Practices"**

In this Notice "you(r)" means you, and/or, your minor dependent that is being treated.

As required via the federal HIPAA regulations (Health Insurance Portability and Accountability Act) the providers at our medical practice, along with its nursing and administrative staff, under the guidance of the Physician(s), may share you (r) health information for the purposes of treatment, payment, and health care operations.

I understand that my health information may be used for the purposes of treatment, payment, and health care operations such as (but not limited to):

A. Sharing my health information among providers (within and outside our medical practice), on a need to know basis, in order to medically treat me.

B. Using my health information for medical billing purposes, including providing referrals to medical specialists, when necessary and appropriate.

C. Sharing my health information with health insurance firms, government agencies, or other claims payers that request information related to benefits determinations, medical claims filed for visits, treatments, admissions, and other billing matters.

D. Using my health care information for health care operations, including monitoring the quality of care, audits, surveys, and carrying out other medical practice business and administrative activities.

E. My permission is given today for any medical treatment including , but not limited to, examination, injections, diagnostic testing or medical procedures as may be deemed advisable by members of this Medical Center.

I understand that all reasonable efforts will be made to protect the privacy of my health information whether maintained as a paper file or electronic file, and regardless of how it is communicated (verbally, or via fax, paper, or electronically).

I have been given the opportunity to read the "Notice of Privacy Practices" which outlines in more detail how my health care information is used and shared with others. The "Notice of Privacy Practices" explains when I need to give further approval for the providers to use my health information or share it outside of the medical practice, and when my permission is not needed for the providers to use my health information or share it outside of the medical practice (such as: required by law, public health activities, and so forth).

I understand that this medical practice has reserved the right to change the "Notice of Privacy Practices" at any time. I may obtain a current copy of the "Notice of Privacy Practices" by contacting the Privacy Officer of this medical practice.

*My signature* below constitutes my acknowledgement that I have been provided the opportunity to read and obtain a copy of the "Notice of Privacy Practices".

_____ ١٠

Signature of adult patient or a minor patient's parent or legal guardian Date

_____

Print the signer's full name

Print

PLASTIC SURGERY OF HOLLYWOOD
JEFFREY CAPLAN, M.D.
BOARD CERTIFIED PLASTIC SURGEON - HAND SURGEON - RECONSTRUCTIVE MICROSURGEON

*Jeffrey Caplan, M.D*

## MALPRACTICE INSURANCE NOTIFICATION

Dear Patient:

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. DUE TO THE MARKED INCREASE IN MALPRACTICE INSURANCE PREMIUM RATES, YOUR DOCTOR HAS BEEN FORCED NOT TO CARRY MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

I, _____ ACKNOWLEDGE RECEIPT OF THE ABOVE NOTIFICATION.

DATE:_____ SIGNED:_____

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