ARC PLASTIC SURGERY
AESTHETIC RECONSTRUCTIVE CENTER

Personal Information

Please complete this form. All information is confidential. Thank You.

Today's Date: _____ **Social Security #**_____

First & Last Name:_____ **Birth Date**: _____ **Age:**_____

Race:_____ **Ethnicity:**_____ **Preferred Language:**_____

Home Address:_____ **City**_____

State_____ **Zip**_____ **E-Mail**_____

Telephone #: Home (_____)_____ Cell (_____)_____ Work (_____)_____

Preferred Language:_____

Preferred method of contact?_____ Would you like to be added to our mailing list?_____

Employer: _____ Occupation: _____

Marital Status: _____Spouse/Significant Other's Name: _____

Spouse's Contact: Cell (_____)_____ Work (_____)_____

Emergency Contact: Name: _____ Phone # (_____)_____

Primary Care Physician: Name: _____ Phone # (_____)_____

Insurance Information: Company _____

Member #_____ Group #_____

Name of Insured _____ Relationship to Patient _____

Insured DOB _____/_____/_____Insured SS# _____-_____-_____ Insured Home Number (_____)_____

Secondary Insurance Information: Company _____

Name of Insured _____ Relationship to Patient _____

Insured DOB _____/_____/_____Insured SS# _____-_____-_____ Insured Home Number (_____)_____

Responsible party (if patient is a minor):

Name: _____ Birth Date: ____/____/____ SS#:_____-_____-_____

Preferred Pharmacy:_____ Phone Number: (_____)_____

How did you hear about our office? _____

Whom may we thank for the referral? _____

Reason for consultation: _____

_____

_____

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History and Physical

Height:_____ **Weight**:_____ **Normal Weight:**_____

Do you have any allergies to medication? (Yes/No) ____

Please List:_____

Reaction:_____

Please list ALL medications and herbal supplements (including vitamins, herbs, sleep aids, etc.)_____

_____

_____

Do you take Aspirin or Ibuprofen on a regular basis?__Yes__No

Do you smoke or use tobacco products? ____ How many per day?____(cigarettes/packs) Number of years?____

If you have stopped smoking when did you quit?_____ mo/years Date you quit:____/____

Tobacco use other than cigarettes?_____

Do you consume alcohol?___ How many drinks containing alcohol per week?____

Do you use recreational drugs?___ Have you ever been treated for drug or alcohol dependency?_____

Are you on a diet pill or diet program now?___ Have you been in the last 3 years?___

Do you exercise?___ How often?_____

Medical History

Do you have or have you ever been treated for: (Y/N)

Malignant hyperthermia?___	Thyroid problems? ____	Mental illness? ____
Autoimmune disorder? ____	Bulimia or anorexia? ____	Drug Dependency? ____
Chronic illness? ____	Hepatitis/Jaundice? ____	Depression? ____
Heart Disease? ____	Ulcers? ____	Lung Disease? ____
Heart attack? ____	Epilepsy/Seizures? ____	Cancer? ____
Stroke? ____	Cold Sores? ____	Serious Accident? ____
High blood pressure? ____	Mitral Valve Prolapse? ____	Sleep apnea? ____
Blood disorder? ____	Kidney problems? ____	CPAP machine? ____
Blood clotting disorder? ____	Shortness of breath? ____	Latex allergies? ____
Anemia? ____	Asthma? ____	Environmental allergies? ___
Diabetes? ____	Emphysema? ____	

Other?_____

If you answered yes to any of the above, please explain: _____

_____

Have you ever received a blood transfusion?_____ Date:_____

Have you ever been diagnosed with:

Tuberculosis?____ Date:_____ HIV?____ Date:_____ Hepatitis?____ Date:_____

Female Patients Only:

Are you pregnant?_____ Are you breastfeeding?_____

Have you ever been treated for:

Abnormal bleeding?_____ How long ago?_____ Anemia?_____ How long ago?_____

Do you use any birth control?_____ What type?_____

Do you have children?_____ Number of pregnancies?_____

Surgical History

PLEASE LIST ALL PREVIOUS SURGERIES (including cosmetic and dental procedures):

Type:_____ Date:_____ Doctor:_____

Type:_____ Date:_____ Doctor:_____

Type:_____ Date:_____ Doctor:_____

Type:_____ Date:_____ Doctor:_____

Type:_____ Date:_____ Doctor:_____

Anesthesia problems?(include nausea/vomiting, slow to wake up or high temperature) _____

_____

Past hospitalizations_____

Please initial the following:

• The above information is current and correct to the best of my knowledge._____

• I authorize the release of my medical records to insurance companies and authorize the release of any medical information necessary to process my insurance claim._____

• I give my permission to be treated by Dr. Jeremy White and his staff now and in the future and assign all benefits directly to Dr. White. I assume full responsibility for my balance regardless of the status of my insurance claim. In the event that my insurance company is billed, I authorize payment of medical benefits to the physician(s) or supplier of rendered services. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay a claim in full, I understand that I am responsible for payment of charges for services rendered._____

• If computer imaging is used in my evaluation, I understand that the alteration is purely for the purpose of illustration and discussion and in no way constitutes an expressed or implied warranty as to my final results and appearance._____

Patient's Name:_____

Signature:_____Date:_____

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AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH

Name _____

Address _____
(street address, city, state and zip code)

I do hereby voluntarily participate and give authorization to appear in filming, photographs, videotaping and/or interviews for ARC Plastic Surgery public relations and advertising. I do hereby consent to the unlimited use of such product or interview in ARC Plastic Surgery's publications and/or website, news media reports, newspapers, magazine, television or radio, billboard or any type of advertising. I do hereby release ARC Plastic Surgery and, 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 provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs may be used in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Jeremy White.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

I release and discharge Jeremy White M.D., ARC Plastic Surgery and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

Signature_____ **Date:**_____

Print Name: _____

Witness Signature: _____

Print Name: _____

ARC PLASTIC SURGERY
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Plastic and Reconstructive Surgery Arbitration Agreement

This is an agreement between Jeremy B. White MD PA and its present and former officers, directors, and employees (collectively, "Doctor") and their patient _____ **("patient")**, to arbitrate any claims, disputes, or controversies between the parties before the American Arbitration Association.

The parties recognize and agree that arbitration is a desirable alternative to the filing of a lawsuit, as a means to resolve any claim that one may have against the other. Arbitration is generally considered to be a less time consuming and expensive process. Therefore, in consideration of the mutual promise contained herein, and as a consideration to the Doctor agreeing to provide the Patient with medical services, the parties agree that:

1. All claims, disputes or controversies (collectively, "claims") whether such claims arose prior, on, or subsequent to the date hereof, between Patient and Doctor or any of Doctor's present or former officers, directors, or employees shall be submitted to arbitration before American Arbitration Association, with such proceedings to be held in Dade County, Florida. This agreement relates to arbitration of all claims, including without limitation, any claim asserted against Doctor for professional negligence, malpractice, or otherwise arising out of or related to the provision of medical services to the patient.
2. The parties shall comply with all of the rules and regulations of the American Arbitration Association in effect at the time that any claim is filed against Doctor.

The parties further acknowledge and agree that:

1. Arbitration is final and shall be binding upon the parties.
2. The parties are waving their right to seek remedies in court, including the right to jury trial.
3. Pre-arbitration discovery is generally more limited than and different from court proceedings.
4. The arbitrator's award is not required to include factual findings or legal reasoning, and any party's right to appeal or to seek modification of rulings by the arbitrator is strictly limited.

Dated:_____ _____

Jeremy B. White, MD PA

Dated:_____ _____

Patient Signature

ARC PLASTIC SURGERY
AESTHETIC RECONSTRUCTIVE CENTER

I acknowledge that I have been provided with ***ARC PLASTIC SURGERY.,*** **"**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Patient Name: *(please print)* _____

Patient Signature *(or legal representative; proof may be requested)* _____

Date: ***(****dd/mm/yy)* _____

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **ARC PLASTIC SURGERY., (ARCPS)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **ARCPS** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However**, ARCPS** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **ARCPS** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Patient Acknowledgment & Agreement

My Consented Email Address is: _____

My Consented for Text Messaging to: _____

Fax to the following No. _____

X

_____

Patient Signature

_____

Date

In Case of Any Emergency Please Call 911 or Proceed to the Nearest Emergency Room, DO NOT USE THIS WAY OF COMMUNICATION FOR THAT PURPOSE.

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to **Arc Plastic Surgery** and **Dr. Jeremy White, MD** (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to **Arc Plastic Surgery** and **Dr. Jeremy White, MD** for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate' (including Howard Healthcare Group) under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third- party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: _____ Date: _____

Patient Signature:_____