Jefrey R A Fishman MD FACS

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Novi, Michigan 48374

PERSONAL INFORMATION

Name_____ Sex _____ Age _____ Marital Status_____

Address_____ Birth Date _____

City _____ Social Security_____

State _____ Zip _____ Home Phone _____

E-mail Address _____ Cell Phone_____

Referred by_____ Work Phone_____

Fax _____

Preferred Pharmacy_____

Family Physician_____

EMERGENCY INFORMATION

In case of emergency please notify _____

Relationship _____ Home Phone _____

Work Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

HEALTH INFORMATION

Please describe reason for seeing us today _____

_____

_____

_____

_____

AMERICAN SOCIETY OF PLASTIC SURGEONS

Board Certified by The American Board of Plastic Surgery

Jefrey R A Fishman MD FACS

List all **MEDICATIONS** you are taking or have taken within the last six months. (Please list prescription and non-prescription medications, as well as inhalers, patches, and herbal or homeopathic remedies.)

List all know drug or medical related **ALLERGIES**:

Have you ever smoked? _____
How much? _____
No. of years _____

How often do you drink alcohol? _____

List all prior operations, including medical difficulties for which you have been hospitalized. Please provide year of occurrence.

MEDICAL HISTORY

Have you ever had problems with anesthesia? _____
Have you ever had problems with bleeding? _____ Do you bruise easily? _____
Check the conditions that apply to you. Please write the year of onset or occurrence next to each one.

YEAR NOTED	CONDITION	DETAILS	YEAR	CONDITION	DETAILS
	Anemia/Sickle Cell			Heart Murmur	
	Angina/Chest Pain			Hepatitis/Jaundice	
	Arthritis			High Blood Pressure	
	Asthma			High Cholesterol	
	Back Problems			Kidney Problems	
	Bleeding/Blood Problems			Liver Problems/Cirrhosis	
	Blood Transfusion			Marked Weight Change	
	Bone or Joint Problems			Mitral Valve Prolapse	
	Breathing Problems			Nosebleeds	
	Bronchitis			Paralysis/Weakness	
	Cancer (Type)			Phlebitis/Blood Clots	
				Seizures/Convulsions	
	Circulation Problems			Skin Changes	
	Diabetes/Sugar Problems			Skin Disorders	
	Dizziness or Fainting			Sinus Trouble	
	Drug Dependency			Stomach Problems	
	Ear Problems			Stroke	
	Emphysema			Ulcers	
	Eye Problems			Urinary Problems	
	Glaucoma			Thyroid Difficulties	
	Headaches/Migraines			Tuberculosis	
	Hearing Problems			Vision Changes	
	Heart Attack			Weakness or Numbness	
	Heart Failure			Other	
	Heart Irregularities				

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PATIENT CONSENT FOR MEDICAL TREATMENT

Name _____ Date of Birth _____

I hereby request and authorize, now and anytime in the future, any type of medical services Jefrey R.A. Fishman, M.D., his assistants or designees advise. These include routine history and physical examinations, routine diagnostic radiology and laboratory procedures, therapeutic procedures, drugs, and routine medical care pertaining to Dr. Fishman's specialty of Plastic and Reconstructive Surgery. I understand that in emergencies it may be necessary to expand or deviate from the services listed here in order to preserve my life or health, and I consent to these expanded services and procedures,

Dr. Fishman has made no guarantees or assurances about the results of my treatment. I understand that I will receive the usual and ordinary care rendered in this community, and that no other contract, written, verbal or implied is made.

Dr. Fishman participates with Medicare, workers' compensation and some other insurance programs. However, Dr. Fishman does not participate with every insurance program, and may not participate with yours (including some Blue Cross/Blue Shield of Michigan plans). Some insurance programs require that you only see certain physicians and will allow payment to non-approved physicians only with specific written permission from the insurance program. In addition, coverage varies among insurance programs. I understand that I am responsible for submitting claims to insurance programs which Dr. Fishman does not participate with for any non-surgical service (i.e., office visits, x-rays, etc.) provided to me by Dr. Fishman. As a courtesy, Dr. Fishman will submit claims for payment for surgical procedures to your insurance programs, even if Dr. Fishman does not participate with that program.

I agree personally to pay for any and all charges incurred by me during the course of my medical care, including charges not covered by or collected from my health care insurance or benefit program, including any deductibles and co-insurance amounts. If my insurance program pays me directly for any services rendered by Dr. Fishman, I agree to immediately endorse the check and remit it directly to Dr. Fishman.

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 Dr. Fishman, and all parties acting under his license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use, including any claim for payment in connection with distribution of these materials in any medium.

PLEASE READ THIS AGREEMENT CAREFULLY BEFORE SIGNING, AND LET US KNOW IF YOU HAVE QUESTIONS. YOU ARE RESPONSIBLE FOR WHAT YOU SIGN.

Signature_____Date:_____

If signed by Patient Representative: Signature_____Date_____

Printed Name:_____ Relationship to Patient:_____

Jefrey R A Fishman MD FACS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Dr. Jefrey Fishman, M.D. or his employees may disclose any and all information from my entire medical record. Please list any exceptions:

_____

I understand that my health information may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), hepatitis, tuberculosis, behavioral or mental health services, and treatment for alcohol and drug abuse. Employees of Dr. Jefrey Fishman and covering physicians may disclose my health information. Dr. Fishman and his employees may disclose my health information to the following persons, or class of persons.

_____Relationship_____

_____Relationship_____

_____Relationship_____

This authorization will remain valid, unless I request in writing otherwise. I understand that I have the right to revoke this authorization at any time, except to the extent that Dr. J. Fishman has already relied on it. I understand that if I decide to revoke this authorization, I must notify Dr. J. Fishman of my decision in writing. I understand that my health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law. I understand that Dr. J. Fishman will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Our office is part of the Beaumont Health electronic health record system called Epic. Other physicians who have access to Epic as well as Beaumont Health will have access to your health record. As Epic implements their “Care Everywhere” initiative, there may be other Hospitals and Health Care Providers who may have access as well (such as Henry Ford Hospital). Please feel free to discuss this with Dr. Fishman.

Dr. Fishman and his office very strongly believes in the privacy of our patients. Dr. Fishman does not share the names, email addresses, or telephone numbers of our patients with any other company, or with any other patient.

Yes, please sign me up to receive email information, text messaging to my cell phone and telephone calls. I authorize Dr. Fishman to send text message appointment reminders and other information such as office location and other information regarding services provided in the office. (You may change your mind at anytime. You can simply click the “unsubscribe” link found at the bottom of each email, or reply “STOP” to a text message from us.)

Unless I tell you otherwise, I may be contacted in the following manner:

Ok to leave telephone message (May include protected health information)
Ok to send mail to my home (May include protected health information)
Ok to send email (used to communicate)
Ok to text message to my cell phone (used to communicate)

Signature_____Date:_____

If signed by Patient Representative: Signature_____Date_____

Printed Name_____ Relationship to Patient_____

Jefrey R A Fishman MD FACS

PATIENT VIDEO/PHOTO AUTHORIZATION AND RELEASE

I consent to the taking of photographs or videotapes of me by Dr. Fishman, or his designee, in connection with the medical procedure(s) and service(s) to be performed by Dr. Fishman.

I understand that such photographs, videotapes or case histories may be published by Dr. Fishman in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for my medical records or for the purpose of informing the medical profession or the general public about plastic surgery 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 shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect of any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive form Dr. Fishman.

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 Dr. Fishman, and all parties acting under his license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use I publication, including any claim for payment in connection with distribution of these materials in any medium.

Signature_____Date:_____

If signed by Patient Representative: Signature_____Date_____

Printed Name_____ Relationship to Patient_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices gives you information about how we use and disclose medical information about you.By signing this form, you are acknowledging that you received a copy of our Notice of Privacy Practices.

Signature_____Date:_____

If signed by Patient Representative: Signature_____Date_____

Printed Name_____ Relationship to Patient:_____

……

For internal office use only:

If not signed, reason: ☐_ Patient refused to sign ☐Other_____

☐Patient not able to sign (give additional information below regarding disability, emergency situation, etc.)
Comments:

_____

_____

Name of Reviewer _____Date _____