Valley Plastic Surgery

Steve Lovich, MD

280 S Pacific Hwy, Talent, OR 97540
Phone: (541)512-4771 Fax: (541)512-0880

Full Legal Name _____ **Nickname** _____
First **Middle** **Last**

Primary Physician _____ **How were you referred to us?**_____

Social Security # _____ Date of Birth ____ _____Drivers Lic #_____

Home Address _____ City/State/Zip Code _____

Mailing Address *(if different than home address)* _____

Home Phone _____ Cell Phone _____ Business Phone _____

Fax _____Email _____ Gender: Male ☐ Female ☐

Race: _____ Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined to Answer

Marital Status: Married ☐ Divorced ☐ Widowed ☐ Single ☐ Student Status: Full-time ☐ Part-time ☐

Occupation _____ Employed: Full-time ☐ Part-time ☐

Employer Name/Phone _____

Employer Address _____

Responsible Party (if different from patient)

Full Legal Name _____ Relationship _____

Address _____ City/State/Zip Code _____

Contact Phone _____ Date of Birth _____

Emergency Contact

Full Name _____ Contact Phone _____

Address _____ Relationship _____

Is your visit related to an injury? Yes ☐ No ☐ If yes, is the injury work related? Yes ☐ No ☐

If yes, name/address of Employer where injured _____

Claim Number _____ Claim Adjustor _____

Motor vehicle accident? Yes ☐ No ☐ Date of injury or accident _____

Claim Number _____ Claim Adjustor/Phone _____

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communications of PHI may be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Phone: ☐ Cell Phone: ☐

☐ *Ok to leave detailed message*

☐ *Leave message with call back number only*

Written Communication: ☐

☐ Ok *to mail to my home*

☐ *Ok to mail to my work/office*

Work Phone: ☐

☐ *Ok to leave detailed message*

☐ *Leave message with call back number only*

☐ *Fax to this Number*_____

Email: ☐

☐ *Ok to email me all medical information*

OK to leave Personal Health Information with the following Person(s):

Name_____ Phone #_____

Name_____ Phone #_____

Name_____ Phone #_____

I have an Advance Directive on file NO ☐ YES ☐ If Yes Where? _____

I would like a copy of an Advance Directive to complete. YES ☐ NO ☐

You may request and review Steve Lovich, MD's "Notice of Privacy Practices" for additional information about the uses and disclosures. ***Please verify that you reviewed our laminated sheet of the Notice of Privacy Practices by initialing here. _____***

Patient Initials Here

I understand that I have the right to revoke this consent, provided that I do so ***in writing***, except to the extent that Steve Lovich, MD, has already used or disclosed the information in reliance on this consent.

NOTE: Uses and disclosures may be permitted without prior consent in the case of an emergency.

I authorize Steve Lovich, MD to use and disclose my personal health information to other doctors involved in my continuing care:

_____ _____

Print Patient Name **DOB**

_____ _____

<u>Patient</u> or Guardian Signature **Today's Date**

PLEASE READ AND SIGN THE FOLLOWING CONSENT FORM

I understand that in consideration of the services rendered, I am obligated to pay Dr. Steve Lovich in accordance with his regular rates, terms or contractual agreements. I understand that I am responsible for any and all services not covered by insurance. I understand that Dr. Lovich or his agents shall, as a courtesy to me, bill my insurance company. I authorize the release of any information to my insurance company necessary for the processing of my claim. I further authorize my insurance company to pay Dr. Lovich directly any benefits due.

PROCEDURES NOT COVERED BY INSURANCE
I understand that in consideration of the services rendered, I am obligated to pay Dr. Steve Lovich in accordance with his ***"Policy on Patient Accounts".***

You may request a copy or review Steve Lovich, MD's "Policy on Patient Accounts" for additional information. Please verify that you have reviewed our laminated sheet titled "Policy on Patient Accounts" by initialing here. _____
Patient Initials Here

_____ _____
Print Patient Name **DOB**

_____ _____
Patient or Guardian Signature **Today's Date**

Insurance information and Assignment of Benefits

Please have your insurance card for the Receptionist.
If you do not have your card with you, be prepared to pay for your office visit today.

YOU DO NOT NEED TO FILL THE INSURANCE PORTION OUT IF YOU ALREADY PROVIDED YOUR INSURANCE CARD AT CHECK IN.

Primary Insurance

Insurance Company/Plan Name _____ Co-Pay _____

Name of ***Policy Holder*** _____Date of Birth _____

Insured's Address _____ Phone _____

ID# _____Group# _____ Relationship _____

Secondary Insurance

Insurance Company/Plan Name _____Co-Pay Amt _____

Name of ***Policy Holder*** _____ Date of Birth _____

Address _____Phone _____

ID# _____Group# _____Relationship _____

NOTICE OF PRIVACY PRACTICES

(Effective March 23, 2013)

Please review carefully

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information.

Valley Plastic Surgery takes the responsibility to safeguard your protected health information very seriously. This notice is intended to inform you of how we protect, use and disclose your information as well as to explain your right to control these disclosures.

Your Privacy Rights:

- To inspect and copy your health information
- To request an amendment to your records
- To request restrictions on use and disclosure of your information
- To request confidential communications
- To receive a paper copy of our Notice of Privacy Practices
- To an accounting of disclosures
- To file a complaint about how we have used and disclosed your information
- To be notified following a breach of your information by Valley Plastic Surgery

We may use and disclose information about you without your permission for:

- Treatment purposes and alternatives
- Payment
- Health care operations
- Appointment reminders

Special Situations your information may be used and disclosed:

- To avert a serious threat to your health or safety
- As required by law
- For research if you are involved in a research project
- To an organ/tissue donation organization if you are a donor
- If required by armed forces, national security or intelligence if you were or are a member
- To Workers Compensation if you are being treated under this program
- For public health reporting purposes
- For health oversight audits
- For court order/subpoena
- To law enforcement
- To coroner/medical examiner/funeral directors
- To family/friends if we can infer from the circumstances based on our professional judgment that you will not object. (You have the right to object)
- To family or others involved in a deceased person's care or payment for care

Note: We will not use or disclose your information for any purpose other than described without your written authorization. (You may revoke that authorization at any time)

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with our facility or with the secretary of the department of Health and Human Services. To file a complaint with our office, contact:

The VPS Privacy Officer
Valley Plastic Surgery
280 S. Pacific Hwy
Talent, OR 97540
541-512-4771

****You will not be subjected to any negative consequences for filing a complaint**

A more detailed version of this Notice may be obtained at the Registration Desk

POLICY ON PATIENT ACCOUNTS FOR STEPHEN LOVICH, MD

To keep health care costs down while maintaining a high level of professional care, we have established the following payment policies for the convenience of our patients. It is our policy that the responsibility for paying for care will be placed on those who receive it. Therefore, all accounts will be administered under the following guidelines.

1. **Any first-time patient of Dr. Stephen Lovich is required to pay for his/her visit on the day of service, if he/she is not covered by health insurance.**

2. **INSURANCE PATIENTS**: We will be happy to bill your insurance for you if you provide us with the appropriate billing information. Many insurance companies require a referral from primary care physicians. It is my responsibility to contact my insurance company to verify covered benefits on my plan. If a referral is required, I will request it from my primary care physician. Failure to do so may result in a reduction or rejection of payment by the insurance company.

3. **ASSIGNMENT OF INSURANCE BENEFITS**: I hereby authorize my insurance company to pay Stephen Lovich, MD directly. I understand that I am responsible for charges not covered by my insurance company, such as deductible, co-payment, or other patient balances, including any late charges. I also understand that my co-**payment is due at the time of service**. I agree that a photocopy of this authorization is as effective and valid as the original.

4. **DISCLAIMER:** It is the patient's responsibility to provide accurate information to Dr. Stephen Lovich, MD and Valley Plastic Surgery. If incorrect information is provided or we are not informed of the change in benefits, it is the patients responsibility to pay the full amount owed.

5. **PAYMENT OPTIONS:** Payment options include cash, check, Visa, MasterCard, Discover, and Care Credit.

6. **MEDICARE AUTHORIZATIONS, PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient named above to release such information to the Social Security Administration or its intermediaries or carries, effective the date below.

7. **If you are to have an office surgery that insurance does not cover or if your procedure is cosmetic, payment <u>is due in full two weeks before</u> the date of procedure.**

8. **HOSPITAL CHARGES:** Please remember that any physician services provided by Dr. Lovich while you are in the hospital will be billed to you or your insurance carrier. The hospital bills you receive will be services provided by the hospital, not for Dr. Lovich's services. You may also receive statements from other providers, e.g. a pathologist or physical therapist. These statements are not connected with Dr. Lovich's services. Questions regarding those services must be referred to the provider responsible for the service.

9. **FINANCIAL AGREEMENT**: I understand that in consideration of the services rendered, I am obligated to pay Stephen Lovich, MD in accordance with his regular rates, terms, or contractual agreements. I understand services may not be deferred for any reason. If the account is referred to an agency for collection, I agree to pay all collection expenses, including attorney's fees. All bills are due and payable upon receipt of your monthly statement. If you have special financial needs, please feel free to discuss this with our Office Manager in order to establish an extension of credit terms. Interest accrues on charges not paid after **thirty (30) days** of the billing, at a rate of .75% per month (9% per year) until paid in full.