



# Your time is important to us.

## THINGS TO BRING

- Please fill out the attached New Patient Forms and bring them to your scheduled consultation.
- Bring your medication list.
- Insurance cards.
- Your photo ID.
- Power of Attorney (if applicable)
- Caregiver/translator

## WHAT TO EXPECT AT YOUR FIRST APPOINTMENT

- Consultations are required prior to surgery. Dr. Lovich will meet with you and evaluate the problem. He will review the referral and biopsy results from your Referring Physician. At that time he will make a plan for surgery and write orders.
- You will then be in contact with our surgery scheduler and she will coordinate a time for surgery.
- You will be provided with your Pre and Postop instructions and a Surgical Copay Estimate prior to leaving that day.
- IF you've filled out the New Patient Forms your arrival time will be approximately 10 minutes early.
- If you HAVEN'T filled out the forms, we ask you to be here 30 minutes early.



**Dr. Stephen Lovich (541)512-4771**

Our address is:

**280 S. Pacific Hwy Talent, OR 97540**

### Directions from I-5 [Northbound](#)

- 1. Take I-5 NORTH to EXIT 21 towards Talent and go over the overpass**
- 2. Go to the second stop light and TURN LEFT on S. Pacific Hwy**  
Keep right and go 1 block until you see **SOS PLUMBING** on your RIGHT.
- 3. Once you pass SOS PLUMBING, you'll see our driveway on the RIGHT.** Our building is towards the back of the parking lot.

### Directions from I-5 [Southbound](#)

- 1. Follow I-5 SOUTH to EXIT 21 towards Talent**
- 2. Take EXIT 21 and get in the Lefthand lane**
- 3. Go to the second stoplight and TURN LEFT onto S. Pacific Hwy**  
Keep right and go 1 block until you see **SOS PLUMBING** on your RIGHT
- 4. Once you pass SOS PLUMBING, you'll see our driveway on the RIGHT.** Our building is towards the back of the parking lot.



## 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 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**

\_\_\_\_\_  
**Patient Signature or Guardian Signature if under 18**

\_\_\_\_\_  
**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”*.

*A copy of Steve Lovich, MD’s “Policy on Patient Accounts” is attached to these forms. Please verify that you have reviewed our “Policy on Patient Accounts” by initialing here.*

\_\_\_\_\_  
*Patient Initials Here*

\_\_\_\_\_  
**Print Patient Name**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**Patient Signature or Guardian Signature if under 18**

\_\_\_\_\_  
**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 is due in full two weeks before 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.