VALLEY PLASTIC SURGERY

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.

280 S. Pacific Hwy Talent, OR 97540 • (541)512-4771 • emr@lovichmd.com • drstephenlovich.net

VALLEY PLASTIC SURGERY

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.

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 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 _____

Valley Plastic Surgery
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

***If you have any questions about this notice, please contact the designated privacy officer* of our office at: office@lovichmd.com**	**Valley Plastic Surgery** **280 S. Pacific Hwy Talent, OR 97540** **Ph: 541-512-4771 F: 541-512-0880**

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your physician.

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 Health Information

We may use and disclose health information about you without your permission for the following purposes:

1. We may disclose your information for **treatment purposes and to coordinate your medical care.**
2. We may disclose your information **to ensure that you receive insurance benefits.**
3. We may disclose your information internally **to enhance the operation of our practice.** This includes our commitment to reviewing the quality of care we provide.
4. We may disclose your information **to comply with a limited number of legal requirements**, as outlined in this notice.

Additional information regarding each of these disclosures is provided in this notice. In any case, we will only disclose the minimum amount of information necessary for the purpose it was requested.

Our Duties

We are required by law to keep your information private. We must also provide you with this Notice and abide by its terms. We may need to revise our privacy practices from time to time. We expressly reserve the right to change our Notice of Privacy Practices and make the new terms effective for all information covered by our Notice. If such changes occur, we will let you know about the new terms by providing a copy of the changes.

Your Privacy Rights

Please note that you are entitled to specific rights regarding the use and disclosure of your information. We have listed your rights below:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our designated contact to inspect and/or copy your information. If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or other associated supplies. You may also choose to receive a copy of your health information in electronic form.

We may deny your request to inspect and/or copy information in certain limited circumstances. If you are denied access to your health information, you can ask that the denial be reviewed. If the law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe our records contain errors, you may make a written request that they are amended. We reserve the right to review your request and can decline to amend the record. We are required to place a copy of your proposed amendment in the record, even when we do not agree to amend the record itself.

We may deny your request for an amendment if we did not create the information unless the person or entity that created the information is no longer available to make the amendment.

Right to Request Restrictions

You have the right to request restrictions on the use and disclosure of your information. We are not required to agree to your request. If we do agree, we will comply to the best of our ability unless the information is needed to provide you with emergency treatment. To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to our designated Privacy Officer/Contact. If your restriction invalidates your insurance coverage, we may require you to execute a waiver of insurance benefits and a payment agreement.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the form Request for Restriction on Use/Disclosure of Medical Information to our designated Privacy Officer/Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our designated Privacy Officer/Contact.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and health care operations.

To obtain this list, you must submit your request in writing to our designated Privacy Officer/Contact. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what format you want the list (for example, on paper or electronically).

The first list you request within 12 months will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any charges are incurred.

Complaints and Investigations

We have developed procedures for investigating any complaints or concerns you may have regarding our use and disclosure of your information or any other complaint regarding our services. The law allows you to contact the Secretary of the Department of Health and Human Services with complaints about our use and disclosure of information.

You may also contact our on-site Privacy Officer/Contact, who is dedicated to investigating complaints regarding the use and disclosure of information in our care. We will not, and legally cannot, retaliate against you for any complaint.

Types of Use and Disclosure of Your Protected Health Information

We may disclose your information for the following purposes without your consent:

For Treatment Purposes

We may disclose information needed for the provision, coordination or management of health care and related services, including the coordination between our office and a third party, such as a consultation between medical providers or a referral from our office to another provider. Personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning prescriptions to your pharmacy, scheduling lab work, and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

To obtain reimbursement from your insurer, we may be required to disclose your information. This may be necessary for determining your eligibility for coverage and adjudication of claims, billing, claims management, and collections activities. We may also be required to disclose your information to your insurer to review the medical necessity, coverage, appropriateness, or justification of our charges.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you will receive to obtain prior approval or determine whether your plan will cover the treatment. You have the right to restrict disclosures of your PHI to a health plan if you have paid out-of-pocket in full for the treatment.

For Health Care Operations

We may use and disclose health information about you to run the office and make sure that you and our other patients receive quality care. Healthcare operations may include:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals or evaluating practitioner and provider performance
- Conducting training programs, accreditation, certification, licensing, or credentialing activities
- Arranging for or conducting a medical review, legal services, or auditing functions, including fraud and abuse detection and compliance programs
- Managing and operating our practice, including activities such as customer service and complaint resolution

Appointment Reminders

We may contact you (via voicemail messages, postcards, or letters) as a reminder that you have an appointment for your treatment or medical care at our office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may interest you. We also may tell you about health-related products or services that may be of interest to you.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written, prior authorization. We will not sell your PHI to another organization for marketing or any other purposes.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

1. **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
2. **Required By Law.** We will disclose health information about you when required to do so by federal, state, or local law.
3. **Research.** We may use and disclose health information about you for research projects subject to a unique approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care at the office.
4. **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or an organ donation bank, as necessary to facilitate such donation and transplantation.
5. **Military, Veterans, National Security, and Intelligence**. Suppose you are or were a member of the armed forces, or part of the national security or intelligence communities. In that case, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
6. **Workers' Compensation**. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
7. **Public Health Risks**. We may disclose health information about you for public health reasons to prevent or control disease, injury, or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products.
8. **Health Oversight Activities**. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for specific state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
9. **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
10. **Law Enforcement**. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
11. **Coroners, Medical Examiners, and Funeral Directors**. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.
12. **Information Not Personally Identifiable**. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
13. **Family and Friends**. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we allow you to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances that you would not object based on our professional judgment.
14. **Deceased Person's PHI** may be disclosed by our practice to family or others involved in the person's care or payment for care, unless our practice knows the deceased preferred that certain people not receive the PHI. Disclosures are limited to the PHI directly relevant to the person's involvement.

For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time.

If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*. However, we cannot take back any uses or disclosures already made with your permission.

You have the right to be notified following a breach of your PHI by our practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact: office@lovichmd.com	Valley Plastic Surgery 280 S. Pacific Hwy Talent, OR 97540 Ph: 541-512-4771 F: 541-512-0880

You will not be penalized for filing a complaint.

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.