ORLANDO
PLASTIC SURGERY ASSOCIATES

Please help us with the following information:
(for minors, please use the next form)

PATIENT PERSONAL INFORMATION

Today's Date		Reason for visit		
Title / First Name		Middle	Last Name	Nickname
Address			City	State
Zip Code	Date of Birth	Age	Social Security #	Gender
E-mail address			Driver's License #	State of Issuance
Home Phone	Cell Phone		Work Phone	
Employer		Occupation		

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

☐ New Patient
☐ Existing Patient

Primary Language:
☐ English. ☐ Spanish
☐ Other: _____

Ethnicity:
☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic/Latino
☐ American Indian ☐ Other: _____

How did you hear about us?
☐ Existing Patient ☐ Referral (_____) ☐ Facebook ☐ Instagram ☐ Other: _____

Please help us with the following information:
(only complete if patient is a minor

MINOR'S PERSONAL INFORMATION

Child's First Name	Middle	**Child's** Last Name	Nickname
Date of Birth	Age	Gender:	
Primary Language: ☐ English. ☐ Spanish ☐ Other: _____	Ethnicity: ☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic/Latino ☐ American Indian ☐ Other: _____		

FATHER'S PERSONAL INFORMATION

Title	First Name	Middle	Last Name	Nickname
Address			City	State
E-mail address			Driver's License #	State of Issuance
Home Phone	Cell Phone		Work Phone	
Employer		Occupation		

MOTHER'S PERSONAL INFORMATION

Title	First Name	Middle	Last Name	Nickname
Address			City	State
E-mail address			Driver's License #	State of Issuance
Home Phone	Cell Phone		Work Phone	
Employer		Occupation		

RESPONSIBLE PARTY INFORMATION

Head of household or parent with custody of minor:			Relationship:
Address		City	State
Home Phone	Cell Phone	Work Phone	

In case of an emergency, I authorize the provider to contact the following people: (filling this out allows for release of your medical information as necessary).

EMERGENCY CONTACT INFORMATION		
Name		Relationship
Home Phone	Cell Phone	Work Phone
Name		Relationship
Home Phone	Cell Phone	Work Phone

If accident related, please complete the following:

ACCIDENT DETAILS		
Date of Accident	Time	Are legal proceedings involved in this visits?
Describe how accident happened		
Name of Insurance Carrier		How do you plan to pay for this visit? ☐ Cash ☐ Check ☐ Insurance ☐ Credit Card

Please skip if you are not going through an insurance company.

INSURANCE INFORMATION			
Primary Insurance Company		Secondary Insurance Company / Worker's Comp Info	
Policy ID #	Group #	Policy ID #	Group #
Group Name		Group Name	
Insured Party		Insured Party	
Date of Birth	SS #	Date of Birth	SS #
Relationship		Relationship	
Insured's Employer		Insured's Employer	
		Insurance Adjustor Name and Contact Information	

INSURANCE RELATED SERVICES

The patient is responsible for all fees, subject to individual insurance requirements. We accept payment in the form of cash, check, or credit card. When insurance coverage applies, our office will complete the necessary forms (using information that you provide) to expedite insurance payments. Prior authorization of services (especially surgery) and pre-verification of coverage may be necessary. Depending upon insurance coverage, you will be asked to pay deductible amounts, co-payments and charges for no-covered services.

I authorize release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. I hereby authorize Orlando Center for Advanced Plastic Surgery, LLC dba Orlando Plastic Surgery Associates to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents.

Patient's Name_____ Date _____

Authorized Representative Name _____
If applicable

Patient's Signature _____
Or Authorized Representative Signature

NON-INSURANCE RELATED SERVICES

The patient is responsible for all fees for any and all service provided by our physicians. I agree to pay for all services rendered by my physician per the office policy of Orlando Center for Advanced Plastic Surgery, LLC dba Orlando Plastic Surgery Associates.

Patient's Name_____ Date _____

Authorized Representative Name _____
If applicable

Patient's Signature _____
Or Authorized Representative Signature

PAYMENT POLICY WITHOUT INSURANCE COVERAGE

Orlando Center for Advanced Plastic Surgery, LLC dba Orlando Plastic Surgery Associates and the physicians and/or physician extenders who work for this practice are considered to be "private practice plastic and reconstructive surgeons." This office does not receive subsidy or funding from the State of Florida for taking care of patients who are uninsured.

We will certainly render treatment to you in any life-threatening situation or if we are on call for the emergency room whether or not you have insurance and provide the same high-quality level of care irrespective of insurance status.

However, we do reserve the right to bill you for our services. If you have no health insurance coverage for your condition, it remains your responsibility to make payment arrangements for your treatment.

Please consult with our office manager with regards to what the expected costs will be for your treatment and/or your surgery. We are willing to work with you and negotiate payment arrangements on a term that is manageable for your situation.

Please understand that it is not possible for us to extend charity care to all patients who walk in our door. It is very expensive to run a medical practice and some form of payment will be expected for the services you receive.

I have read and understand the payment policy and agree to abide by guidelines:

Patient's Name_____ Date _____

Authorized Representative Name _____
If applicable

Patient's Signature _____
Or Authorized Representative Signature

Please help us assure you the highest quality care by carefully answering each question below.

YOUR MEDICAL HISTORY		
Today's Date	First Name	Last Name
Age	Height	Weight
Briefly state the reason for your visit:		

Please list all of the physicians that you see consistently:

PHYSICIAN LIST	
PHYSICIAN'S NAME	Specialty
Address:	Work Phone
PHYSICIAN'S NAME	Specialty
Address:	Work Phone
PHYSICIAN'S NAME	Specialty
Address:	Work Phone
PHYSICIAN'S NAME	Specialty
Address:	Work Phone
PHYSICIAN'S NAME	Specialty
Address:	Work Phone
PHYSICIAN'S NAME	Specialty
Address:	Work Phone
PHYSICIAN'S NAME	Specialty
Address:	Work Phone
PHYSICIAN'S NAME	Specialty
Address:	Work Phone

Please list all past surgical procedures, major or minor, that you have had.

PAST SURGICAL PROCEDURES	
Date of Surgery	Type of Surgery
Surgeon & Facility	
Date of Surgery	Type of Surgery
Surgeon & Facility	
Date of Surgery	Type of Surgery
Surgeon & Facility	
Date of Surgery	Type of Surgery
Surgeon & Facility	
Date of Surgery	Type of Surgery
Surgeon & Facility	

Please list all major illnesses, accidents of injury, or hospitalizations:

MAJOR ILLNESSES, ACCIDENTS, HOSPITALIZATIONS	
Date of Incident	Describe in more detail
Date of Incident	Describe in more detail
Date of Incident	Describe in more detail
Date of Incident	Describe in more detail
Date of Incident	Describe in more detail
Date of Incident	Describe in more detail

Please list any known allergies with which you have had SEVERE SIDE AFFECTS OR REACTIONS.

ALLERGIES					
MEDICATION Example: Penicillin				Reaction Hives, itching, hard to breath	
MEDICATION				Reaction	
MEDICATION				Reaction	
Latex	Y ☐ N ☐	Bee stings	Y ☐ N ☐	Milk	Y ☐ N ☐
Lidocaine	Y ☐ N ☐	Eggs	Y ☐ N ☐	Adhesive tape	Y ☐ N ☐
Vaccines	Y ☐ N ☐	Peanuts	Y ☐ N ☐	Other? _____	

Please list any and all prescription, non-prescription, and over the counter medications, home remedies, vitamins, birth control pills, inhalers, etc. that you currently take.

MEDICATION LIST	
MEDICATION	Dose (e.g. mg/pill)
Frequency	Purpose
MEDICATION	Dose (e.g. mg/pill)
Frequency	Purpose
MEDICATION	Dose (e.g. mg/pill)
Frequency	Purpose
MEDICATION	Dose (e.g. mg/pill)
Frequency	Purpose
MEDICATION	Dose (e.g. mg/pill)
Frequency	Purpose
MEDICATION	Dose (e.g. mg/pill)

DAILY ROUTINE

Smoke Cigarettes? ☐ No (skip to next section) ☐ Yes	Did you quit? ☐ No ☐ Yes	Quit Date:	Years smoked:	Packs a day:
Other Tobacco Products: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape				
Drink Alcohol? ☐ No (skip to next section) ☐ Yes	Drinks per week:	Beer: ☐	Wine: ☐	Liquor: ☐
Drink caffeinated beverages? ☐ No (skip to next section) ☐ Yes	Drinks per day:	Coffee: ☐	Tea: ☐	Soda: ☐
Marijuana or recreational drugs? ☐ No ☐ Yes	Use of needles to inject drugs? ☐ No ☐ Yes			
Exercise Regularly? ☐ No (skip to next section) ☐ Yes	If yes, please explain:			
Special Diet? ☐ No (skip to next section) ☐ Yes	If yes, please explain:			

SOCIAL HISTORY

Occupation (or prior occupation):		Employer:
Number of children:	Ages if under 18 years:	Who lives at home with you?

WOMEN'S HEALTH

Chance you are pregnant: ☐ No ☐ Yes	Number of pregnancies:	Number of births:
Date of last menstrual period:	Age menstruation began:	Age menstruation ended:
Are you breastfeeding? ☐ No ☐ Yes	Have you had a mammogram? ☐ No ☐ Yes	If yes, date of last:

List which family member next to affected disease:

FAMILY HISTORY			
Disease	**Family Member**	**Disease**	**Family Member**
Heart Disease		Endocrine Disorder	
Cancer (specify)		Autoimmune Disorders	
Diabetes		Anesthesia Problems	
Stroke		Malignant Hypothermia	
High Blood Pressure		Lung Disease	
Bleeding or Clotting Disorder		Liver Disease	
Hemophilia		Hepatitis	
Von Willebrand's Disease		Kidney Disease	
Other:		Other:	

Please select any persistent symptoms you have had in the past few months. If you have symptoms that are not listed, please list them on the following page.

GENERAL HEALTH FACTORS

General
- ☐ Unexplained weight loss or gain
- ☐ Unexplained fatigue or weakness
- ☐ Fever/Chills
- ☐ Falling asleep when sitting (daytime)
- ☐ **NO PROBLEMS**

Neurological
- ☐ Migraine Headache
- ☐ Seizures or Convulsions
- ☐ Chemical Imbalance
- ☐ Change in Memory
- ☐ Trouble with Balance
- ☐ Stroke
- ☐ Nerve injury or Numbness
- ☐ Psychiatric Care
- ☐ Nervous System Disorder
- ☐ Polio or Neuromuscular Disease
- ☐ **NO PROBLEMS**

Respiratory
- ☐ Frequent Colds
- ☐ Asthma
- ☐ Bronchitis or Emphysema
- ☐ Chronic cough/Wheezing
- ☐ Loud Snoring
- ☐ Altered Breathing During Sleep
- ☐ **NO PROBLEMS**

Digestive
- ☐ Constipation
- ☐ Ulcers
- ☐ Hiatal Hernia
- ☐ Frequent Heartburn
- ☐ Vomiting Blood
- ☐ Liver Disease or Hepatitis
- ☐ Jaundice
- ☐ Black, Tarry Bowel Movements
- ☐ Blood in Bowel Movements
- ☐ **NO PROBLEMS**

Endocrine
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ **NO PROBLEMS**

Head/Eyes/Ears/Nose/Throat
- ☐ Glaucoma
- ☐ Contact Lenses
- ☐ Blurred/Double Vision
- ☐ Ringing in Ears
- ☐ Hearing Aid
- ☐ Hoarseness for over 1 month
- ☐ Neck Stiffness
- ☐ Dentures or Partial Plates
- ☐ Capped Tooth
- ☐ Loose or Chipped Teeth
- ☐ Difficulty Swallowing
- ☐ Difficulty Opening Mouth Fully
- ☐ Frequent Headaches
- ☐ Arthritis
- ☐ Spinal Column Deformity
- ☐ Chronic Pain Problem
- ☐ **NO PROBLEMS**

Cardiovascular
- ☐ Heart Attack
- ☐ Shortness of Breath Lying Flat
- ☐ High Blood Pressure
- ☐ Abnormal Heart Beats
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ Swelling/Edema
- ☐ Heart Murmur
- ☐ Pacemaker or Defibrillator
- ☐ Chest Pain
- ☐ Kidney Disease
- ☐ Heart Related Angina
- ☐ **NO PROBLEMS**

GENERAL HEALTH FACTORS (continued)

Bladder/Kidney

- ☐ Prostate Problems
- ☐ Kidney Disease
- ☐ Blood in Urine
- ☐ Burning Urination
- ☐ **NO PROBLEMS**

Hematological

- ☐ Abnormal Bleeding Tendencies
- ☐ Anemia or Low Blood Count
- ☐ Sickle Cell Anemia
- ☐ Cancer or Tumors
- ☐ Chemotherapy or Radiation Therapy
- ☐ Abnormal Chest X-Ray
- ☐ **NO PROBLEMS**

ADDITIONAL HEALTH CONCERNS

Have you ever seen a psychologist or psychiatrist? ☐ No ☐ Yes
Are you currently under treatment by a psychologist or psychiatrist? ☐ No ☐ Yes
Personal or family history of anesthesia or bleeding problems? ☐ No ☐ Yes
If yes, please explain:
Other symptoms or medical problems that I have not asked you about?

The above information is complete and correct to the best of my knowledge. I consent to consult with Dr. Sosa for his recommendations of treatment and/or surgical opinion for which I made this consultation. In addition, I consent to any photographs which may be taken and permit their use strictly for medical, educational and scientific purposes. Photographs will be property of Edgar T. Sosa, DO.

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Edgar T. Sosa, DO., Inc. all insurance benefits payable to me for services rendered. I understand that I am responsible for co-pays, deductibles, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize any physician or medical facility that has treated me in the past to release a copy of my record to Edgar T. Sosa, DO, Inc. authorize use of this signature on all insurance benefits.

Patient's Name _____ Date _____

Authorized Representative Name _____
If applicable

Patient's Signature _____
Or Authorized Representative Signature

ELECTRONIC PRESCRIPTIONS

Dear Patients,

As we are transferring to electronic medial recording, we would like to help accommodate you by transmitting your prescriptions electronically. Please provide us with the following information for E-Prescribing:

Patient Name:_____

Name of your Pharmacy: _____

Pharmacy Phone Number: _____

Pharmacy Location: _____
(Full Address)

**If you should change your pharmacy in the future, please notify us so we can update our records.

NOTICE OF PRIVACY PRACTICES

- This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
- At Orlando Center for Advanced Plastic Surgery, LLC dba Orlando Plastic Surgery Associates, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- Our Electronic medical records database is protected by encrypted.
- Our patient portal is protected through our software company, Nextgen/Health Fusion that allows a secure connection from user to our office using secured socket layer (SSL).
- Even though our computer database is well protected, should your PHI ever be compromised you would receive a notice of breach.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may be required by your insurance company to send a report of your progress, history and physical, photos and/or surgical report for their review to determine payment benefits.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may use or disclose your medical information with one of our business associates, such as a billing or transcription service. We have an updated written contract with each business associate that requires them to protect your privacy. This contract is in compliance with the new HIPAA.
- We may use your information to contact you. For example, we may send newsletters or other information to you. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- We may use or disclose your demographic information and the dates that you received treatment from our physician, as necessary, in order to contact you for fundraising activities supported by our office. All fundraising communications will include information about how you may opt out of future fundraising communications. If you do not want to receive further fundraising communications, please contact our Privacy Officer and request that these fundraising materials not be sent to you. We will then make reasonable efforts to ensure that no further fundraising communications be sent to you.
- In an emergency, we may disclose your health information to a family member or another person responsible for you care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.

- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond that above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number we have on file for you.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you need. If you also want a copy of your records, we may charge you a reasonable fee for the copies based on Florida law.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the change at your next appointment after the effective date of the change.
- We reserve the right to have your medical records and files reviewed by our corporation's attorney as part of our medical quality assurance.
- If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. Any complaints should be in writing, state the nature of the complaint, and how to contact you. Our privacy officer will be happy to try to resolve any adverse event with you or write to: Secretary of Health and Human Services; The U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint and your complaint will not affect your diagnosis or any treatment we are providing you.

Acknowledgement

I have received a copy of the Orlando Center for Advanced Plastic Surgery, LLC dba Orlando Plastic Surgery Associates; Notice of Privacy Practices.

Patient's Name _____ Date _____

Authorized Representative Name _____
If applicable

Patient's Signature _____
Or Authorized Representative Signature

CONSENT TO RELEASE INFORMATION

Name:_____ Date of Birth: _____

I, the undersigned, hereby authorize Orlando Center for Advanced Plastic Surgery, LLC dba Orlando Plastic Surgery Associates to release medical information concerning the above-named patient to:

CONTACT DETAILS	
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
You **may/may NOT** call me at <u>home</u> ☐ No ☐ Yes	You **may/may NOT** call me at <u>work</u> ☐ No ☐ Yes
I give permission to leave a message on **home/work** recorder ☐ No ☐ Yes	
I give permission to **email** me at:	

☐ I understand that I may revoke this consent at any time by sending a written notice to the office.

☐ I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

☐ I do not want information released regarding: _____

Patient's Name _____ Date _____

Authorized Representative Name _____
If applicable

Patient's Signature _____
Or Authorized Representative Signature

I,_____, authorize the release of medical information, psychiatric, alcohol, HIV testing, and/or drug abuse information from my medical record to:

Orlando Center for Advanced Plastic Surgery, LLC
dba Orlando Plastic Surgery Associates
4106 W. Lake Mary Blvd., Suite 212
Lake Mary, FL 32746

Any alcohol or drug abuse information release is protected by Federal Regulation (396.112) and may not be redisclosed without specific written consent of the undersigned. Any psychiatric information released is similarly protected by Florida Statue 394.459. Any HIV testing and test result information is similarly protected from redisclosure by Florida Statue 381.609.

Patient's Name _____ Date _____

Authorized Representative Name _____
If applicable

Patient's Signature _____
Or Authorized Representative Signature

DISCLOSURE AND AUTHORIZATION

By signing this authorization form, I understand that:

- Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. **This authorization shall be in force and effect until revoked.**
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Office at the following address:

  Orlando Center for Advanced Plastic Surgery, LLC
  dba Orlando Plastic Surgery Associates
  Attn: Health Information Management
  4106 W. Lake Mary Blvd, Suite 212
  Lake Mary, Florida 32746

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

- ***Please keep in mind that communications via email over the Internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.***
- ***Please do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us. No one can diagnose your condition from email or other written communications, and communication via our website cannot replace the relationship you have with a physician or another healthcare practitioner.***

Patient's Name _____ Date _____

Authorized Representative Name _____
If applicable

Patient's Signature _____
Or Authorized Representative Signature

INSURANCE AND PAYMENTS

Thank you for choosing Orlando Center for Advanced Plastic Surgery, LLC dba Orlando Plastic Surgery Associates as your service provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy to explain things more clearly. Please read it, ask any questions you may have, and sign in the space provided. A copy may be provided to you upon request.

1. **INSURANCE**. We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit and prior to surgery. If you are insured by a plan, we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **CO-PAYMENTS, COINSURANCE, & DEDUCTIBLES**.
   Deductible: This is the portion of your bill that you must pay out of pocket, before your insurance policy is required to pay any benefits.

   Copayment: This is the payment your insurance policy requires you to pay directly to the doctor each time you have a visit, or when medical services are rendered.
   Copayments are usually required, even after your insurance deductible has been met.

   Coinsurance: This is generally defined as the percentage of the payment you are required to pay for your service after the deductible has been met, up to a certain limit as defined by your insurance plan. This must be paid before any policy benefit is payable by an insurance company.

   Copayments usually do not contribute to any policy out-of-pocket maximums, whereas coinsurance payments usually do.

   All co-payments, deductibles and co-insurance must be paid at the time of service and prior to surgery. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payment, deductibles and co-insurance from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit and prior to your surgery.

3. **NON-COVERED SERVICES**. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other private insurers. You must pay for these services in full at the time of each visit.

4. **PROOF OF INSURANCE**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **CLAIM SUBMISSION**. We will submit your claim and assist you in any way we reasonably can to help your claims get paid. We utilize a billing agency called **Roberts billing service** for the purposes of submitting our claims and performing our billing through insurance carriers. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between *you* and *your* insurance company; we are not a party to that contract.

6. **COVERAGE CHANGES**. If your insurance changes, please notify us before your next visit and prior to your surgery so we can make appropriate changes to help you receive your maximum benefits. **If your insurance company does not pay your claim within 180 days, the balance will be automatically billed to you.**

7. **NONPAYMENT**. It is our office policy to give your insurance carrier 120 days from the date of service of your surgery to make good on payment for the claim. During this time, if your insurance carrier denies payment for the service, we will make every attempt possible to re-bill and work this claim diligently. However, at the end of 120 days, if the claim is still not paid by your insurance company, we will inform you in writing of the situation and advise you that your insurance carrier has not paid on your claim, that your account is now delinquent, and you will be given 60 days time to make restitution and payment in full. Please be aware that if a balance remains unpaid after 60 days, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be available to treat you on an emergency basis.

8. **MISSED APPOINTMENTS**. Our policy is to charge for missed appointments not cancelled by you with at least 24 hours advance notice. These charges will be your responsibility and billed to you directly. Your insurance carrier is not responsible for coverage for your missed appointments. Please help us to serve you better by keeping your regularly scheduled appointments.

9. **COSMETIC PROCEDURES/SELF PAY.** Elective procedures must have financial arrangement made in advance of scheduling. Payment for service is due two weeks prior to the procedure. The practice will accept money orders, cashier's checks, personal checks and the following credit cards: Visa, MasterCard, Discover, American Express. We charge a $30 service fee for all returned checks. As a convenience to you, financing is also available through our participating carriers. For those individuals who pay by credit card, debit card or finance companies, you are not eligible for credit card challenge or "charge back" to the finance companies once the service has been provided as per this agreement.

10. **FORM COMPLETION**. Completing Disability Forms, Family Leave Forms or your third party insurance forms require office staff time, copies to be made and time out of Dr. Sosa's schedule, which takes away from patient care. Therefore, our charge for this service is $20.00 per form and we request up to three business days for completion of this task.

11. **REFERRALS/AUTHORIZATIONS.** We are required to follow the guidelines of your managed care plan, which may require a referral from your primary care physician prior to your appointment when visiting a specialist's office. Therefore, if a referral is required and not presented or received by the time of your visit, your appointment will be rescheduled or you will be financially responsible for services received, paid in full at the time of your visit.

12. **PAYMENT POLICY.** All past due balances will be due in full at the time of your office visit. We will provide you with a copy of your bill and the insurance credits upon request. We reserve the right to charge a $50.00 fee for missed appointments and an additional charge for missed surgical appointments. If you are unable to make your appointment, please cancel or reschedule by calling our office at least 24 hours in advance.

If I am paying by insurance, I the undersigned certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Edgar T. Sosa, DO all insurance benefits payable to me for services rendered. I understand that I am responsible for copayments, coinsurances, deductibles and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize release of medical information to my insurance carrier, or requested physician, to provide continuity of care. I authorize any physician or medical facility that has treated me in the past to release a copy of my records to Edgar T. Sosa, DO. I authorize use of this signature on all insurance benefits.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and/or contact information.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by guidelines:

Patient's Name _____ Date _____

Authorized Representative Name _____
If applicable

Patient's Signature _____
Or Authorized Representative Signature

CONSENT FOR PHOTOGRAPHY

I,_____, consent to the taking of photographs by Dr. Edgar T. Sosa or his designee of me, or parts of my body, in connection with the plastic surgery procedure(s) to be performed by Dr. Edgar T. Sosa.

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Society of Plastic Surgery (ASPS) and The American Board of Plastic Surgery, Inc. (ABPS).

I understand that Dr. Edgar T. Sosa may publish such photographs 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 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 won't have any effect on any actions taken prior to my revocation. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Edgar T. Sosa.

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

I further understand that, because the ASPS/ABPS is not receiving the information in the capacity of a healthcare provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be disclosed by ASPS/ABPS. I release and discharge Dr. Edgar T. Sosa, ASPS/ABPS, 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 grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Patient's Name _____ Date _____

Authorized Representative Name _____
If applicable

Patient's Signature _____
Or Authorized Representative Signature

I have read the above authorization and release. I am the parent/guardian or conservator for _____, a minor. I am authorized to sign this consent on his or her behalf and I grant this consent as a voluntary contribution in the interest of public/medical education.

Thank you for allowing us the Privilege of Caring for You.