ALON AESTHETICS

Regina Fearmonti, MD, PA

11503 NW Military Hwy, Suite 114, San Antonio, TX 78231

PHONE: (210) 343-1089 FAX: (210) 247-0021

Name: ____ Date: ________________________

Home Address: ____________________________City: ______________ State: _________ Zip:___________
Telephone: ______________________________________ Mobile:____
DOB: ______/________/_______ Age: _________
SSN: _______________________________
Email: ____ May We Send Information Here? YES NO
Occupation: ___________________________________ Employer: ______________________________________
Employer's Address: ____ City: ______________________
State: ____________________ Zip: __________________ Work Phone: ___________________________________

*********** Please provide us with your current Primary and/or Secondary Health Insurance card.

Primary Health Insurance:

Company: ____
Policy Number:_________________________________ Group Number:_________________________________
Insured: _______________________ DOB: ______/________/_______ Employer:_________________________

Secondary Health Insurance:

Company: ____
Policy Number:_________________________________ Group Number:_________________________________
Insured: _______________________ DOB: ______/________/_______ Employer:_________________________

Personal/Primary Physician:

Name of Personal/Primary Physician:____

Address:____

Business Telephone:________________________________Fax:____
Date of last physical examination:____
PCP referral required? YES NO Referral on file? YES NO

In Case of Emergency Contact:
Name: ____ Relation: __________________________________
Phone: ____________________________________ Work Phone: _______________________________________

Whom may we thank for referring you?

☐ Magazine ☐ Radio ☐ Internet ☐ Friend/Family: ☐Other Physician:

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PLASTIC SURGERY

Complete this section only if someone other than the patient is financially responsible.

Responsible Party:___________________________________Relationship to Patient:______________________
Home Address:____
City:___________________________________State:______________Zip:__________________________________
Telephone:_______________________________________DOB: ______/________/_______
Occupation:____SSN:____
Employer:____Work Phone:__________________________________

Patient Consent for Use of Credit Cards, Debit Cards, and Financing
Disclosure of Protected Health Information

It may be necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Regina M Fearmonti, MD, PA and/or SKIN@Alon to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment.

_______ I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow up interaction to address any issues that might arise, which are further addressed in the Revision policy.

_______ I agree that this non credit card challenge is irrevocable.

____
Signature of Patient or Legal Guardian

____
Print Patient's Name **Date**

Debit/Credit Card Information: (Must be your name)

Name on Card: ____

Billing Address: ____**Zip Code:**______________________

Card Number: ____ **Expiration Date (00/00):** _________________

Cv2 Code: ______________

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MEDICAL HISTORY:

Patient name: ______________________ Age: __________Height: _____________ Weight: _________________

Do you or have you had:	YES	NO		YES	NO
Prolonged Bleeding When Cut	☐	☐	Hyperlipidemia	☐	☐
Cardiovascular Disease	☐	☐	High blood pressure	☐	☐
Diabetes	☐	☐	Malignancy	☐	☐
Fainting/Blackout Episodes	☐	☐	Obstructive Sleep Apnea	☐	☐
Fever Blisters/Cold Sores	☐	☐	Personal Anesthesia Reactions	☐	☐
Acid Reflux	☐	☐	Pulmonary Embolism	☐	☐
Heart Disease/Heart Attack	☐	☐	Rheumatoid Arthritis	☐	☐
Heart Murmur	☐	☐	Stroke	☐	☐
Hepatitis	☐	☐	Systemic Lupus Erythematosis	☐	☐
Other Significant Illnesses	☐	☐	Tape / Adhesive Reactions	☐	☐

Surgical History: (include any childbirths)

OPERATION(S):	DATE OF OPERATION(S):

Family History:

Condition in immediate family?	*YES*	*NO*	*If so, please list the family member:*
Heart Disease/Heart Attack:	☐	☐	
Breast Cancer:	☐	☐	
Other Cancers (type?):	☐	☐	
Diabetes:	☐	☐	
Blood Disorders:	☐	☐	
Stroke:	☐	☐	
**Reactions to Anesthesia:	☐	☐	
**Prolonged Bleeding?	☐	☐	

Personal History:

Do you smoke? ☐ YES ☐ NO If yes, how many packs per day? ___________________________

Do you drink alcohol? ☐ YES ☐ NO ☐ OCCASIONALLY

Allergies: (Are you allergic or have you had reactions to medications, drugs, or local anesthetic medication?)

MEDICATION(S):	REACTION WHEN LAST TAKEN:

Current Medications: (List all medications, including aspirin and birth control.)

Do you take or have you taken Accutane? YES ☐ NO ☐

MEDICATION(S):	DOSE:	FREQUENCY TAKEN:

Bleeding/Transfusions:

Have you taken Aspirin in the past 2 weeks? YES ☐ NO ☐

Family History of prolonged bleeding? YES ☐ NO ☐

Personal prolonged bleeding when cut? YES ☐ NO ☐

Have you had blood transfusions? YES ☐ NO ☐

Reaction to blood transfusions? YES ☐ NO ☐

Scarring:

Have you formed excessive, unsatisfactory scars, or keloid formations in the past? YES ☐ NO ☐

If yes, explain:

____

Your Pharmacy:

Pharmacy's Name: ____

Address: _________________________________ Phone: _______________________

Fax:____________________

ALON AESTHETICS
Regina Fearmonti, MD, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Attached, you will find the Notice of Privacy Practices for *Fearmonti Plastic Surgery*. Your name and signature on this form indicates that you have reviewed a copy of the Notice of Privacy Practices on the date indicated, of which a copy can be provided at your request. If you have any questions regarding the information set forth in the form, please do not hesitate to ask the clinic staff. If you need further assistance, please contact the Practice Manager at (210) 343-1089.

PATIENT or GUARDIAN SIGNATURE: ____ DATE: ____________________

STATEMENT OF FINANCIAL RESPONSIBILITY AND PATIENT PAYMENT POLICY

Thank you for choosing Regina Fearmonti,MD, Fearmonti Plastic Surgery as your surgical provider. Dr. Regina Fearmonti and her staff are committed to providing you with the highest quality of care. We ask that you read, initial and sign this form to acknowledge your understanding of our patient financial policies.

(Initial) __________ As a courtesy to our patients, the office informs all patients of recommended services and the costs associated with them. Our office will help you contact your insurance provider and obtain a general quote of coverage and benefits as it applies to the procedure/services in question and the current status of your individual policy. Please note that each medical insurance company or health insuring agent(s) make the final determination regarding medical necessity of all services rendered.

(Initial) __________ Our office policy is to file a claim of benefits to the insurance institution provided to us by the patient. The claim of benefits is submitted with diagnosis and procedure codes that mostly appropriately reflect the procedures performed by our doctor. If the insurance carrier fails to issue payment 90 days after services are rendered, the patient then becomes financially responsible for all non-paid fees. Accounts with any remaining balance may be turned over to a third-party collection agency. Further action to collect from the insurance carrier can be made by the patient, even after they have issued payment to our office. Our office can provide you with the needed information to pursue a claim with your insurance carrier.

(Initial) __________ In the event that your insurance company does not agree to pay for the performed services, for any reason, including services deemed not medically necessary, you are financially responsible for all the unpaid fees and charges. By signing this, you acknowledge full financial responsibility for all services rendered, and promise to pay any balance in full.

Payment Policy: All professional services rendered are charged to the patient. The patient is responsible for payments regardless of insurance coverage

Surgery Fees: All Surgeons fees are not covered by your insurance plan or when your deductible has not been met are to be paid in full prior to the date of surgery

Cancellation of Surgical Procedures: Any scheduled surgical procedure will be assessed a $500.00 administration fee if cancelled. Any surgical procedure cancelled 7 days or less prior to the scheduled date will be subject to forfeiture of the full 20% surgery deposit.

Assignment of Benefits: I hereby consent to the release of any medical information necessary to process any of the insurance claims. I also authorize the release of medical records to any referring physicians.

Release of Medical Information: I consent to the release of any medical information necessary to process any and all insurance claims, I also authorize the release of medical records to any referring physicians or third party payors.

Your signature verifies that you have read the above statements, understand your patient responsibility, and agree to all the terms and policies of our office listed above.

SIGNATURE: ____

DATE: ___________________________

PATIENT PHOTOGRAPHIC RELEASE AND CONSENT FORM

PATIENTS NAME: ____ DOB: ______________________________

I hereby acknowledge that I have been advised that the practice may take preoperative and postoperative photographs of my person for confidential and clinical records purposes. The photographs will be taken by a designated representative of *Fearmonti Plastic Surgery* staff or Dr. Fearmonti. These photographs will remain the property of *Fearmonti Plastic Surgery*. I hereby give my consent for *Fearmonti Plastic Surgery* to use the photographs under one of the following circumstances.

*** Please initial **ONE** of the following:

ALL MEDIA

(Initial) __________ Photographs taken of me or parts of my body as well as details regarding medical services I have received at *Fearmonti Plastic Surgery* may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, the company website and television, in order to inform the public about plastic surgery methods. Further, I release and discharge *Fearmonti Plastic Surgery*, all employees of *Fearmonti Plastic Surgery*, the facility used and the American Board of Plastic Surgery, and all parties under their license and authority from any and all claims or action that I have or may have relating to such use and publication and all rights, if any, that I have in such photographs and details regarding medical services rendered to me, including any claim for payment in connections with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject to only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

DOCTORS WEBSITE ONLY

(Initial) __________ Photographs taken of me or parts of my body as well as details regarding medical services I have received at *Fearmonti Plastic Surgery* may be used on the company website in order to inform the public about plastic surgery methods. Further, I release and discharge *Fearmonti Plastic Surgery*, all employees of *Fearmonti Plastic Surgery*, the facility used and the American Board of Plastic Surgery, and all parties under their license and authority from any and all claims or action that I have or may have relating to such use and publication and all rights, if any, that I have in such photographs and details regarding medical services rendered to me, including any claim for payment in connections with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject to only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

PHOTO ALBUM ONLY

(Initial) __________ Photographs taken of me or parts of my body as well as details regarding medical services I have received at *Fearmonti Plastic Surgery* may be used on the company photograph album in order to inform other patients of *Fearmonti Plastic Surgery* about plastic surgery methods. Further, I release and discharge *Fearmonti Plastic Surgery*, all employees of *Fearmonti Plastic Surgery*, the facility used and the American Board of Plastic Surgery, and all parties under their license and authority from any and all claims or action that I have or may have relating to such use and publication and all rights, if any, that I have in such photographs and details regarding medical services rendered to me, including any claim for payment in connections with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject to only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

MEDICAL CARE ONLY

(Initial) __________ Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with *Fearmonti Plastic Surgery*. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at *Fearmonti Plastic Surgery*. By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photographic consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or completions of a new form.

Patient
Signature:____Date:_________________________________

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PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES

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

1. **Purpose:** Dr. Fearmonti and office staff follow the privacy practices described in this Notice. The office maintains your health information in records that are kept in a confidential manner, as required by law. The office must use and disclose or share your health information as necessary for treatment, payment, and health care operation to provide you with quality health care.
2. **What Are the Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with the pharmacist to discuss medications, or with radiologists or other consultants to make a diagnosis. The office may use health information as required by your treatment. The office may use and disclose your health information to improve the quality of care and for education and training purposes of UTHSC students, residents, and faculty.
3. **How will Dr. Fearmonti's office use and disclose my health information?** Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure:

***** Note: you will have the opportunity to refuse some of these communications about your health information, indicated by (*)

- Religious affiliation to a hospital chaplain or member of the clergy
- Family member or close friends involve in your care or payment for treatment
- Disaster relief agency if you are involved in a disaster relief effort
- To inform you of treatment alternatives or benefits or services related to your health
- Appointment reminders
- Public health activities, including disease prevention, injury or disability, reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence
- Health oversight activities, such as audits, inspections, investigations, and licensure
- Law enforcement
- Coroners, medical examiners, and funeral directors
- Organ and tissue donation
- Certain research projects
- To prevent a serious threat to health or safety
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority
- National security and intelligence activities to authorized persons to conduct special investigations
- Workers' Compensation. Your medical information regarding benefits for work related injuries or illnesses may be released as appropriate
- Alcohol and drug abuse information has special privacy. The office will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient consents in writing; to carry out treatment, payment, and operation; or as required by law

- To carry out health care treatment, payment, and operations functions through business associates, such as to install a new computer system.

4. **Your Authorization is Required for Other Disclosures.** Except as described above, we will not use or disclose your medical information, unless you allow the office to do so. For example, we will not use your photographs for presentations outside the office without your written permission. You may withdraw or revoke your permission, which will be effective only after the date of your written withdraw.
5. **You Have Rights Regarding Your Health Information.** You have the following rights regarding your medical information, if requested on the form(s) provided by the office.
    - **Right to request restrictions.** You may request limitations on your health information that we use or disclose for health care treatment, payment. Or operations, although we are not required to comply with your request. For example, you may ask us not to disclose that you have had a particular procedure. We will release the information if necessary for emergency treatment.
    - **Right to confidential communications.** You have the right to review and obtain a copy of medical and health record. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by other licensed health care professionals chosen by the office. The office will comply with the outcome of the review.
    - **Right to request amendment.** If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by the office. The office is not required to accept the amendment
    - **Right to accounting disclosures**. You may request a list of the disclosures of your health information that have been made to persons or entities for disclosures unrelated to health care treatment, payment, or operations within the past six (6) years, but not prior to April 1, 2014. After the first request, there may be a charge.
    - **Right to a copy of this notice.** You may request a paper copy of this notice at any time.
6. **Requirements Regarding This Notice.** The office is required by law to provide you with this Notice. We will comply with this Notice for as long as it is in effect. The office may change this Notice, and these changes will be effective for health information we have about you, as well as any information we receive in the future. Each time you register at the office for health services, you may receive a copy of the Notice in effect at the time.
7. **Compliance**. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the United States Department of Health and Human Services. We will not penalize or retaliate against you in any way for making a complaint with The Department of Health and Human Services.

Contact Dr. Regina Fearmonti's office at (210) 343-1089 if you have any questions about this notice or you wish to obtain a form to exercise your individual rights described on paragraph 5.