JAMES S. ALBERTOLI, MD, FACS, LLC

PATIENT INFORMATION

Please print clearly and complete all information. Thank you.

Patient Name: ____
(First) (Middle) (Last)

Home Address: ____

City: ____________________ State:_______ Zip Code: _______ Social Security No.: ___/___/___

Date of Birth: ___/___/___ Age: _____ Sex: M ☐ F ☐ Marital Status: S ☐ M ☐ D ☐ W ☐

Contact Information

Home Phone: _____/_____/_____ Work Phone: _____/_____/_____

Cell Phone: _____/_____/_____ Email: ____________________

Emergency Contact

Contact Name: ____
(First) (Middle) (Last)

Relationship to Patient: __________________ Phone Number: _____/_____/_______

Employment

Occupation: ________________________ Employer: ________________________

Employer's Address: ____

City: ____________________________________ State:__________ Zip Code: ___________

Employer Phone: _____/_____/_____

Primary Insurance / Responsible Party Information

Insurance Company: ____

Subscriber Name: ____
(First) (Middle) (Last)

Relationship to Patient: ___________ *(Parent, Spouse)* Subscriber's Employer: _____________

Policy ID #: ___________________________ Group #: _________________________

Subscriber Date of Birth: _____/_____/_____ Home Phone: _____/_____/_____

Social Security No.: _____/_____/_____ Cell Phone: _____/_____/______

Secondary Insurance /Responsible Party Information

Insurance Company: ______________________________

Subscriber Name: ______________________________
(First) (Middle) (Last)

Relationship to Patient: ________ *(Parent, Spouse)* Subscriber's Employer: ________

Policy ID #: ______________ Group #: ______________

Subscriber Date of Birth: ____/____/____ Home Phone: ____/____/____

Social Security No.: ____/____/____ Cell Phone: ____/____/____

Physician Information

Referring Provider: ______________ Phone: ______________

Primary Care Provider: ______________ Phone: ______________

PLEASE READ CAREFULLY:

1. **All charges, co-payments and / or deductibles are due at the time of service, where applicable.**
2. **I authorize the James S. Albertoli MD, FACS, LLC to apply for benefits on my behalf for services rendered by James S. Albertoli M.D. I request payment from my insurance company to be made directly to James S. Albertoli, MD, FACS, LLC.**
3. **I certify that the information I have provided with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim. I permit a copy of this authorization to be used in place of the original.**
4. **This authorization may be revoked at any time in writing.**
5. **I understand that nothing herein relieves me of the primary responsibility and obligations to pay for medical services provided, when a statement is rendered.**
6. **I understand it is my responsibility to notify this office of any change of personal information including address change, telephone number change or insurance change**

____
Patient Signature

____
Date

James S. Albertoli MD, FACS, LLC
56 Thomas Johnson Dr.
Suite 100
Frederick, MD 21702
Phone: 301.698.9999
Fax: 301.698.9699

FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for all charges incurred during visits with James S. Albertoli MD, FACS, LLC, whether or not paid by any insurer, including without limitation any health insurance deductible, co-payments, coinsurance, denied claims or the failure for any reason by any insurance carrier or the Workers' Compensation Commission to pay charges incurred for services rendered.

It is my responsibility to know and understand the terms and conditions of any insurance plan and / or policy I may have, and I accept full financial responsibility if incorrect insurance information or a failure to provide correct information in a timely manner results in a denial of claims. I agree to pay in full to, the James S. Albertoli MD, FACS, LLC, any outstanding balance prior to my visit today and at the end of my visit today, and any deductibles, co-payments and/ or coinsurance incurred as a result of today 's visit and all future visits.

I agree that any balance outstanding more than thirty (30) days from my visit are subject to late charges at the rate of 1.5% monthly (18% annually). In the event my account is assigned to an attorney for collection, then in addition to the amounts due on my account, I agree to be responsible for payment of all costs of collection, including without limitation, attorney's fees in the amount of twenty-five percent (25%) of the outstanding balance due on my account (which I expressly agree is a reasonable attorney's fee), court cost and private processing fees. I understand James S. Albertoli MD, FACS, LLC reserves the right, in its sole discretion, to waive, reduce, or otherwise negotiate any of the foregoing on a case-by-case basis.

I certify that I have read and understand all of the information on this document and have completed the questionnaire in a true and correct manner to the best of my knowledge. I certify I will notify the James S. Albertoli MD, FACS, LLC, in a timely manner of any changes in my status or any of the information I have supplied.

____
Patient Signature

____
Date

____
Witness Signature

____
Date

James S. Albertoli MD, FACS, LLC
56 Thomas Johnson Dr.
Suite 100
Frederick, MD 21702
Phone: 301.698.9999
Fax: 301.698.9699

Welcome:

Thank you for choosing our practice. We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing healthcare services to our patients.

Dr. Albertoli participates with most insurance plans. Each plan has different benefits for you as well as different financial obligations, and not all insurance policies cover all services. Payment is based on the terms of the patient's plan and eligibility when the services are received. It is your responsibility to check with your insurance company to determine covered benefits.

The following are our financial guidelines relative to financial responsibility:

- ◊ **Payment is expected at the time of service unless alternate arrangements have been made in advance.** Patients are responsible for deductibles, co-pays, and other charges not covered by insurance.
- ◊ Please provide a copy of your insurance card at each visit.
- ◊ It is the patient's responsibility to bring a referral to the initial appointment, when required by insurance.
- ◊ Accounts may be turned over to our attorney for collections if past due by 60 days or more.

If you have any questions regarding this policy, please let us know.

I have read, understand and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays, and deductibles are my responsibility.

____
Patient Name

__________________________ __________________________
Patient Signature Date

James S. Albertoli MD, FACS, LLC
56 Thomas Johnson Dr.
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Participating Insurances

Thank you for choosing the office of Dr. James S. Albertoli and The Ambulatory Center for Aesthetic and Reconstructive Surgery to provide you with your medical treatment. We participate with the following insurances:

- ◊ Aetna
- ◊ Aetna Better Health
- ◊ Anthem BC/BS
- ◊ Blue Cross / Blue Shield
- ◊ Carefirst
- ◊ Cigna
- ◊ Champ VA
- ◊ Coventry
- ◊ Department of Labor
- ◊ Humana
- ◊ Johns Hopkins Health Plans
- ◊ Medicare
- ◊ MDIPA
- ◊ MD Medical Assistance
- ◊ Maryland Physician's Care
- ◊ Priority Partners
- ◊ Railroad Medicare
- ◊ Tricare
- ◊ UMR
- ◊ United HealthCare
- ◊ United HealthCare Community Care
- ◊ United HealthCare GEHA
- ◊ University of Maryland Health Partners
- ◊ Workers Compensation

Although we participate with your insurance, you will be responsible for any co-payments, co-insurance, and fifty percent (50%) of your outstanding deductible per your individual surgery prior to your surgical appointment. If you have a secondary policy, these balances may be covered by your insurance. If you do not have a secondary insurance you will be responsible for the payment. If you do not have a secondary insurance and are interested in obtaining one, please let us know and we will assist you with your options. Some secondary insurances you may like to review are:

- ◊ AARP
- ◊ GEHA
- ◊ Gerber Life
- ◊ Transamerica

If you need any assistance understanding your insurance, please call our office during routine business hours. One of our staff members will be happy to assist you.

____
Patient Signature

____
Date

____
Witness Signature

____
Date

James S. Albertoli MD, FACS, LLC
56 Thomas Johnson Dr.
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Consent for Medical Treatment

Please read the following carefully.

I hereby give permission to James S. Albertoli, M.D. to perform examinations, procedures, laboratory tests and to administer such medications as, in his opinion, are necessary for my care. Any surgical procedure will require separate consent from me.

I further understand that I may still refuse any examination, test or treatment at any time for any reason.

_______________________ Patient Signature

_______________________ Date

_______________________ Witness Signature

_______________________ Date

HIPAA Acknowledgement Form

James S. Albertoli, MD, FACS, LLC's "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practices by initialing below:

_______________________ Patient Initials

Our Notice of Privacy Practices states that we reserve the right to change the terms described.

_______________________ Patient Initials

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

_______________________ Patient Initials

James S. Albertoli MD, FACS, LLC
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Smoking and Wound Healing

Wound Healing: there are three phases of wound healing. The first phase is the Inflammatory Phase, during this phase healing begins. This phase lasts from four to six days. The second phase is the Proliferative Phase, during this phase granulation tissue fills in the wound and the wound edges begin to pull together. This phase lasts four to twenty-four days. The last phase sis the Maturation Phase, during this phase scar tissue is formed. This phase lasts twenty one days to two years.

Nicotine is a vasoconstrictor: it causes blood vessels to become smaller. Smaller blood vessel have a harder time carrying nutrients and oxygen to the wound which can cause the healing process to take longer. Nicotine patches are not an acceptable alternative to smoking since they contain nicotine. Carbon monoxide from the cigarette smoke competes with the oxygen in the blood. This causes there to be less oxygen available to the tissue for healing. It takes three full days of no smoking to get rid of all the carbon monoxide in your blood.

Smoking and Nicotine containing products may cause many problems with wound healing. Problems include but are not limited to:

- ◊ Infection (usually involving the need for antibiotics)
- ◊ Stitches coming apart
- ◊ Skin grafts not attaching or failing
- ◊ Slow wound healing (months instead of weeks)
- ◊ Skin loss (resulting in scabbing)

I have read the following information, and understand the consequences of smoking and wound healing.

____________________ ____________________
Patient Signature Date

____________________ ____________________
Witness Signature Date

James S. Albertoli MD, FACS, LLC
HEALTH SURVEY

1. Have you ever had any problems with your heart? Y____N____
   If yes, please respond to the following:
   - Within the last three months? Y____N____
   - Do you have a history of chest pain or angina? Y____N____
     - If so, have your symptoms increased recently? Y____N____
   - Do you have a history of congestive heart failure? Y____N____
     - If so, have your symptoms increased recently? Y____N____
   - Have you ever had a heart attack or cardiac arrest? Y____N____
   - Do you have cardiac arrhythmia (irregular heartbeat)? Y____N____
     - If so, do you take medication for treatment? Y____N____
   - Do you have any problems with your heart valves? Y____N____
     - If so, does this problem limit your physical activity? Y____N____
   - Do you need to take antibiotics prior to dental or other procedures? Y____N____

2. Do you have high blood pressure? Y____N____
   If yes, do you take medication for treatment? Y____N____

3. Are you a diabetic? Y____N____
   If yes, do you use insulin? Y____N____

4. Have you had a stroke, TIA (mini-stroke) or seizure? Y____N____

5. Have you had problems with your lungs or breathing? Y____N____
   If yes, please check one:
   Asthma ☐ Emphysema ☐ Other ☐ ________________
   COPD ☐ Bronchitis ☐

6. Have you ever had liver problems or hepatitis? Y____N____
   If so, please check one:
   Hepatitis A ☐ Hepatitis B ☐
   Hepatitis C ☐ Don't know type ☐

   Describe other liver problems: ______________________________
   ____

7. Have you ever had problems with kidney function? Y____N____
   If yes, describe problem: ______________________________
   ____

8. Have you ever been treated for cancer? Y____N____
   If yes, please list type of cancer: ______________________________

   Did you receive radiation therapy? Y____N____

9. Do you have a bleeding disorder, bruise easily, or take a blood thinner like Coumadin? Y____N____
   If yes, please describe: ____

10. Is there any chance you could be pregnant? Y____N____

11. Do you history of sleep apnea? Y____N____
    If so, do you use a C-Pap or Bi-Pap machine? Y____N____

12. Have you ever been treated for MRSA or any other wound infection? Y____N____

13. Please list ALL previous surgeries and dates:
    ____
    ____
    ____

14. Have you or any member of your family had a major problem with anesthesia? Y____N____

    If yes, please describe:
    ____
    ____
    ____

15. Tobacco history:
    - ☐ current every day smoker, approximate # of packs per day ______
    - ☐ former smoker, quit ____ years ago
    - ☐ never smoked

16. Do you drink alcohol? Y____N____
    Approximate number of drinks per day: ________
    Approximate number of drinks per week: ________

17. Do you take a diuretic (water pill), digoxin (Lanoxin) or a steroid? Y____N____

18. Please list **ALL** medications you are currently taking:
    ____
    ____
    ____

19. Please list **ALL** food allergies and reactions:
    ____
    ____
    ____

20. Please list **ALL** allergies to medications and reactions:
    ____
    ____
    ____

21. Please list **ALL** environmental allergies:

____
____
____

22. Are you up to date on your immunizations: Y____ N____

23. Have you seen a medical physician (internist, cardiologist, etc?) within the last six months? Y____ N____

    Physician's Name: ______________________________
    Phone #: ______________________________

24. Please list any other medical problems not discussed above:

____
____
____

25. Are you allergic to LATEX? Y____ N____

26. Do you have Advance Directives: Y____ N____

27. Can you provide us with a copy? Y____ N____

28. What brings you here today?

____
____
____

    Date of injury or onset of problem: ______________________________

____ ____________________
Patient Signature Date

____
Printed Name

____ ____________________
Witness Date

Effective 09/14/2015

James S. Albertoli MD, FACS, LLC

Patient's Bill of Rights

Each patient of James S. Albertoli MD, FACS, LLC has the right to:

- ◊ Respectful care given by competent personnel with consideration of his/her privacy concerning his/her own medical care.
- ◊ To remain free from harm.
- ◊ Expect that all communications and records pertaining to his/her care will be treated as confidential except in cases when reporting is required by law as mandated by the Health Information Portability and Accountability Act of 1996.
- ◊ Every consideration of Privacy.
- ◊ To review the records pertaining to his/her treatment and to have the information explained or interpreted as necessary.
- ◊ Expect reasonable response for appropriate and medically indicated care and services.
- ◊ Be informed of the procedure for resolving disputes, grievances and conflicts.
- ◊ Receive quality care from competent, and credentialed professionals.
- ◊ Review provider's credentials and to be informed of the credentialing process upon request.
- ◊ Receive services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability or source of payment.
- ◊ Receive information regarding the cost of services, available payment methods, and payment status by insurance providers, in so far as this is known.
- ◊ Receive treatment in a supportive environment with freedom from physical or mental abuse.
- ◊ Ask and be informed of the existence of any relationships of the facility to other health care and related institutions insofar as the patient's care is concerned.
- ◊ Know the identity of those involved in their care, as well as when those involved are students or other trainees.
- ◊ Refuse services and have the possible consequences of the refusal explained.
- ◊ Know any ownership interests of those involved in their care may have.
- ◊ The patient has the right to have services performed by another physician at another facility
- ◊ Participate in the development of his/her individualized treatment plan to ensure that the plan is consistent with the needs and preferences of the patient.
- ◊ Receive information regarding process, or lack of progress anticipated discharge and any other pertinent information related to his/her treatment and prognosis. This information will be provided to assist the patient in making informed choices regarding treatment.
- ◊ Receive information regarding methods of expressing suggestions or grievances to the organization.
- ◊ Be informed that procedures performed at the Ambulatory Center for Aesthetic and Reconstructive Surgery are elective and, therefore, Advance Directives will not be honored. If there are any questions you may contact our office at any time.
- ◊ Receive information regarding Advanced Directives upon request.
- ◊ Expect that no experimental surgery or procedures for research will be performed.
- ◊ Be informed that the contact information to the Office of the Medicare Beneficiary Ombudsman is 1.800.633.4227 and/or www.medicare.gov
- ◊ To file a grievance, first contact the office of the *Ambulatory Center for Aesthetic and Reconstructive Surgery* at *56 Thomas Johnson Drive Suite 100 Frederick, MD 21702.*
- ◊ Be informed of the address and phone number to file a complaint with the *Office of Healthcare Quality Ambulatory Care Unit at 410.402.8040 (800.492.6005)* or by mail at *Spring Grove Hospital Center Bland Bryant Building 55 Wade Avenue Catonsville, MD 21228.*

James S. Albertoli MD, FACS, LLC

Patient's Responsibility

Patient's of James S. Albertoli MD, FACS,LLC have the responsibility to:

- ◊ Provide the care team with complete, and accurate information about present complaints, past illnesses, hospitalizations, medication(s) and other matters relating to your health.
- ◊ Be considerate of care team, staff members, others.
- ◊ Follow office rules and regulations affecting patient care and conduct.
- ◊ Follow all safety measures.
- ◊ Provide the staff with all information regarding third party insurance coverage.
- ◊ Fulfill financial responsibility, for all services received, as determined by the patient's insurance carrier and the Surgery Center.
- ◊ Participate in all prescribed therapies.
- ◊ Identify your goals to team members.
- ◊ Inform the team of any changes in your conditions, or plans.
- ◊ Notify us of any cancellations at 301.698.9999.
- ◊ Share any questions or concerns about your treatment plan, discharge plan or medical management.
- ◊ Notify the staff if you have an Advance Directive, Living Will, and Medical Power of Attorney.

Disclosures

This describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Understanding our Office Policy for Specific Disclosures:

Notification: Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or your whereabouts.

Communications with Family: Using best judgment, a family member, or close personal friend, identified by you, may be given information relevant to your care and/or recovery.

Organ Procurement Organizations: Your PHI may be disclosed consistent with laws governing entities engaged in procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.

Appointments: This office reserves the right to conduct you with appointment reminders.

Research: Your PHI will be disclosed to researchers upon Institutional Review Board approval, and upon assurance that established protocol to ensure the privacy of your health information is followed.

Food and Drug Administration (FDA): We are required by law to disclose health information to the FDA related to any adverse by law effects of food, supplements, products, and product defects for surveillance to enable products recalls, repairs, or replacements.

Worker's Compensation: We will release information to the extent authorized by law in matters of workers compensation.

Public Health: We are required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. We are further required to report communicable disease, injury, disability.

Correctional Facilities: We will release medical information on incarcerated individuals to correctional agents or institutional necessary for the welfare of the individual or for the health and safety of other individuals. The rights outlined in the Notice of Privacy Practices will not be extended to incarcerated individuals.

Law Enforcement: (1) Your PHI will be disclosed for law enforcement purposes as required under the state law or in response to valid subpoena. (2) Provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct of violations of professional or clinical standards that may endanger one or more patients, workers, or the general public.

HIPAA Notice of Privacy Practices

This describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Understanding Your Health Record:

A record is made each time you visit a hospital, physician, or other health care provider. An effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others. Use or disclosure of your health information will follow more stringent State or Federal Laws.

Understanding Your Health Information Rights:

Your health record is the physical property of James S. Albertoli, MD, FACS, LLC but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosure of your information, and to request amendments to be made to your health record. You may review or request a copy of your health information as well was an accounting of the disclosures we have made of your PHI. Other than activity that has already occurred you may revoke any further authorization to use or disclose your health information. You may also request communications of your health information be made by alternative means to alternative locations. If you believe your privacy rights have been violated, you have the right to file a complaint with us or contact the Secretary of Health and Human Services.

Our Responsibilities:

James S. Albertoli MD, FACS, LLC is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices. James S. Albertoli MD, FACS, LLC reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event changes are made, we will post them in the office. Other than for reasons described in this notice, the office agrees not to use or disclose your health information without your authorization.