PLASTIC SURGERY ASSOCIATES
LOUIS MORALES, JR. M.D.
RODNEY SCHMELZER, M.D.
LISA MORRIS, M.D.
5089 SOUTH 900 EAST, SUITE 100
SALT LAKE CITY, UT 84117

				TODAY'S DATE
PATIENT'S NAME (First, M, Last)	DATE OF BIRTH	AGE	GENDER	HOME PHONE NUMBER
PATIENT'S ADDRESS	CITY	STATE	ZIP	CELL PHONE NUMBER
SOCIAL SECURITY NUMBER	HOW WERE YOU REFERRED TO US?			EMAIL ADDRESS
PRIMARY CARE PHYSICIAN	ADDRESS			PHONE NUMBER
REASON FOR CONSULTATION			DATE SYMPTOMS FIRST APPEARED	
IF ACCIDENT, PLEASE LIST DATE	TIME	PLACE		
DESCRIBE WHAT HAPPENED				
PERSON RESPONSIBLE FOR ACCOUNT (Guardian)	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
ADDRESS (If different from above)	CITY	STATE	ZIP	PHONE NUMBER
EMPLOYER	ADDRESS			WORK PHONE NUMBER
SPOUSE OF RESPONSIBLE PARTY	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
SPOUSE EMPLOYER	ADDRESS			WORK PHONE NUMBER
IN CASE OF EMERGENCY (not living with patient)	RELATIONSHIP TO PATIENT	ADDRESS		PHONE NUMBER
PRIMARY INSURANCE COMPANY	INSURED'S NAME		POLICY NUMBER/GROUP NUMBER	
INSURANCE ADDRESS	CITY	STATE	ZIP	INSURANCE PHONE NUMBER
DO YOU HAVE OTHER INSURANCE COVERAGE?	YES NO	(if yes, please complete)		
SECONDARY INSURANCE COMPANY	INSURED'S NAME		POLICY NUMBER/GROUP NUMBER	
INSURANCE ADDRESS	CITY	STATE	ZIP	INSURANCE PHONE NUMBER

I hereby authorize Dr. Louis Morales, Jr. / Dr. Rodney Schmelzer to release to my insurance carrier any medical information necessary to secure payment. I authorize benefits to be made payable directly to Dr. Louis Morales, Jr. / Dr. Rodney Schmelzer. I understand that I am financially responsible to the physician for charges not covered by my insurance policy. I certify that all information given on the patient information sheet is complete and correct to the best of my knowledge. In the even of default of payment of charges, the responsible party agrees to pay collections fees including reasonable attorney fees. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original.

I hereby give permission to Dr. Louis Morales, Jr. / Dr. Rodney Schmelzer to render treatment as he sees fit upon myself, my son or daughter or anyone else I have guardianship over, and to call any consultant or anesthesiologist, laboratory personnel, etc. as he deems advisable in the care of this case. I also agree to be responsible for their charges, as well as the surgeon's, hospitals, or surgical center's charges. I also give them permission to take and use, as they deem proper, photographs, pertinent to this case. I am advised that though good results are expected, they cannot be and are not guaranteed, nor is there any guarantee against untoward results.

Signature ______________________ Date ______________________

DOES THE PATIENT HAVE ANY OF THE FOLLOWING CONDITIONS?

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Kidney Disease	☐	☐
Heart Problems	☐	☐	Lung Disorders	☐	☐
Liver Disease or Hepatitis	☐	☐	Neurological Problems	☐	☐
Jaundice	☐	☐	Seizures	☐	☐
Diabetes	☐	☐	Asthma	☐	☐
Cancer	☐	☐	HIV	☐	☐
Bleeding Disorder	☐	☐			

If yes to any above, please explain: ____

____

List any allergies to medications/anesthetics: ____________________________________

____

List any medications currently being taken: ______________________________________

____

List other doctors, treatments patient has had regarding same problem: _______________

____

List previous surgeries: ____

____

List additional medication problems: ____

____

Additional Comments: ____

____

____

Doctors notes: ____

____

Doctors signature: ____

Patient and Billing Policy

Louis Morales, Jr., M.D., Rodney Schmelzer, M.D., & Lisa Morris, M.D.
Cosmetic, Aesthetic, Reconstructive and Craniofacial Surgery

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to do this, we need your assistance and your understanding of our payment and billing policy.

Insurance Billing

Co-payments are due at the time of the office visit. A $10.00 billing fee may be applied to your account if arrangements have not been made ahead of time.

We will be happy to submit claims to your insurance company if you have provided us with the necessary insurance information. We require a copy of your insurance card that lists the name of the insurance company, address, telephone number, and policy/group numbers. It is YOUR responsibility to bring a current referral from your primary care physician or a completed claim form for each visit if this is required by your insurance company.

While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility, regardless of what your insurance company pays, your account is **due in full within 90 days.** Balances over 60 days are subject to a monthly billing fee. It is important that you bring your current Medicaid card to every office visit.

Private Pay

Payment is due in full at the time of the office visit.

Non-emergency/Cosmetic procedures require full payment 10 business days prior to surgery. Deposits for surgery are non refundable.

We realize that temporary financial problems may affect timely payment on your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

____________________________ __________________
Signature Date

NOTICE OF PRIVACY PRACTICES

Louis Morales Jr., M.D.
Rodney Schmelzer, M.D.
Lisa Morris, M.D.
5089 South 900 East, #100
Salt Lake City, UT 84117
(801) 743-0700

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.

Privacy Promise-Dr. Morales & Dr. Schmelzer and their staff understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

How We Use Your Health Information-When you receive care, we may use your health information for treating you, billing for services, and conducting our normal business known as health care operations. We may also use your health information to recommend treatment alternatives or to tell you about health services and products that may benefit you. We may share information with family or friends involved in your care or payment for your care. We may share your information with third parties who assist us with treatment, payment and health care operations. All of our business associates must follow our privacy practices. We may notify you to remind you of an appointment by calling, emailing, or sending you a note.

Sharing Your Health Information-There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations are:

- ♦ For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law, and reporting reactions to drugs and problems with medical devices.
- ♦ To protect victims of abuse, neglect, or domestic violence.
- ♦ For health oversight activities such as investigations, audits, and inspections.
- ♦ For lawsuits and similar proceedings or when otherwise required by law or requested by law enforcement as required by law or court order.
- ♦ For research approved by our review process under strict federal guidelines.
- ♦ To reduce or prevent a serious threat to public health and safety.
- ♦ For workers' compensation or similar programs if you are injured at work.

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

Your Individual Rights-You have the right to request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction. You have the right to request that we use a specific telephone number or address to communicate with you. You have the right to inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial. You have the right to request correction or additions to your health information. Your requests must be in writing and must include the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. You have the right to request a paper copy of this notice even if you agree to receive it electronically.

Our Privacy Responsibilities-We are required by law to maintain the privacy of your health information and to provide this notice that describes the ways we may use and share your health information. We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. You may request a copy of any notice from the Privacy Officer.

More Information-If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, please contact:

Privacy Officer
5089 South 900 East, #100
Salt Lake City, UT 84117
(801) 743-0700
E-mail: louismorales@louismoralesmd.com
info@craniofacialmd.com

We will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services.

I, ________________________________, have received a copy of Plastic Surgery Associates Notice of Privacy Practices and IHC's Notice of Privacy Practices.

______________________________________ ____________________
Signature of patient or guardian Date