# SOVEREIGN PLASTIC SURGERY

941-366-5476

## Patient Information as of _____

**(Please Print Legibly & Fill In or Correct All Fields)**

**Patient's Name** _____

First Middle Last

Address _____

Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate ___/___/___ SS# ___-___-___ Gender Female Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Phone _____

**Patient's Employer** _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____

Street & Suite # City State Zip

**How did you hear about us?**

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

**Emergency Contact**

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

_____ _____ TURN PAGE OVER

**Areas of Interest:** (mark all that apply)

**Facial Procedures**

- ❒ Botox (Injections)

**Breast Procedures**

- ❒ Breast Augmentation
- ❒ Breast Reconstruction
- ❒ Breast Reduction
- ❒ Mastopexy (Breast Lift)
- ❒ Nipple Reduction or Inversion
- ❒ Implant removal
- ❒ Implant Exchange
- ❒ Gynecomastia

**Body Procedures**

- ❒ Abdominoplasty (Tummy Tuck)
- ❒ Brachioplasty (Arm Lift)
- ❒ Liposuction (Thighs, Abdomen, Etc.)
- ❒ Thigh or Buttock Lift

**Preferred Pharmacy Name** _____

Address or cross streets: _____ Phone _____ Fax _____

MEDICAL RECORDS RELEASE. ASSIGNMENT OF BENEFITS. PATIENT PAYMENT & "NO SHOW" POLICIES

I hereby authorize Sovereign Plastic Surgery, PLLC ( SPS)to furnish my medical information to insurance carriers, referring physicians and/or any persons I designate. I give permission for any of my medical records, x-rays, or other hospital test and/or any additional information contained in my medical records to be sent to SPS via mail or fax. I give my permission for the release of any HIV information. I also assign SPS all payments for medical services rendered to myself or my dependent(s). I understand that I am responsible for all co-pays and/or balances not covered by my insurance carrier and that all payments are to be rendered at time of service. A twenty-four hour prior notice of appointment is required in order to avoid a $30.00 "no show" fee.

**There will be a pre-paid $25.00 fee for all additional forms that need to be filled out above and beyond our normally generated insurance claims. (i.e: employer forms, Aflac, FMLA, etc.)**

**As of 1/1/2023 we are no longer accepting any NEW patients wishing to use Insurance as a form of payment.- all new patients will be considered cosmetic**

**Signature** _____ **Date** _____

# SOVEREIGN PLASTIC SURGERY

941-366-5476

## Health Information as of _____

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Physician(s): PCP: _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Aids / HIV | No | Yes | Epilepsy / Seizures | No | Yes | Kidney/ Renal Problems | No | Yes |
| Arthritis | No | Yes | Facial Pain | No | Yes | Pacemaker | No | Yes |
| Asthma | No | Yes | Fever Blisters | No | Yes | Pneumonia | No | Yes |
| Bronchitis | No | Yes | Goiter / Thyroid | No | Yes | Sinus problems / Infections | No | Yes |
| Cancer | No | Yes | Hay Fever / Allergies | No | Yes | Stroke | No | Yes |
| Depression | No | Yes | Headaches / Migraine | No | Yes | Tonsillitis | No | Yes |
| Diabetes | No | Yes | Heart / Cardiac conditions | No | Yes | Tuburculosis | No | Yes |
| Dizziness / Vertigo | No | Yes | Hepatitis | No | Yes | Ulcers | No | Yes |
| Ear Infection | No | Yes | High Blood Pressure | No | Yes | Sleep Apnea | No | Yes |

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

Do you use recreational drugs? No Yes If yes, describe: _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

Do you have any history of problems with anesthesia? No Yes If yes, describe: _____

Did you receive a COVID Vaccine? No Yes Booster? Yes No

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List **ALL** drug and/or latex allergies.

**The above information is accurate and complete to the best of my knowledge.**

**Signature** _____ **Date** _____

# Alissa M. Shulman, M.D., F.A.C.S.

1950 Arlington Street, Suite 112
Sarasota, Florida 34239
**Sovereign Plastic Surgery 941.366.5476**


**Patient Name:**_____

## HIPAA PRIVACY INFORMED CONSENT- PHYSICIANS OFFICE

WE ONLY USE YOUR PERSONAL INFORMATION TO HELP TRANSACT THE BUSINESS YOU HAVE WITH US. We have established policies to maintain physical, electronic and procedural safeguards to insure the confidentiality of your personal information, We do not share information about you for marketing purposes. None of your personal or medical information will be used for marketing without your prior written consent.

A records release must be signed by you for release of any information to other physicians, Practitioners, family, or friends. Please list below anyone that you would allow us to discuss your medical condition with. THIS NOTICE MAY BE CHANGED BY WRITTEN REQUEST AT ANY TIME

**INFORMATION WILL NOT BE GIVEN BY PHONE TO ANYONE NOT LISTED. PLEASE PRINT**

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

*IF you do not want any of your information to be released to any family or friend, Initial this statement
** Please ***DO NOT*** allow my information to be released to any family/Friend. _____

Please check the following:

| | | |
|---|---|---|
| Did you receive a copy of our notice of privacy practices | Yes ___ | No___ |
| You are aware we DO NOT accept or submit any insurance | Yes ___ | No___ |

**DO WE HAVE YOUR PERMISSION TO?**

| | | |
|---|---|---|
| Send information to your home | Yes ___ | No ___ |
| Email you with information | Yes ___ | No ___ |

Leave the following information on your **PERSONAL** voicemail:

| | | |
|---|---|---|
| Appointment Information | Yes ___ | No ___ |
| Billing Information | Yes ___ | No ___ |
| Medical Information | Yes ___ | No ___ |

Leave the following information on your **WORK** voicemail:

| | | |
|---|---|---|
| Appointment Information | Yes ___ | No ___ |
| Billing Information | Yes ___ | No ___ |
| Medical Information | Yes ___ | No ___ |

*My signature verifies that I have read the understand this form.*

**Patient Signature:**_____ **Date:** _____

# Alissa Shulman, M.D., F.A.C.S.

## Sovereign 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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

To avoid a serious threat to your health or safety or the health or safety of others.
As required by state or federal law such as reporting abuse, neglect or certain other events.

As allowed by workers compensation laws for use in workers compensation proceedings.

For certain public health activities such as reporting certain diseases.
For certain public health oversight activities such as audits, investigations, or licensure actions.
In response to a court order, warrant or subpoena in judicial or administrative proceedings.

For certain specialized government functions such as the military or correctional institutions.
For research purposes if certain conditions are satisfied.

In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.

To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.
To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment and only to those persons whose names you have provided.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are- not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you $1.00 per page for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others. You may request that your protected health information be amended. We may deny your Request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.

You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may Charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we

maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

8. Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Privacy Officer: Char Shulman
Phone: 941-366-5476
Address: 1950 Arlington St. Suite 112
E-mail: Char@sovereignps.com

Effective Date. This Notice is effective September 23, 2013