MARC R. POLECRITTI, DO

Julian Institute
OF PLASTIC SURGERY

DEREK C. POLECRITTI, DO

10429 Spring Hill Drive | Spring Hill, Florida 34608 | Phone: 352-556-5248 | Fax: 352-556-5249

First Name_____ MI ____ Last Name _____

SSN_____ DOB _____ Male_____Female_____

Address_____

City_____ State_____ Zip_____

Home ( ) _____ Cell ( )_____

EMAIL _____

MARITAL STATUS:Single _____Married_____Widowed_____Divorced_____ Separated_____

We are now required to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose Refused to report/ unreported.

(Please check **ONE** in **EACH CATEGORY** that applies)

RACE		ETHNICITY	PREFERRED LANGUAGE	
☐ White	☐ More than one	☐ Hispanic or Latino	☐ English	☐ Hindi
☐ Black or African American	☐ Native Hawaiian	☐ Not Hispanic or Latino	☐ Spanish	☐ Vietnamese
☐ Asian	☐ Other Pacific Islander	☐ Refused to report/unreported	☐ Refused to report/ unreported	
☐ American Indian or Alaskan	☐ Undefined	☐ Undefined	☐ Other _____	
☐ Refused to Report/ Unreported	☐ Native			

Employer _____ Occupation_____

Emergency Contact: _____ Relationship: _____

Home ( )_____ Work ( )_____ Cell ( )_____

IF PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE PARENT/ GUARDIAN SECTION BELOW.

Parent/ Guardian name: _____

Address:_____City_____State_____Zip_____

Home ( )_____ Work ( )_____ Cell ( )_____

Social security number:_____ D.O.B:_____ Male____Female_____

Marital status: Single_____ Married _____ Widowed_____ Divorced _____Seperated_____

PHYSICIAN'S RELEASE AND ASSIGNMENTS

I understand that I am responsible for all charges incurred by me, and I agree that in the event this account is referred to collections, to pay all collection expenses, attorney fees and court costs.I authorize the staff of THE JULIAN INSTITUTE OF PLASTIC SURGERY to give me reasonable and proper medical care by today's standards in the community.

PATIENT/PARENT/GUARDIAN **SIGNATURE**_____ Date_____

Primary Physician: _____

We would like to thank the person who referred you; Please tell us how you heard about Dr. Polecritti

_____Thank You.

The Julian Institute of Plastic Surgery
Medical History

Name:_____ Date of Birth_____Age:____ Ht:____Wt:____ Male__/Female__
Reason for your visit: _____

Medication Allergies Please list medical allergies and type of reaction.

1_____ 2_____3_____
4 _____5_____ 6_____
Type of reaction:_____

Current Medications (including vitamins, herbals, and supplements)

1._____dose_____ 6._____dose_____
2._____dose_____ 7._____dose_____
3._____dose_____ 8._____dose_____
4._____dose_____ 9._____dose_____
5._____dose_____10._____dose_____

Pharmacy Name _____ Pharmacy Phone # _____

Medical History Please check all that apply.

___Anemia
___Bleeding disorders
___High blood pressure
___Breathing problems
___Diabetes
___Heart attack(s)
___Pregnancies (if applicable)
___Hepatitis
___HIV
___Kidney disease
___Liver disease
___Depression
___Other(please document)_____

Surgical History Please list previous surgeries and date of surgery.

1._____Date_____
2._____Date_____
3._____Date_____
4._____Date_____
Any problems with anesthesia? _____

Do you smoke? Yes___No___ If yes, how much _____ For how long _____
If you quit, when did you quit? _____

Do you use alcohol? Yes___No___ If yes, how many drinks/day/week _____ Do you use recreational drugs? Yes___No___

Please list any pertinent family medical history:

_____

_____

Have you had any previous **cosmetic surgery? If yes, please list what procedure you had and date of procedure:

_____

Name of Primary Care Doctor_____Who referred you to our office? _____
Please list any other physicians:_____

I certify that the above represents my complete and accurate medical and psychiatric medical conditions.
Signature_____Date_____

The Julian Institute of Plastic Surgery

Marc R. Polecritti, D.O.

Derek C. Polecritti, D.O.

Plastic, Reconstructive & Cosmetic Surgeon

Permission for Treatment: I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Dr. Marc Polecritti or Dr. Derek Polecritti deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for treatment from any prior providers. I am consenting to have my photograph taken. I am aware that my photos may be used for lectures, educational materials, office website and pre and postoperative for my file.

Signature: _____

Authorization and Assignment: I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by Dr. Polecritti/The Julian Institute of Plastic Surgery, PLLC. I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services.

I hereby authorize Dr. Polecritti/The Julian Institute of Plastic Surgery, PLLC to furnish information to CMS/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier(s) to make payment directly to The Julian Institute of Plastic Surgery, PLLC for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that CMS and or other insurance carriers do not cover all services/procedures. I agree to take **full responsibility for any unpaid balances and that such payment will be made to this physician's office for services rendered**. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Designated Relative: I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and health care operations) with:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Messages may be left on my answering machine regarding my health and appointments yes or no

Signature: _____ Date: _____

HIPAA Privacy Notice: I have received a copy of The Julian Institute of Plastic Surgery's privacy notice.

Patient's Name (Printed): _____ Signature: _____

Witness Name (Printed): _____ Signature: _____

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Financial Policy

The Julian Institute of Plastic Surgery and Laser Center prides itself with dedicated staff and the personal care each patient receives. We thank you for entrusting us to providing you with our service.

We would like to inform you of the following Financial Policy

When you have an appointment, we must do several things prior to your visit.

1. Verify your insurance coverage and benefits including co-pay and deductible amounts.
2. Secure the necessary specialized equipment and sterilize the appropriate instruments.
3. Order and pay for surgical supplies that may be needed for you.

Because of these financial and time commitments we ask that you call 24 hours prior to your appointment if you need to cancel.

Co-payments and deductible amounts will be due prior to your visit. We will take great effort to notify you prior to your visit these amounts; however, on occasion this may not be possible; you will receive a bill from this office for any remaining balance. Do not hesitate to contact your insurance prior to your appointment to find out your benefit information.

Prior to any surgical procedure in office or outpatient you will be expected to pay any deductible or co-insurance amount. Please understand that the amount is only an **estimate** based on your in office consultation; Dr. Polecritti will notify the staff what procedure(s) he will be performing, the actual procedure(s) may change. You will either be billed the additional amount due or issued a refund after your insurance processes the claim.

There is a **$25.00** service charge for any returned check. You will be notified by either phone or mail.

This office **does** charge for FMLA, life insurance, insurance forms, medical leave paper work and jury excuses. We ask that you attach a separate sheet of paper designating dates that are in question on the forms. The fee for this service is **$50.00**.

Copies of your medical records are $1.00 per page up to 25 pages than .25 cents thereafter. We ask that you give us 72 hour notice before picking up your records.

Thank you,
Dr. Marc R. Polecritti
Dr. Derek C. Polecritti

Patient Signature

Witness

The Julian Institute of Plastic Surgery

Marc R. Polecritti, D.O.

Derek C. Polecritti, D.O.

Plastic, Reconstructive & Cosmetic Surgeon

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

DON'T LOSE YOUR RIGHT TO DECIDE!

You cannot remove all uncertainty about your future healthcare needs but by having an advance directive, you can have the peace of mind that comes from making your wishes known in advance.

Declaration to Decline Life-Prolonging Procedures

Living Will

☐ I HAVE made a living will

☐ I DO NOT HAVE a living will

Health Care Surrogate

☐ I HAVE a designated health care surrogate

☐ I HAVE NOT designated health care surrogate

Durable Power Of Attorney

☐ I HAVE APPOINTED a durable power of Attorney for health care decisions

☐ I HAVE NOT APPOINTED a durable power of Attorney for health care decisions

Print Name _____ Date _____

Signature of Patient or Representative _____

If you have any further questions, you can contact your family attorney, local hospital, or local medical association for information.

Omnibus Budget Reconciliation Act of 1990 (Patient Self Determination Act) Chapter 765, Florida Statutes

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to changes its *Notice of Privacy Practices* from time to time that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but I do agree that you are bound to abide by such restrictions.

Patient Name _____
(PRINTED)

Relationship to Patient _____

Patient's Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Initials _____ Reason _____