RICHMOND
AESTHETIC SURGERY

Neil J. Zemmel, MD, FACS
Certified American Board of Plastic Surgery
Emily Leisy, PA-C

611 Watkins Centre Pkwy, Suite 350
Midlothian VA 23114
(P) 804.423.2100 (F) 804.423.2102

www.richmondplasticsurgery.com
www.vabreastsurgery.com
www.dermlounge.com

PATIENT INFORMATION

PLEASE COMPLETE ENTIRE PACKET

***Confidential Information*:** *The information herein will not be released except when you have authorized us to do so. This information will be used by the doctors in their decisions regarding your care.*

Today's Date: _____

Patient's Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone Numbers:

Home: _____ Cell: _____ Work: _____

Email Address: _____

Date of Birth: _____ Height: _____ Weight: _____ Female ☐

Age: _____ Male ☐

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Social Security Number: _____

Emergency Contact Name: _____

Telephone: Home: _____ Cell: _____ Wk: _____

Employer *(if patient is a minor, parent's place of employment)*:

_____

Employer Address: _____

Telephone: _____

Family Physician's Name: _____

Medical Insurance Company: _____

Policy # _____ Group # _____

Primary Policyholder's Name: _____ DOB: _____

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What brings you to our office today? Please be as specific as possible.

_____

_____

How long has this concerned you?

_____

Have you had any previous treatment for this?

_____

If **YES**, how and when was this treated?

_____

Review of systems:

Do you have or have you had any of the following? *(Please check yes or no)*

	YES	NO		YES	NO
AIDS or HIV positive	☐	☐	Cancer	☐	☐
Hepatitis	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Chest Pains	☐	☐
High Blood Pressure	☐	☐	Seizures	☐	☐
Arthritis	☐	☐	Colitis	☐	☐
Irregular Heart Beat	☐	☐	Shortness of Breath	☐	☐
Asthma	☐	☐	Diabetes	☐	☐
Kidney Problems	☐	☐	Skin Cancer	☐	☐
Back Problems	☐	☐	Ear/Eye Problems	☐	☐
Migraine Headaches	☐	☐	Stomach Problems	☐	☐
Blood Clots in legs	☐	☐	Stroke	☐	☐
Blood Disorders	☐	☐	Heart Problems	☐	☐
Nose/Throat Problems	☐	☐	Thyroid Problems	☐	☐
Bleeding Problems	☐	☐	Heart Murmur	☐	☐
Pneumonia	☐	☐	Tuberculosis	☐	☐
Breathing Problems	☐	☐	Heart Palpitations	☐	☐
Psychiatric Condition	☐	☐	Transfusion	☐	☐

Past Medical History:
List all medical conditions and any major hospitalizations including dates:

_____

_____

_____

Past Surgical History:

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List all past surgical procedures including dates:

_____
_____
_____

Are you allergic to or have you ever had a reaction to any medication or drug, local anesthetic, or general anesthetic? If so, please list medication and type of reaction:

_____
_____
_____

What medications do you take regularly? (aspirin, birth control pills, herbs, vitamins, etc.)

_____
_____
_____
_____

Do you have a problem with excessive scarring or keloid formation after being cut? ☐ Yes ☐ No

Is your general health good? ☐ Yes ☐ No

Have you ever had psychiatric problems, a nervous breakdown or been under the care of a psychiatrist, psychologist or mental health counselor? ☐ Yes ☐ No

If so, please list what condition you have been treated for:

_____
_____

Family History:
Do you have any diseases or conditions that run in your family? If yes, please list condition and which family member has been affected.

_____
_____
_____

Have you or a member of your family ever had a problem with anesthesia? ☐ Yes ☐ No
If yes, please explain

_____

Social History:
What is your profession?

_____

Do you currently smoke? ☐ Yes ☐ No
If yes, how many packs per day? _____ For how many years? _____

Have you ever smoked? ☐ Yes ☐ No

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If yes, how many packs per day? _____ For how many years? _____ When did you quit? _____

Social History, continued:
Do you drink alcohol? ☐ Yes ☐ No
If yes, how much? _____ How often? _____

Please list all of your doctors. Please include primary care physicians, specialists, and mental health care professionals.
_____
_____
_____
_____
_____

How did you learn about us? *(Please check all statements that apply)*
____ A friend referred me. (Name) _____
____ A doctor referred me.(Name) _____
____ I saw an ad in a magazine or newspaper.
____ I visited your website. **(*Please circle which site or all that apply)***

www.drzemmel.com **www.vabreastsurgery.com** **www.richmondplasticsurgery.com**

Thank you for taking the time to complete this information.

I certify the above to be true to the best of my knowledge.

_____ _____
Patient (or legal guardian) **Date**

_____ _____
Reviewed by Physician **Date**

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RELEASE OF MEDICAL INFORMATION

I authorize to any holder of medical or other information about me to release to Neil J. Zemmel, MD, PC dba Richmond Aesthetic Surgery, as well as my insurance carrier any information needed for this or any related claim.

I hereby authorize, request and assign payment directly to Neil J. Zemmel, MD, PC dba Richmond Aesthetic Surgery for bills rendered by this office covering services and any past and future treatments if related to the incident or condition giving rise to these services by all insurance carriers with whom I have coverage or settlements or judgments flowing from the incident for which I am receiving treatment. This authorization shall include all benefits specified and/or master medical benefits otherwise payable to me.

I permit a copy of this authorization to be used in place of the original

_____ _____

Patient (or legal guardian) **Date**

_____ _____

Witness **Date**

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DESIGNATION FOR RELEASE OF MEDICAL INFORMATION

Richmond Aesthetic Surgery understands that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. We want you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition or medical needs. To enable that, we ask that you complete the information below as an aid to the physicians and/or office staff in making a determination on disclosing such information.

I, _____, designate the following person to be able to speak to a physician, a nurse or other staff member, should it be necessary, on my behalf. I hereby give permission to Richmond Aesthetic Surgery through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release Richmond Aesthetic Surgery, its physicians and staff, from any claim of confidentiality in connections with the release of this information. ***The designation is valid until you cancel it in writing.***

Name of Designated Person _____

Relationship _____ Phone # _____

Name of Designated Person _____

Relationship _____ Phone # _____

Patient Signature _____ Date _____

Witness _____ Date _____

I decline to designate another person to speak with my physician or clinical staff.

Patient Signature _____ Date _____

Witness _____ Date _____

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PATIENT CONSENT TO TREATMENT

Please read each section carefully. You may request a copy of this form for your own records.

Patient Name _____ **Date** _____

I, the undersigned, do hereby request and consent to an evaluation and treatment by Richmond Aesthetic Surgery. I wish to rely on Richmond Aesthetic Surgery to exercise judgment for my best interest, me or that of my dependent, the above-named patient, during the course of treatment. I will inform Richmond Aesthetic Surgery or his staff who is treating me or my dependent of any sensitive areas or adverse conditions that I or my dependent may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, may be charged directly to me and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable.

I acknowledge that Richmond Aesthetic Surgery participates directly with several insurance plans (including managed care plans and Medicare) and that I am responsible for any outstanding fees for services provided to me or to my dependent, the above-named patient, by Richmond Aesthetic Surgery that are not reimbursed through insurance or other third party payers; this includes all co-payments, deductibles, and out of pocket costs. I understand that a potentially refundable deposit to cover fees for uncovered services may be required at the time of service or follow-up.

For cosmetic procedures, I understand that I will be responsible for all facility and anesthesia fees incurred for subsequent revision and/or emergency procedures performed on me or my dependent, the above-named patient, as well as necessary supplies including but not limited to implants, unless otherwise specified by Richmond Aesthetic Surgery. Any surgeon's fee that may be incurred for subsequent revision and/or emergency procedures will be addressed on a case by case basis.

I authorize Richmond Aesthetic Surgery to submit all precertifications and claims directly to the insurers on my behalf. I hereby authorize the release of my medical records and other information necessary to process insurance claims. I understand and agree that any and all monies received from insurance companies and/or other third party payers as reimbursement for services rendered to me or to my dependent, the above-named patient, by Richmond Aesthetic Surgery shall be forfeited in full to Richmond Aesthetic Surgery. Any other arrangements that may involve insurance billing, reimbursement, payment plan, or payment deferral, must be made in writing with the office manager and/or business manager of Richmond Aesthetic Surgery. Verbal agreements are not acceptable.

Signature _____ **Date** _____

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

YOU MUST PROVIDE YOUR INSURANCE CARD AND PICTURE IDENTIFICATION TO THE RECEPTIONIST FOR PHOTOCOPYING AT EACH APPOINTMENT. IN THE EVENT THAT NO INSURANCE IS AVAILABLE, OR IT HAS BEEN DETERMINED THAT THE PATIENT IS INELIGIBLE FOR COVERAGE OF SERVICES, THIS ACCOUNT WILL BE DETERMINED TO BE SELF-PAY AND PAYMENT IN FULL IS DUE AT THE TIME OF EACH SERVICE.

I hereby authorize Richmond Aesthetic Surgery to release medical information to my physicians and/or insurance company(ies). I further authorize direct payment from my insurance company(ies) to Richmond Aesthetic Surgery.

I understand that I am responsible for obtaining all necessary referrals prior to the scheduled appointment. All co-payments required by my insurance plan will be paid at the time of service. I further acknowledge that all deductibles, co-insurance and non-covered items as determined by my insurance plan will be due and payable upon notice either sent by U.S. mail in the form of a statement and/or telephone communication from Richmond Aesthetic Surgery.

After the first missed appointment without 24-hour notice given to Richmond Aesthetic Surgery, I will be responsible for a $50.00 NO SHOW fee.

All returned checks shall be assessed a $40.00 bank processing fee, for which I will be responsible.

I acknowledge that a 1.5% per month interest charge may be added to any balance unpaid after 90 days of aging. I further acknowledge that I will be held responsible for any and all expenses incurred by Richmond Aesthetic Surgery for a 30% collection fee and/or a 30% attorney fee on any balance referred to an attorney for collection as a result from my delay in payment for services rendered by Richmond Aesthetic Surgery.

I further agree that if this account is not paid when due I will be responsible for a collection expense of 35% on the balance, plus any court costs incurred by Richmond Aesthetic Surgery, in addition to interest accrued after the initial 90 days of debt at 1.5% monthly.

Richmond Aesthetic Surgery reserves the right to assess a charge for telephone calls when medical care is dispensed in lieu of an office visit.

_____ _____

Patient (or legal guardian) **Date**

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COSMETIC SURGERY CANCELLATION POLICY

Richmond Aesthetic Surgery makes every effort to ensure that appointments are scheduled and completed in an efficient manner, and the hospital will contact you on the business day prior to your appointment to confirm the details. Preparing and scheduling with the surgery center involves a significant amount of time for the physician and staff.

Our office requires a 25% deposit of the total fee be made in order to reserve a surgery date.

If you cancel your surgery **anytime** after your surgery date has been reserved and/or deposit has been made, a $500 administrative and consultation, non-refundable fee will apply.

If you cancel your surgery 7 business days to 48 hours prior to surgery, you will be charged 25% of the total surgical costs.

If you cancel your surgery between 48 and 24 hours, you will be charged 50% of the total surgical costs.

Cancellations within 24 hours of surgery will be charged at 100% of the total fee.

Patients who are cancelled by Dr. Neil Zemmel (or any other providing physicians, i.e. anesthesia) for medical reasons will be rescheduled without financial penalty. *This policy only applies to Richmond Aesthetic Surgery and is not the policy of the anesthesia provider or the surgery center.*

We appreciate your cooperation in this matter.

I have read the above policy and agree to its terms.

_____

Patient Name (Please Print)

_____ _____

Patient Signature (or legal guardian) **Date**

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WRITTEN ACKNOWLEDGMENT OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose Private Healthcare Information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have read and/or received a copy of the Notice of Privacy Practices of Neil J. Zemmel, MD, PC and Richmond Aesthetic Surgery.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to Neil J. Zemmel, MD, PC and Richmond Aesthetic Surgery if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____
Patient (or legal guardian) **Date**

_____ _____
Witness **Date**

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NOTICE OF PRIVACY PRACTICES SUMMARY

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide medical or enable other health care providers to provide medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this office properly. We are required by law to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This summary of the Privacy Practices lists how we may use and disclose your medical information. It also lists your rights and our legal obligations with respect to your medical information. If you have any questions about the Notice, please contact our Privacy Officer.

A. How This Office May Use or Disclose Your Health Information

This office collects health information about you and stores it in a chart and/or computer. This is your medical record. The law permits us to use or disclose your health information for the following purposes.

1. **Treatment**
2. **Payment**
3. **Health Care Operations**
4. **Appointment Reminders**
5. **Notification and Communication with family**
6. **Required by Law**
7. **Public Health**
8. **Health Oversight Activities**
9. **Judicial and Administrative proceedings**
10. **Law Enforcement**
11. **Coroners**
12. **Organ and Tissue Donation**
13. **Public Safety**
14. **Specialized Government Functions**
15. **Workers Compensation**
16. **Change of Ownership**

B. When This Office May or May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this office will not use or disclose health information which identifies you without your written authorization. If you do authorize this office to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections**
2. **Right to Request Confidential Communication**
3. **Right to Inspect and Copy**
4. **Right to Amend or Supplement**
5. **Right to an Accounting of Disclosures**
6. **You have a right to a paper copy of the complete Notice of Privacy Practices**

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, you may contact our Privacy Officer at (804)423-2100. Our Privacy Officer is available during normal business hours to discuss your privacy questions, concerns or complaints.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this notice. After an amendment is made, the revised notice will apply to all protected health information that we maintain, regardless of when it was created or received. A copy will be available.

E. Complaints

Complaints about this Notice of Privacy Practices or how this office handles your health information should be directed to the licensed healthcare professional. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Department of Health and Human Services.

EFFECTIVE DATE: This notice was published and becomes effective on 07/07

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