

Vincent N. Zubowicz, M.D., F.A.C.S.  
Plastic, Reconstructive, and Maxillo-Facial Surgery  
Diplomate of the American Board

**Welcome**  
**Patient Information**  
**YOU NEED TO PUT YOUR LEGAL NAME. NO NICK NAMES**

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ County \_\_\_\_\_

Home Phone (    ) \_\_\_\_\_ Work (    ) \_\_\_\_\_ Ext. \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_ Sex \_\_\_\_\_

Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated \_\_\_

E-Mail Address \_\_\_\_\_

Place of Employment \_\_\_\_\_

Who referred you to our practice? \_\_\_\_\_

**Guarantor's Information (if patient is child, this is parent's information):**

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (    ) \_\_\_\_\_ Work (    ) \_\_\_\_\_ Ext. \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Place of Employment \_\_\_\_\_

## INSURANCE INFORMATION SHEET

With this completed form, please present proof of insurance for photocopy.

Primary Insurance – Name of Company \_\_\_\_\_

Name of Insured \_\_\_\_\_

Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Birth date of Insured \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Company Phone Number \_\_\_\_\_

Secondary Insurance – Name of Company \_\_\_\_\_

Name of Insured \_\_\_\_\_

Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Birth date of Insured \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Company Phone Number \_\_\_\_\_

Workman's Compensation - Name of Company \_\_\_\_\_

Contact Person \_\_\_\_\_

Phone Number \_\_\_\_\_

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**Guarantee of Account:**

I understand that I am ultimately financially responsible for this account.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Authorization To Release Information:**

I hereby authorize the treating physicians to release any information in the course of my treatment for insurance purposes. I authorize the filing of insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Office Policy

### Our Philosophy

Payment for services is due when services are rendered. While it is the expressed purpose of this practice to provide the best medical care possible, these services do generate financial obligations. Payment of the obligations should be prompt and in good faith. Exceptions (exceptions do not include cosmetic procedures) must be cleared in advance through our Business Manager. Payment may be made in cash, by check (only for office visits), Visa, MasterCard, American Express or Discover. No personal checks are accepted for surgeries. Surgery payment is due on the day of your pre-op visit. If you are paying for your surgery with a debit card make sure call your bank and raise your limit on the card before you come in to pay. Most debit cards have a very low amount you can run through each day. Please make sure to check this **before** you come in for your pre-op. This will keep us on time with your appointment.

### Consultation

The cost of a consultation with Dr. Zubowicz is \$75.00. This amount will be due today after you have finished your visit with the doctor. If your visit is an Insurance related matter you will be responsible for all co-payments when visiting our office. If our staff does not collect these fees, you will be billed for the amount due the doctor.

### Regarding Insurance

When a medically necessary operation is considered, our office will attempt to obtain prior approval from your insurance carrier. This requires the submission of letters and photographs for medical review, and may take a great deal of time. Surgery will not be scheduled until prior approval has been granted. Ultimately, it is the patient's responsibility to know the provisions of their insurance policy.

Should an insurance company deny coverage for a procedure (i.e. cosmetic, or a preexisting condition clause), the patient will be given an estimate for the cost of the surgery. This estimate will include Dr. Zubowicz' professional fee, the facility's fee, and anesthesia's fee. The estimate will be honored for 90 days from the day it was issued.

### Insurance vs. Cash Payment

Patients are given estimates for surgical procedures that insurance will not cover. We refer to these estimates as "cash quotes". A cash quote is just that – a lump sum that is substantially lower than the actual, itemized cost of the surgery. We discount our fees to the aesthetic patient who is paying for surgery due to the time and labor saved by not filing insurance.

### Disability and FMLA Paperwork Information

Patients who need our office to complete disability and FMLA forms will be charged **\$25**. Patients will be charged **\$25** each time we have to complete new paperwork. Please allow 10 business days for the forms to be completed.

### Assistant's Fees

Many operations require the assistance of a trained professional in addition to Dr. Zubowicz. This professional is employed only when such services contribute to the betterment of patient care. Such services generate additional fees. The assistant may be either Dr. Zubowicz' surgical assistant or another physician. When insurance is involved, a separate fee equaling 20% of Dr. Zubowicz' fee will be submitted for this person. If the assistant is Dr. Zubowicz' surgical assistant, you will not be held responsible for fees not paid by your insurance company. If the assistant is a fellow surgeon, fees will be billed through that surgeon's office and their office policy will apply.

### Cancellation Policy

**There is a lot involved when scheduling your surgery.**

**If you change your surgery date: \$200.00 will be due each time you change it.**

**If you totally cancel your surgery: \$200.00 will be due.**

**If you wait to cancel 48 hours before your surgery: 10% of Dr. Zubowicz' professional fee will be due.**

**If you cancel and have already had your pre-operative visit: Not only will you be billed the cancellation fee for your surgery but also \$75.00 for the time spent with you during your preoperative visit, \$65.00 if you had skin care, lab fees if you had a lab work up and shipping costs for any implants ordered. We encourage our patients to take every aspect of surgery seriously, including the scheduling.**

### Revisional Surgery

When a surgical procedure requires revision to be performed at The Center for Plastic Surgery, the patient is responsible for the facility cost. If anesthesia is required, the fee for anesthesia is based on the length of the revision, and will be quoted accordingly. You will also be responsible for any implants that are required.

### The Financial Contract

The financial contract for services is between Dr. Zubowicz and the patient. It is important that the patient understand this philosophy as well as our fees and methods of payment. We will always help to resolve payment issues. It is imperative that the patient communicates with us and seeks help when needed. Additionally, we encourage you to share your complaints as well as your compliments. Please call us anytime with your concerns.

Vincent N. Zubowicz, M.D.

I have read and understand the policy of this office.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding of Dr. Vincent N. Zubowicz Privacy Practices

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Previous name: \_\_\_\_\_

I understand that the patient's health information is private and confidential. I understand that Dr. Vincent Zubowicz works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Dr. Vincent Zubowicz may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [\*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

Dr. Vincent Zubowicz has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Dr. Vincent Zubowicz may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Dr. Vincent Zubowicz will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Dr. Vincent Zubowicz has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Dr. Vincent Zubowicz by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Dr. Vincent Zubowicz "Notice of Privacy Practices".

\_\_\_\_\_  
Date Time

\_\_\_\_\_  
Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

\*You have the right to amend, restrict, inspect and copy your medical information upon request during our normal business hours. You also have the right to appeal a denial of access to your records. Do you want to exercise any of these rights now? \_\_\_\_\_.

*Patient refused to sign Acknowledgement:*

- \_\_\_ *Unable to read*
- \_\_\_ *Did not understand English*
- \_\_\_ *Other*

# Health History

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Phone #: (\_\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**Purpose of visit/procedure:** \_\_\_\_\_

Have you seen other plastic surgeons for the same problem that brings you here today?

Name of Plastic Surgeon: \_\_\_\_\_

Is this the result of a personal injury?  Yes  No If yes, date \_\_\_\_\_

Is this the result of a work-related injury?  Yes  No If yes, date \_\_\_\_\_

Besides the reason for this consultation, would you like the Dr. to cover other procedures that would enhance your appearance?  Yes  No

Do you have any personal problem that preoccupies you, that you would like to share with the Dr.?  Yes  No

**Your current physical health is:**  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No

Are you being treated for any medical condition at this time?  Yes  No

If yes, please explain: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Have you been treated for psychological problems like anxiety or depression?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you form large scars or keloids?  Yes  No

Do you have frequent boils or infections?  Yes  No

Have you ever had any previous cosmetic surgery performed?  Yes  No

Do you have an allergy to tape?  Yes  No

## Do you presently have or have you experienced the following?

Y N Acquired Immune Deficiency Syndrome (AIDS)

Y N Alcohol Abuse

Y N Arthritis

Y N Artificial Bones/Joints

Y N Artificial Valves

Y N Cancer

Y N Chemotherapy

Y N Chicken Pox

Y N Colitis

Y N Congenital Heart Defect

Y N Drug Abuse

Y N Epilepsy

Y N Fainting Spells

Y N Fever Blisters

Y N Frequent Headaches

Y N Hay Fever

Y N Herpes

Y N Hospitalized For Any Reason

Y N Low Blood Pressure

Y N Lupus

Y N Mental Illness

Y N Persistent Cough

Y N Radiation Treatment

Y N Reproductive Disorders

Y N Rheumatic Fever

Y N Scarlet Fever

Y N Shingles

Y N Sinus Problems

Y N Stroke

Y N Tonsillitis

Y N Venereal Disease (VD)

## IMPORTANT:

After filling out the second page, please list any additional medical condition(s) that you have experienced that were not listed:

PLEASE NOTE: It is mandatory for patients who do smoke to Quit smoking TWO WEEKS before surgery and a minimum of TWO WEEKS after the procedure. IF YOU THINK THAT YOU CANNOT REFRAIN FROM SMOKING THIS LONG, PLEASE TELL US!!!

Yes, I can refrain from smoking  No, I cannot  Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**THE CENTER FOR PLASTIC SURGERY PREOPERATIVE ANESTHESIA EVALUATION**

**YES      NO**

		<b>Allergies:</b> Latex: <input type="checkbox"/> Yes <input type="checkbox"/> No    Reaction: Meds: <input type="checkbox"/> Yes <input type="checkbox"/> No    Reaction:
		Previous Surgeries:
		Anesthesia Problems (patient or family member):
		CNS (seizure, stroke, spinal cord injury, muscle weakness, migraines)
		High Blood Pressure:
		Heart Problems (chest pain, heart attack, heart murmur, mitral valve prolapse, pacemaker):
		Bleeding Problems (sickle cell, transfusion, anemia, hemophilia):
		Breathing Problems (bronchitis, emphysema, asthma, shortness of breath):
		Smoke or Chew Tobacco (Amt/day):                      Years:
		Alcoholic Beverages – Amt:
		Diet Pills / Recreational Drugs:
		Diabetes: Diet Controlled _____ Insulin Dependent _____
		Glaucoma:
		Thyroid Problems:
		Liver Problems (cirrhosis, jaundice, hepatitis):
		Renal Disease (kidney):
		GI (hiatal hernia, ulcers, rectal bleeding):
		Infectious (tuberculosis, HIV):
		Under the care of a psychiatrist?:
		Dentures /Partials/Caps/Bonding/Loose or Chipped Teeth:
		Limitations/Devices (Glasses, Contacts, Hearing Aid, Mobility):
		Do you have an Advance Directive? Other: _____

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

**MEDICATIONS** (inc: prescriptions & non-prescriptions) \_\_\_\_\_

Last Menstrual Period (if applicable): \_\_\_\_\_ n/a: \_\_\_\_\_ Post-hysterectomy ( ) Post-menopausal ( )

**Patient Signature:** \_\_\_\_\_ **RN Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Comments: \_\_\_\_\_

**~ Patient: Do Not Write Below This Line ~**

**PE** (Day of Surgery): VS: BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ O2SAT \_\_\_\_\_

Gen/psych-social: \_\_\_\_\_ A/W: \_\_\_\_\_ **Lab results reviewed** \_\_\_\_\_

CV: \_\_\_\_\_ EKG: \_\_\_\_\_ N/A \_\_\_\_\_ **Patient acceptable for surgery** \_\_\_\_\_

Lungs: \_\_\_\_\_

**Plan:** Gen    MAC    **Discussed with patient/responsible adult who agrees** \_\_\_\_\_

**ASA Class:** I    II    III    IV    **Expl:** Tob    Obese    COPD    SAH    IDDM    CASHD    Other \_\_\_\_\_

**Anesthesiologist** \_\_\_\_\_ **Date** \_\_\_\_\_ **Time** \_\_\_\_\_

## **Notice of Privacy Practices for Protected Health Information**

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!

If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he will need to consult with another specialist in the area. He will share the information with such specialist and obtain his/her input.

Example of use of your health information for payment purposes:

- We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

- We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

## **Your Health Information Rights**

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office - we are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record - you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request (The physician or other health care provider is not required to make such amendments);
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care. All accounting disclosures (anything not related to treatment, payment or health operations) will be documented on the lined sheet in the patient' chart.
- Request that communications of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request; and
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Julie Bennefield at 404-814-1100 or 365 East Paces Ferry Road Atlanta, GA 30305 in person or in writing, during normal hours.

She will provide you with assistance on the steps to take to exercise your right. You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment and health care operations purposes.

### **Our Responsibilities:**

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

### **To Request Information or File a Complaint:**

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Julie Bennefield, Privacy Officer at 404-814-1100.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Julie Bennefield.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with Secretary of Health and Human Services.

## **Other Disclosures and Uses**

**Notification** - Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

**Communication with Family** - Using our best judgement, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

**Research** - We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information has approved their research.

**Disaster Relief** - We may use and disclose your protected health information to assist in disaster relief efforts.

**Funeral Directors or Coroners** - We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

**Organ Procurement Organizations** - Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**Marketing** - We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

**Fund Raising** - We may contact you as part of a fund raising effort.

**Food and Drug Administration (FDA)** - If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

**Public Health** - As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Abuse & Neglect** - We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

**Correctional Institutions** - If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

**Law Enforcement** - We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

**Health Oversight** - Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

**Judicial/Administrative Proceedings** - We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order.

**Serious Threat to Health or Safety** - To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

**For Specialized Governmental Functions** - We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

**Other Uses** - Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with written authorization and you may revoke the authorization as previously provided.

**Website** - If we maintain a website that provides information about our entity, this Notice will be on the website.

**Effective Date:** April 14, 2003

We would like to Welcome and Thank you for choosing our facility for today's visit. We understand that your time is very important. We hope to assist you in a manner that will address all areas of aesthetic interest. Below you will find many of our services to be explored. We would greatly appreciate your direction.

Please check which services you would like to discuss in today's consultation.

#### Facial Concerns

- Facelift
- Eyelids
- Neck
- Rhinoplasty (Nose)
- Other

#### Body Contour

- Abdominoplasty (Tummy)
- Liposuction
- Other

#### Breast Concerns

- Breast Augmentation (Enlargement)
- Breast Reduction
- Breast Lift
- Breast Implant change out

#### Skincare Services

- Microdermabrasion
- Facials
- Peels
- Waxing
- Brow Tinting
- Products

#### Injectables

- Botox
- Restylane
- Juvederm
- Perlane
- Spider Vein Therapy

#### Laser Resurfacing

- Pearl Laser
- C02 Laser