Rodney A. Green, M.D. FACS

Plastic & Reconstruction Surgery/Hand Surgery

Name: _____ Date: _____

Birthdate: _____ Age: _____

Address: _____ City/State/Zip: _____

Cell phone: _____ Home phone : _____ Sex: _____

Email:_____If you do not want to receive our email, check here □

Social Security Number (required) _____ - _____ -_____

Marital Status: □ Single □ Married □ Divorced □ Widow

Specific problem for which you are seeking consultation: _____

_____

_____

Have you consulted any other doctors: □ No □ Yes. If yes, whom: _____

Whom may we thank for your referral? _____

Family Doctor (PCP) _____ Phone number: _____

Employer: _____ Occupation:_____

Employer full address: _____

Is this a work-related injury? □ No □ Yes. If yes, date of injury: _____

Workers Compensation # _____ Name of MCO _____

Has Dr. Green ever treated any member of your family? □ No □ Yes. If yes, whom:_____

Emergency Contact name: _____ Relationship: _____

Phone number: _____

Insurance Information – Please give secretary your insurance card. If illegible, please fill out:

Name of insurance:_____ Subscriber DOB _____

Subscriber Name:_____Relationship to subscriber:_____
Copay amount due _____

ID # _____ Group # _____

May we leave information on your answering machine with a family member regarding your appointments? □ No □ Yes.

Race: _____ Ethnicity: □ Hispanic □ Non-Hispanic □ Prefer not to answer

Language: □ English □ Other _____

Are you allergic to any medications? □ No □ Yes. If yes, which one(s)? _____

_____

Have you or any family member ever reacted badly to being put to sleep for surgery? □ No □ Yes

Have you ever had a bad reaction to local anesthetic (Novocain, etc.)? □ No □ Yes
Are you allergic to adhesive tape? □ No □ Yes
Do you have high blood pressure? □ No □ Yes
Have you ever had scarlet fever or rheumatic fever? □ No □ Yes
Do you bleed easily (from cuts, surgery, tooth extractions?) □ No □ Yes
Are you a poor healer? □ No □ Yes
Do you form large scars or keloids? □ No □ Yes
Do you have any skin diseases, hives, eczema or rash? □ No □ Yes
Do you have frequent infections or boils? □ No □ Yes
Have you taken steroid injections or medications (ie: cortisone?) □ No □ Yes
Do you have shortness of breath with walking? □ No □ Yes
Do you have, or have you had any back trouble? □ No □ Yes
Does your religion prohibit blood transfusions? □ No □ Yes
Do you have, or have you had any significant emotional problems? □ No □ Yes
Have you ever had or been advised to seek psychiatric care? □ No □ Yes

Have you had any of the following illnesses or disorders? (check if the answer is yes)

□ Brain (Including strokes, epilepsy)	□ Intestines	□ Breast
□ Heart or blood vessels	□ Diabetes	□ Reproductive
□ Blood	□ Lungs	□ Face (paralysis)
□ Eyes (including glaucoma, dryness)	□ Stomach	□ Liver
□ Nose, Sinuses, Throat	□ Nervous system	□ Arms or legs
□ Ears	□ Urinary System	□ Bones or joints

If “yes” to any of the above, please explain:

_____

_____

_____

Height_____ Weight_____

Any major weight gain or loss within the last year? □ No □ Yes. If yes, please explain:

_____

Medical History

General Health: □ Good □ Fair □ Poor If not "good" please explain: _____

_____

Have you had children? If so, how many? _____

How long ago was your most recent physical checkup? _____

Did it include an electrocardiogram? □ No □ Yes ---- Did it include a chest x-ray? □ No □ Yes

Please list any **serious illnesses**: _____

Please list any **previous surgeries**:

Operation	Year	Hospital / City	Surgeon's name	Local or general anesthesia

Have you had significant complications after any of these operations? □ No □ Yes. If yes, please explain:

_____

Please list any **major injuries**:

Type	Year	Hospital / City	Doctor's name	After effects

What is your approximate **daily consumption** of the following:

Coffee/Tea _____ Alcohol_____ Tobacco_____

Other intoxicating or mind-altering drugs (specify) _____

Does anyone else in your household smoke? □ No □ Yes. If yes, how much? _____

Please list all your **medications and their dosages:** (including over the counter)

_____

_____

_____

Pharmacy of choice and location:_____

Phone number_____ Fax number_____

BILLING POLICY

We would like to welcome you to our practice. We strive to provide quality care for our patients in a pleasant, comfortable atmosphere.

Health Insurance

If you are covered by health insurance, we will submit the necessary forms to your insurance company. Your policy is a contract between you and your insurance company; it is important that you understand its provisions.

- If you need a referral to see Dr. Green or Karen Bird (our occupational therapist) it is your responsibility to obtain it.
- If applicable, it is your responsibility to keep track of the number of referrals from your initial visit to your end date, and if necessary, to obtain more referrals. (You will be responsible for your balance if these arrangements are not met.)
- We cannot guarantee payment for your insurance claims or accept responsibility for negotiating your claim.
- You will be required to pay your copayments each visit. You will be billed for any deductible and/or coinsurance.
- The contract holder for your insurance will receive an explanation of benefits; this will inform you of any outstanding balance you owe Dr. Rodney A. Green. Payment is due at the time you receive a statement.

Self-pay / Cosmetic Surgery

- Payment for self-pay or cosmetic surgery is due in full prior to surgery.
- Deposits put down for surgery are non-refundable if surgery in canceled within 2 weeks of your planned procedure date.

We accept cash, check, and all major credit cards. The fee for returned checks is $25.

If your account is overdue or unpaid after sixty (60) days, it will be turned over to collections.

We ask that you help us keep the cost of your health care down by paying promptly. If you have any questions regarding our policy, please do not hesitate to discuss them with us.

I have read and understand this policy:

_____ _____

Signature of responsible party Date

Photographic Release and Consent

for Dr. Rodney A. Green, M.D., FACS

Before & after photographs for all cosmetic surgeries and occasionally other surgeries/cases are taken.

You have 2 options. Please sign only the one you are comfortable with:

1. ALLOW OTHERS TO SEE PHOTOS

I authorize Dr. Green to use my photographs, videotapes and/or case information in the following educational settings. Care will be taken to avoid revealing my identity.

Dr. Green to show others in office only	□ No	□ Yes
Dr. Green's website or linked websites	□ No	□ Yes
For medical lectures and articles	□ No	□ Yes

_____ _____

Patient Signature Date

2. NOT ALLOW OTHERS TO SEE PHOTOS

I do not authorize Dr. Green to use my photographs, videotapes and/or case information for any educational settings.

_____ _____

Patient Signature Date

DR. RODNEY A. GREEN, M.D. FACS 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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are that are described in this notice while it is in effect. This notice will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided which changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF MEDICAL INFORMATION

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

TREATMENT: We may use your medical information to treat you or disclose your medical information to a physician or other health care provider providing treatment to you.

PAYMENT: We may use and disclose your medical information to obtain payment for services we provide to you.

HEALTH CARE OPERATIONS: We may use and disclose your medical information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

TO YOU AND ON YOUR AUTHORIZATION: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We WILL NOT disclose any information to any other family member or friend without your express written permission.

APPOINTMENT REMINDERS: We may use your medical information to contact you to provide appointment reminders.

PERSONS INVOLVED IN CARE: We may use or disclose medical information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, your location, your general condition, or death. If you are

present, then prior to use or disclosure of your medical information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose protected health information based on a determination using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of medical information.

REQUIRED BY LAW: We may use or disclose your medical information when we are required to do so by law. For example, we must disclose your medical information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are following federal privacy laws. We may disclose your medical information when authorized by workers' compensation or similar laws. We may disclose your medical information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

LAW ENFORCEMENT: We may disclose your medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose your medical information to law enforcement officials. We may disclose limited information to a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the medical information of an inmate or other person in lawful custody to a law enforcement official or correctional institution.

ABUSE OR NEGLECT: We may disclose your medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your medical information to the extent necessary to avert a serious threat to your health or safety or the health of others. We may disclose medical information when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

NATIONAL SECURITY: We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, medical information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or individual under certain circumstances.

INDIVIDUAL RIGHTS

ACCESS: You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide photocopies of your records. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associated disclosed your medical information for purposes, other than treatment, payment, health care operations or pursuant to an authorization and certain other activities. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your medical information, a description of the medical information we disclosed the reason for the disclosure, and certain other information. If you request this accounting more than once there will be a $50 charge.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We do not agree to any verbal agreements only those in writing and signed by the security officer or designee.

AMENDMENT: You have the right to request that we amend your medical information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable effort to inform others, including people you name, of the amendment and to include the changes in any further disclosures of that information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office:	Dr. Rodney A. Green, M.D., FACS
Contact Person:	Kim Lucas, Office Manager
Telephone:	440-449-8880
Fax:	440-299-6576
E-Mail:	drgreen@dr-rodgreen.com
Address:	5035 Mayfield Road #100, Lyndhurst, OH 44124

Dr. Rodney Green's office has provided me with a copy of its Notice of Privacy Practices.

Patient or responsible party's signature: _____ Date: _____