WAKE
PLASTIC SURGERY

PATIENT INFORMATION

Full legal name _____ DOB: _____
Preferred name _____ Marital status_____
Home address _____ City_____ State_____ Zip_____
Employer_____ Occupation_____
Person to contact in an emergency_____ Phone_____
Persons with whom we may discuss your medical care: Name_____ Phone_____
Name: _____ Phone_____
Person financially responsible_____Relationship_____Phone_____
Address _____City_____ State_____ Zip_____

HOW DID YOU HEAR ABOUT US?

Thank you for providing this helpful information.

□ Physician Referral Name_____
□ Family/Friend Name_____
□ Wake Plastic Surgery Staff Member _____

□ Internet Search	□ Wake Plastic Surgery Website	□ Realself
□ Care Credit Website	□ Your Insurance Company's Website	□ Hospital
□ Mentor Love Your Look Website	□ Other _____	□ Coolsculpting site

INSURANCE INFORMATION

If you are an insurance patient, please have card ready for copying.

Primary ins co_____ Secondary ins co_____
ID #_____ ID #_____
Group #_____ Group #_____
Effective date_____ Effective date_____

If policyholder is anyone **other** than the patient, please complete the following:
Policyholder's name_____ Relationship to patient_____
Policyholder's DOB_____ Policyholder's SSN_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS

I authorize **Wake Plastic Surgery** to furnish my insurance company(s) and/or other physicians all information about my health which may be requested. I also assign claim payments to be made payable to **Wake Plastic Surgery**.

Insurance co-payments are due at the time of service. Giving fraudulent insurance information could be considered theft of services. I understand that this account is my responsibility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at the legal rate.

Signature: (Patient or responsible party)_____ **Date:** _____

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HEALTH HISTORY

Name: _____ Date: _____

Reason for today's visit: _____

Previous cosmetic procedures and dates: _____

Previous other surgeries and dates: _____

_____

Habits:

Tobacco	Y N	Amount:	Coffee/tea/soda	Y N	Amount:
Alcohol	Y N	Amount:	Daily exercise	Y N	Amount:

Prescription medications (include dose):_____

_____

Vitamins/herbal:

_____

Regular aspirin use: Y N **NSAIDs/Ibuprofen (Motrin, Advil):** Y N

Medication allergy	Y N	Name & reaction:
Latex allergy	Y N	Name & reaction:
Tape allergy	Y N	Name & reaction:

Personal medical history: **Height: _____** **Weight: _____**

HIV/AIDS	Y N	Sleep apnea	Y N	Acid reflux/heartburn	Y N	Cancer	Y N
Diabetes	Y N	Fainting spells	Y N	High blood pressure	Y N	Anemia	Y N
Asthma	Y N	Heart attack/disease	Y N	Mitral valve prolapsed	Y N	Seizures	Y N
Blood clots	Y N	Heart surgery/stents	Y N	Abnormal bleeding	Y N	Hepatitis	Y N
Thyroid	Y N	Blood transfusion	Y N	Kidney disease/stones	Y N	Other	Y N

Please describe all "**Yes**" responses: _____

Gynecology history:

Number of pregnancies: _____ Did you breastfeed? Y N Total duration: _____

Last menstrual period: _____ Any plans for future pregnancies? Y N Date last mammogram: _____

Family medical history:

Kidney disease	Y N	Heart attack/disease	Y N	Abnormal bleeding	Y N
Tuberculosis	Y N	High blood pressure	Y N	Cancer	Y N
Diabetes	Y N	Anesthesia problems	Y N	Other not listed	Y N

Please describe all "**Yes**" responses: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Signature: _____ Date**:** _____

Wake Plastic Surgery
William T. Stoeckel, MD

WAKE
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HOW DO YOU WANT US TO COMMUNICATE WITH YOU?

There can be many reasons that the doctor or our staff may need to reach you after you have left our office. Your privacy and preferences are important to us, and we want to do our best to communicate with you in the way that works best for you.

Please indicate best contact phone # ( ) ___ ___ ___ - ___ ___ ___ ___

(Please circle) Is this your cell, home or work number?

❒ **YES, you may call me with appointment reminder calls.**

❒ **YES, if I'm not available, you may leave a voice mail message.**

❒ YES, if I'm not available, you may leave a message with the person who answers the phone.

❒ Do NOT call with a reminder.

E-MAIL

We now rely on an automated email reminder system to notify our patients of their upcoming appointments. Please be sure that you have your email set to accept mail from info@wakeplasticsurgery.com. With your permission, we will send a courtesy email reminder approximately 3 days prior to your scheduled appointment. Please indicate your permissions below:

E-mail address that goes **directly** to you (please print clearly)_____

❒ **YES, you may email an appointment reminder to the email address provided above**.

❒ YES**, you may send medical information or a financial quote for surgery by email.**

❒ **YES, you may email quarterly newsletters, special-event notifications, and sales notices.**

TEXT MESSAGE

❒ YES, you may send correspondence by text message.

*Name of cell phone service provider. Required for this option._____

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AUTHORIZATION FOR THE USE OF PHOTOGRAPHS

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent. For various reasons Dr. Stoeckel is often asked to show before and after photos of patients. Many patients have given permission to use their photos anonymously. We now ask that you do so as well. Authorization for the use of these photographs and case histories will include release for the use in medical journals, textbooks, scientific presentations, and teaching courses.

AUTHORIZATION FOR BEFORE AND AFTER PHOTOS

I hereby authorize Dr. William T. Stoeckel to use my preoperative and postoperative photos in his before and after presentation to other patients interested in the same procedures. I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all representations. I understand that this consent has no bearing on medical care. This release will remain in effect for twenty years unless revoked in writing or Dr. William T. Stoeckel or Wake Plastic Surgery has taken action in reliance to this consent.

Signature **Date**

AUTHORIZATION FOR WEBSITE PHOTOS

I hereby authorize Dr. William T. Stoeckel to use my photos for website presentations. I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all representations. I understand that this consent has no bearing on medical care. This release will remain in effect for twenty years unless revoked in writing or Dr. William T. Stoeckel or Wake Plastic Surgery has taken action in reliance to this consent.

Signature **Date**

CONSENT TO EMAIL PHOTOS

Most patients are very interested in seeing the progress they have made since initiating treatment with Dr. Stoeckel. Consequently, Dr. Stoeckel is pleased to share progress photos via secure email. Please indicate your preference with regard to the email transmission of your progress photos.

☐ I consent to allow Wake Plastic Surgery to email photos of me to the email that I have provided.

☐ I decline the opportunity to receive my progress photos via email.

Signature **Date**

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FINANCIAL AGREEMENT FOR INSURANCE PATIENTS

Thank you for choosing our office for your plastic surgery care. Check the appropriate boxes below. This form must be read and signed before treatment can be given.

INSURANCE PATIENTS: Insurance is an agreement between you and your insurance company. It is therefore your responsibility to communicate with your insurance company regarding your plan and coverage for services. **ANY COST PROVIDED TO YOU IS AN ESTIMATE. FINAL COSTS ASSOCIATED WITH YOUR TREATMENT ARE DETERMINED THROUGH THE INSURANCE CLAIMS PROCESS.** *As a courtesy,* we will file your insurance claim if we have been given current insurance information/card. **If insurance cannot be verified, payment will be due at the time of treatment.**

☐ I understand the terms above and request that a claim be submitted to insurance for my treatment at Wake Plastic Surgery. I accept full responsibility for any and all payment my insurance fails to provide. **I accept full responsibility for communication with my insurance company before and after my treatment.**

OUT OF NETWORK PATIENTS: We appreciate your business and are happy to serve you. Because we are not networked with your provider, please call your provider to understand your benefits. As a courtesy, we are happy to submit your claim.

CANCELATION POLICY: Wake Plastic Surgery's cancelation policy requires a 24 hour notice to cancel or change an appointment. **We will need notice on the Friday before, during business hours, if you are scheduled with us on a Monday for any type of appointment. Failure to adhere to the cancelation policy will result in a $50 fee for weekday appointments and $125 fee for Saturday appointments. Any minor procedural appointment will incur a $100 fee if canceled with less than 24 hours' notice. A charge of $125 will occur after (3) late cancellations and /or missed appointments.**

☐I understand that if I am unable to keep my scheduled consultation or follow up appointment for any reason, I will notify the office during business hours (8:30 am to 5:00 pm weekdays) at least 24 hours in advance of my appointment time. **I understand that if my appointment is on a Monday, I will notify Wake Plastic Surgery of my cancellation the Friday prior. I understand that failure to do so will result in a $50 fee for weekday appointments and $125 fee for Saturday appointments. A charge of $125 will occur after (3) late cancellations and /or missed appointments. A $100 fee is charged for procedural appointments.**

MOHS/LESION/SCAR SURGERY REVISION POLICY: Thank you for trusting Dr. Stoeckel to help restore your form and function after Mohs surgery or skin cancer excision. Many of these procedures require multiple visits and operations before the final result is achieved. Insurance companies will likely authorize most of these reconstructive steps. Once the majority of the reconstruction is complete and Dr. Stoeckel is attempting to fine tune scars to optimize the end result, insurance companies often stop their financial assistance. In the event that a scar revision is required for optimal cosmetic results and not medically necessary, Dr. Stoeckel has discounted his normal scar revision charges for his Mohs/Lesion/Scar surgery patients. Wake Plastic Surgery staff will provide the cost of the procedure pertinent to your specific treatment.

Patients Signature: _____ Date: _____

Witness Signature: _____ Date: _____

WAKE PLASTIC SURGERY: NOTICE OF PRIVACY PRACTICES

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

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED: We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice, including, but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities, training of medical students, licensing, contacting, or arranging for other business activities. We may also use and/or disclose your information in accordance with federal and state laws for these purposes:

Appointment Reminders
We may contact you to provide appointment reminders. Appointment reminders and billing/collection issues may be communicated via discreet phone messages or secure email.

Treatment Information
We may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Health Care Operations
Our care coordination team may use your health information to assess the outcome and care of your case and those that are similar. Results of this outcome could help to continually improve quality of care for other patients that we treat.

Disclosure to Department of Health and Human Services
We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation of determination of our compliance with relevant laws.

Family and Friends
Unless you object, we may disclose your medical information to family members, other relatives, or close personal friends when the medical information is directly relevant to that person's involvement with your care.

Notification
Unless you object, we may use or disclose your medical information to notify a family member, a personal representative, or another person responsible for your care of your location, general condition, or death.

Disaster Relief
We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

Health Oversight Activities
We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure, or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect
We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

WAKE PLASTIC SURGERY: NOTICE OF PRIVACY PRACTICES

Legal Proceedings
We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement
We may disclose your medical information for law enforcement purposes or other specialized governmental functions such as, but not limited to Homeland Security, Correctional Facilities, Military Authorities and Food and Drug Administration.

Coroners, Medical Examiners, and Funeral Directors
We may disclose your medical information to a coroner, medical examiner, or a funeral director.

Organ Donation
If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Research
We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization.

Public Safety
We may use or disclose your medical information to Legal Entities who are in charge of controlling/preventing disease, disability or injury to lessen a serious threat to the health or safety of another person or to the public.

Worker's Compensation
We may disclose your medical information as authorized by laws relating to worker's compensation or similar programs.

Business Associates
We may disclose your health information to a business associate with whom we contract to provide services on our behalf. Examples would include, but are not limited to, medical billing and coding companies, laboratory testing and diagnostic imaging companies and pathology. Business associates are required by federal law to safeguard your health information.

For Payment
We may use and disclose health information about you to bill and collect payment from your insurance company or third party payer. For example, we may need to send an operative report to your insurance company so that they will reimburse us for your treatment.

Surveys
We may disclose your health information for communicating satisfaction surveys that pertain to our services.

Fundraising Efforts
We may disclose your health information for fundraising efforts unless you choose not to be involved in such communications.

Training
We may disclose your health information for training purposes for newly hired healthcare professionals in our practice.

AUTHORIZATIONS
We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

Wake Plastic Surgery
300 Keisler Drive, Suite 102
Cary, NC 27518
919-805-3441

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.

You have the right to receive communications from us in a confidential manner.

THIS NOTICE IS EFFECTIVE AS OF
August 18, 2008.
Updated 3/13/2013

WAKE PLASTIC SURGERY: NOTICE OF PRIVACY PRACTICES

Inspect and make copies
Generally, you may inspect and request a copy of your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records. This however, does not include mental health related notes. Limited circumstances will allow us to deny your request to inspect and copy your medical records. If access is denied, your denial can be reviewed by another licensed healthcare professional at your request. This request must be presented to our clinic in writing. We will comply with the decision of the review.

Amendment
You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

Disclosure
You have the right to receive an accounting of the of the disclosures of your medical information made by our practice during the last six years (or following August 1, 2008) except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types. You have the right to receive an accounting of disclosures of your medical information made for treatment, payment and healthcare operations during the last three years.

Limitation/Restriction Requests
You may ask that your health information be limited or restricted for disclosure for treatment, payment or healthcare operations. Requests must be presented to our clinic in writing and must be very specific. Example: You may ask that we not use information regarding a cosmetic surgery that you had.
We are required to honor your request only if:

1. Except as required by law, the disclosure is to your health insurance and related to health care operations or payment.
2. Your healthcare information pertains exclusively to services which you paid in full.

Any other requests, we are not required to concur.

Confidential Communication Requests
You may request that we communicate with you regarding medical affairs at a particular location or manner. Example: You may request that we contact your cell phone instead of your place of business. Reasonable requests for confidential communications will be honored. Requests for confidential communication must be presented to our clinic in writing.
***Notice-**We reserve the right to contact you by other means necessary when failure to obtain a response is an issue.

Notice Copy
You may request a paper copy of this Notice of Privacy Practices for Protected Health Information even if electronic copy is the standard.

You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way.

REVISION OF NOTICE OF PRIVACY PRACTICES
We reserve the right to change the terms of this Notice as mandated by law, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy Practices available upon request. You will be asked to sign an updated copy of this notice on an annual basis.

THIS NOTICE IS EFFECTIVE AS OF
August 18, 2008.
Updated 3/13/2013

WAKE
PLASTIC SURGERY

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our office to acknowledge that you have been provided with a copy of our Notice.

_____
Print name of patient or legal representative

_____
Signature of patient or legal representative

_____
Date