ADVANCED FACES, LLC/DR. CHRISTOPHER JOHNSON

Please fill out this form using Adobe Reader (free software available here). For safari users save the form to your download folder and reopen with Adobe Reader 10.1.1 or later OR open with Firefox (download available here).
When you are finished, you can print out the form and fax it to us at 352-242-0648 or bring it to your appointment.
You can also email the form directly to us by using the "email" button located at the bottom of the last page.

PATIENT INFORMATION

PATIENT'S FULL NAME: ______ Date: ______

EMAIL: ______

ADDRESS ______

CITY/STATE/ZIP ______

HM PH# ( ) ______ WK PH# ( ) ______ CELL # ( ) ______

PATIENT'S AGE ______ BIRTH DATE ___ / ___ / ___ SS# ___ / ___ / ___

SEX: ☐ MALE ☐ FEMALE REFERRED BY ______

HOW DID YOU HEAR ABOUT US? ______

REASON FOR TODAY'S VISIT ______

DUE TO INJURY? ☐ YES ☐ NO

INJURY DATE ___ / ___ / ___ ☐ ON THE JOB? ☐ AUTO ACCIDENT? ☐ OTHER?

PATIENT OR PARENTS EMPLOYER ______

EMERGENCY CONTACT ______

PH # ( ) ______ RELATIONSHIP TO PATIENT ______

RESPONSIBLE PARTY (if different from patient)

NAME OF SPOUSE OR PARENT IF PATIENT IS A MINOR ______

ADDRESS ______

HM PH# ( ) ______ WK PH#( ) ______ RELATIONSHIP TO PATIENT ______

ADVANCED FACES, LLC/DR. CHRISTOPHER JOHNSON

INSURANCE INFO:

ENTER INSURED'S DOB and SSN BELOW IF DIFFERENT FROM PATIENT

DENTAL

NAME OF INSURED

DATE OF BIRTH / /

SSN / /

RELATIONSHIP OF PT. TO INSURED

EMPLOYER NAME

MEDICAL

NAME OF INSURED

DATE OF BIRTH / /

SSN / /

RELATIONSHIP OF PT. TO INSURED

EMPLOYER NAME

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and any other health plans, to Advanced Faces. I transfer my title of reimbursement from my insurance company to Dr. Christopher Johnson. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I hereby authorize said assignee to release all information necessary to secure payment. I authorize claim forms to be sent via electronic claim filing. I authorize the release of my medical records or insurance claims to be sent via fax. I understand this authorization is irrevocable. A photocopy of this assignment is to be considered as valid as an original.

Signature

Date:

WITNESS

ADVANCED FACES, LLC/DR. CHRISTOPHER JOHNSON

MEDICAL HISTORY FORM

PATIENT NAME: ____________

HEIGHT ______ WEIGHT ______ My last physical exam was on ______

Name and phone # of physician ____________

MEDICAL HISTORY (Please check the appropriate box if you have or have had any of the following)

CARDIAC: ☐ No significant history

☐ High Blood Pressure ☐ Chest Pain ☐ Shortness of Breath ☐ Dizziness ☐ Fainting

☐ Pacemaker ☐ Murmur ☐ Abnormal heart rhythm ☐ Valve Disorder ☐ Ankle swelling

☐ Increased Cholesterol ☐ Heart Attack ☐ Arteriosclerosis ☐ Low Blood Pressure

Other: ____________

PULMONARY: ☐ No significant history

☐ Coughing up blood ☐ Asthma ☐ Shortness of Breath ☐ Wheezing

☐ Recent Upper Respiratory Infection ☐ Sleep Apnea ☐ Pneumonia

☐ Bronchitis ☐ Sinus Problems/Hay Fever ☐ Tuberculosis ☐ COPD/Emphysema

Other: ____________

NEUROLOGICAL - NEUROMUSCULAR: ☐ No significant history

☐ Cramps ☐ Numbness ☐ Tingling ☐ Spasms ☐ Stiffness ☐ Weakness

☐ Arthritis ☐ Rheumatoid Arthritis ☐ TMJ ☐ Seizures ☐ Epilepsy ☐ Stroke/TIA

Other: ____________

GI: ☐ No significant history

☐ Diarrhea ☐ Ulcer ☐ Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Blood in Stool

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Irritable Bowel Syndrome

Other: ____________

GU: ☐ No significant history

☐ Frequency ☐ Urgency ☐ Incontinence ☐ Discharge ☐ Discomfort ☐ Stones

☐ Blood in Urine ☐ Recent UTI ☐ Abnormal Vaginal Bleeding

Other:

SKIN: ☐ No significant history

☐ Rashes ☐ Lesions ☐ Bruising ☐ Delayed Wound Healing ☐ Psoriasis

☐ Mole Changes ☐ Frequent or recurring mouth sores ☐ Skin Cancer

Other:

ENDOCRINE: ☐ No significant history

☐ Diabetes Type: Usual Blood Glucose Range

☐ Hyperthyroid ☐ Hypothyroid

Other:

HEMATOLOGY/IMMUNE: ☐ No significant history

☐ Steroid Use ☐ Anemia ☐ Sickle Cell ☐ Bleeding Disorder ☐ Hepatitis

☐ Autoimmune Disorder ☐ Gout ☐ Organ Transplant ☐ Hereditary Angioedema

☐ Radiation ☐ Chemotherapy ☐ Cancer Type:

Other:

MENTAL HEALTH: ☐ No significant history

☐ Depression ☐ Anxiety Disorder ☐ Post-Traumatic Stress ☐ Eating Disorder

Other

PAST SURGICAL HISTORY

(Please list previous operations and dates)

ANY PROBLEMS WITH SURGERY OR ANESTHESIA ☐ YES ☐ NO

If yes, please explain

HAVE YOU EVER HAD A BLOOD TRANSFUSION ☐ YES ☐ NO

MEDICATIONS

Please list any medications you are currently taking with the dose and frequency. Please include any over the counter medications, aspirin, birth control pills and/or herbal remedies.

Have you taken any of these medications for osteoporosis, Paget's disease, or cancer?

☐ Zoledronic (Reclast) ☐ Etidronate (Didronel) ☐ Tiludronate (Skelid)

☐ Alendronate (Fosamax) ☐ Risedronate (Actonel) ☐ Ibandronate (Boniva)

☐ Pamidronate (Aredia) ☐ Zoledronate (Zometa)

DRUG ALLERGIES ☐ No known drug allergies

(Please list reaction you experience due to your allergy)

Have you ever had a reaction to Latex, Betadine, Surgical Tape or Eggs? ☐ YES ☐ NO

(If yes, please check which one) ☐ Latex ☐ Betadine ☐ Surgical Tape ☐ Eggs

SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO If yes, packs per day

Do you drink alcohol? ☐ YES ☐ NO

If yes, frequency: ☐ Occaisionally ☐ Frequently ☐ Regularly

Do you take recreational drugs, such as marijuana and/or cocaine? ☐ YES ☐ NO

GENERAL QUESTIONS

Have you taken aspirin-containing drugs in the past two weeks? ☐ YES ☐ NO

Have you had any trouble associated with previous treatment? ☐ YES ☐ NO

Are you wearing contact lenses? ☐ YES ☐ NO

Are you wearing a removable dental appliance today? ☐ YES ☐ NO

Women:

Are you pregnant or trying to become pregnant? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

Date of your last menstrual period: __________

CHIEF COMPLAINT (why are you here?)

____

Do you consent to having an x-ray taken today if needed? ☐ YES ☐ NO

Please understand we might not be able to render treatment if no x-ray is available and insurance companies require x-rays for payment

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Johnson, or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature __________ Date: __________

Printed Name: __________

If someone other than the patient filled out this form for the patient, please sign and date below.
I certify that I helped the patient fill this form out and that I am 18 years of age or older. I certify that I helped the patient fill out this form for the following reason(s):

____

Signature __________ Date: __________

Printed Name: __________

Relationship to patient: __________

NOTICE OF PRIVACY PRACTICES

ADVANCED FACES, LLC

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.

For purposes of this Notice "us", "we" and "our" refers to Advanced Faces, LLC and "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with Florida informed consent law). When you receive health-care services from us, we will obtain access to your medical information (e.g. your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

Florida law and the Health Insurance Portability & Accountability Act of 1996 (HIPPA) require us to maintain the confidentiality of all of your healthcare records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally ("PHI" or Protected Health Information). HIPPA is a federal law that gives you significant new rights to understand and control how your health information is used. HIPPA and Florida law provide penalties for covered entities and records owners, respectively, that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPPA requires us to provide you with this Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for health-care services. If you have any questions about this Notice, please ask to speak to our privacy officer, Lisa Johnson at 352-242-0627.

Our doctors, clinical staff, business associates (outside contractors we hire), employees and other office personnel follow the policies and procedures set forth in this notice. If your regular doctor is unavailable to assist you (e.g. illness, on-call coverage, vacation, etc.), we may provide you with the name of another health-care provider outside our practice for you to consult with by telephone. If we do so, that provider will follow the policies and procedures set forth in this Notice or those established for his or her practice, so long as they substantially conform to those for our practice.

OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we must have your signature on a written, dated Consent form and/or an Authorization form (not an Acknowledgment form) before we will use and disclose your PHI for certain purposes as detailed in the rules below.
Documentation You will be asked to sign a Consent form and/or Authorization form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our privacy officer. You may take back or revoke your Consent or Authorization at any time (unless we already have acted based on it) by submitting our Revocation form in writing to us at our address listed at the end of this Notice. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (e.g., if after we provide services to you, you revoke your Authorization or Consent in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your Authorization or Consent to provide services before you revoked it).
General Rule If you do not sign our Consent form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. Under Florida law, we are unable to submit claims to payers under assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing or discontinue you as an active patient if you choose not to sign the Consent or revoke it.

<u>Health-care Treatment, Payment and Operations Rule</u> With your signed Consent, we may use or disclose your PHI in order:
*To provide you with or coordinate healthcare treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other healthcare providers, schedule lab work for you, etc.
*To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide your x-rays because your health plan requires them for payment.
*To run our office, assess the quality of care our patents receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your

alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or our privacy officer may review your records to assist you with complaints. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed at the end of this Notice and we will not use or disclose your PHI for these purposes.

Special Rules Notwithstanding anything else contained in this Notice, only in accordance with applicable law, and under strictly limited circumstances, we may use or disclose your PHI without your permission, Consent or Authorization for the following purposes:
*When required under federal, state or local law
*When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety of other persons
*When necessary for public health reasons (e.g. prevention or control of disease, injury or disability; reporting information such as adverse reactions to anesthesia; ineffective or dangerous medications or products; suspected abuse, neglect or exploitation of children, disabled adults or the elderly or domestic violence)
*For federal or state government health-care oversight activities (e.g., civil rights laws, frauds and abuse investigations, audits, investigations, inspections, licensure or permitting, government programs, etc.)
*For judicial and administrative proceedings and law enforcement purposes (e.g., in response to a warrant, subpoena or court order, by providing PHI to coroners, medical examiners and funeral directors to locate missing persons, identify deceased persons or determine cause of death)
*For workers' compensation purposes (e.g., we may disclose your PHI if you have claimed health benefits for a work-related injury or illness)
*For intelligence, counterintelligence or other national security purposes (e.g., Veterans Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you)
*For organ and tissue donation (e.g., if you are an organ donor we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation)
*For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (e.g., if the researcher will have access to your PHI because he/she is involved in your clinical care, we will ask you to sign an Authorization)
*To create a collection of information that is ”de-identified” (e.g., it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you)
*To family members, friends and others, but only if you verbally give permission; we give you an opportunity to object and you do not; we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (e.g., you bring someone with you into the operatory exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (e.g., to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (e.g., your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed.

Minimum Necessary Rule Our staff will not use or access your PHI unless it is necessary to do their jobs (e.g., doctors uninvolved in your care will not access your PHI; ancillary clinical staff caring for you will not access your billing information; billing staff will not access your PHI except as needed to complete the claim form for the latest visit; janitorial staff will not access your PHI). Also, we disclose to others outside our staff only as much of your PHI as is necessary to accomplish the recipient's lawful purposes. For example, we may use and disclose the entire contents of your medical record:
*To you (and your legal representatives as stated above) and any one else you list on a Consent or Authorization to receive a copy of your records
*To health-care providers for treatment purposes (e.g., making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record)
*To the U.S. Department of Health and Human Services (e.g., in connection with a HIPPA complaint)
*To others as required under federal or Florida law
*To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPPA (e.g., clerks who copy records need access to your entire medical record)

In accordance with the law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPPA) are for the minimum necessary amount of PHI to accomplish the requester's purpose. Our privacy officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, the Plan's privacy officer will make a minimum necessary determination based on, but not limited to, the following factors:
*The amount of information being disclosed
*The number of individuals or entities

*The importance of the use or disclosure
*The likelihood of further disclosure
*Whether the same result could be achieved with de-identified information
*The technology available to protect confidentiality of the information
*The cost to implement administrative, technical and security procedures to protect confidentiality

If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requester to document why this is needed, retain that documentation and make it available to you upon request.

Incidental Disclosure Rule We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it (e.g., we require employees to talk softly when discussing PHI with you, we use computer passwords and change them periodically (e.g., when an employee leaves us), we allow access to areas where PHI is stored or filed only when we are present to supervise and prevent unauthorized access).

Business Associate Rule Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associate agreement will allow our Business Associate to violate this re-disclosure prohibition.

Super-confidential Information Rule If we have PHI about you regarding HIV testing, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records (super-confidential information under the law), we will not disclose it under the General or Health-care Treatment, Payment and Operations Rules (see above) without you first signing and properly completing our Consent form (i.e., you specifically must initial the type of super-confidential information we are allowed to disclose). If you do not specifically authorize disclosure by initialing the super-confidential information, we will not disclose it unless authorized under the Special Rules (see above) (e.g., we are required by law to disclose it). If we disclose super-confidential information (either because you have initialed the Consent form or the Special Rules authorize us to do so), we will comply with state and federal law that required us to warn the recipient in writing that re-disclosure is prohibited.

Changes to Privacy Policies Rule We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past (i.e., to PHI about you that we had before the changes took effect). If we make changes, we will post the changed Notice, along with its effective date, in our office. Also, upon request, you will be given a copy of our current Notice.

Authorization Rule We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on a specifically worded, written Authorization form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it on our Authorization form, which is separate from any Consent or Acknowledgment we may have obtained from you. We will not condition treatment on whether you sign the Authorization (or not).

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

If you received this Notice via e-mail or off of our website, you have the right to get, at any time, a paper copy by asking our privacy officer. Also, you have the following additional rights regarding PHI we maintain about you.

To Inspect and Copy You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our privacy officer on our Request to Inspect, Copy or Summarize form. Original records will not leave the premises, will be available for inspection only during regular business hours, and only if our privacy officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impractical) or ask us to
Prepare a summary in lieu of the copies. We may charge you a fee not to exceed Florida law to recover our costs (including postage, supplies and staff time as applicable, but excluding staff time for search and retrieval) to duplicate or summarize your PHI. We will not condition release of the copies or summary on payment of your outstanding balance for professional services (if you have one), but we may condition release of the copies or summary on payment of the copying fees. We will respond to requests in a timely manner, without delay for legal review, in less than thirty days if submitted in writing on our form or otherwise, and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request in certain limited circumstances (e.g., we do not have the PHI, it came from a confidential source, etc). If we deny your request, you may ask for a review of that decision. If required by law, we will select a licensed health-care professional (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed health-care professional who is not affiliated with us, we will ensure a Business Associate agreement is executed that prevents re-disclosure of your PHI without your consent by the outside professional.

To Request Amendment/Correction If another doctor involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will

send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (so long as we have it) by submitting a Request for Amendment/Correction form to our privacy officer. We normally will act on your request within 60 days from receipt, but we may extend our response time (within the 60-day period) no more than once and by no more than 30 days, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within 5 business days to persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (e.g., it is not in writing, it does not give a reason why you want the change, we did not create the PHI you want changed (and the entity that did can be contacted), it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will (in writing within 5 business days) tell you: why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosures of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

To an Accounting of Disclosures You may ask us for a list of those who got your PHI from us by submitting a Request for Accounting of Disclosures form to us. The list will not cover some disclosures (e.g., PHI given to you, given to your legal representative, given to others for treatment, payment or health-care-operations purposes). Your request must state in what form you want the list (e.g., paper or electronically) and the time period you want us to cover, which may be up to but no more than the last six years (excluding dates before April 14, 2003). If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Request Restrictions You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set forth in this Notice) by submitting a written Request for Restrictions on Use/Disclosure form to us (e.g., you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will
not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (e.g., we are required by law to use or disclose your PHI in a manner that you want restricted; you signed an Authorization form, which you may revoke, that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

To Request Alternative Communications You may ask us to communicate with you in a different place by submitting a written Request for Alternative Communication form to us. We will not ask you why and we will accommodate all reasonable requests (including, e.g., to send appointment reminders in closed envelopes rather than by postcards, to send your PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payments to us will be made if we communicate with you as you request.

To Complain or Get More Information We will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (e.g. you disagree with a decision of ours about inspection/copying/ amendment/correction, accounting of disclosures, restrictions or alternative communications), we want to make it right. We will never penalize you for filing a complaint. To do so, please file a formal, written complaint within 180 days with:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
(877) 696-6775 (toll free)

Or, submit a written Complaint form to us at the following address:

Advanced Faces, LLC
Attn.: Lisa Johnson, Privacy Officer
855 Oakley Seaver Dr
Clermont, Fl 34711
352-242-0627 (Phone),
352-242-0648 (Fax)

You may get your complaint form by calling our privacy officer.

These privacy practices will be effective April 14, 2003, and will remain in effect until we replace them as specified above.

ADVANCED FACES, LLC/DR. CHRISTOPHER JOHNSON

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Lisa Johnson - Privacy Officer
Telephone: 352-242-0627 Fax: 352-242-0648
E-mail: lisa.johnson@advancedfaces.com
Address: 855 Oakley Seaver Drive, Clermont, FL 34711

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

Patient, the personal representative, or I certify that I have received a copy of Advanced Faces Notice of Privacy Practices and have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to Advanced Faces use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature ____________________ Date: __________

If a personal representative on behalf of the patient signs this consent complete the following - I certify that I am 18 years old or older and I signed this form for the patient for the following reason(s):

____

Name: ____________________

Relationship: ____________________

ADVANCED FACES, LLC/DR. CHRISTOPHER JOHNSON

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Sign this form **ONLY IF YOU ARE DECLINING** to give consent for use and disclosure of health information.

Please understand that if you decline to consent for use and disclosure of health information Advanced Faces/Dr. Christopher Johnson may decline to treat you.

I, the patient or personal representative, acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for Advanced Faces, LLC but decline to give consent for use and disclosure of health information. I understand that by refusing to sign the consent for use and disclosure of health information Advanced Faces/Dr. Christopher Johnson may decline to treat me as a patient.

Signature ____________________ Date: __________

If a personal representative on behalf of this patient signs this form complete the following - I certify that I am 18 years old or older and I signed this form for the patient for the following reason(s):

____

Name: ____________________

Relationship: ____________________

If you have any questions about this form or the attached Notice of Privacy Practices, please contact our Privacy Officer.

Lisa Johnson
Telephone: 352-242-0627 Fax: 352-242-0648
E-mail: lisa.johnson@advancedfaces.com
Address: 855 Oakley Seaver Drive, Clermont, FL 34711

For office use only

As privacy officer, I attempted to obtain the patient's (or representatives') signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign
- ☐ Other (please describe)

____

Signature of Privacy Officer ____________________ Date: __________

ADVANCED FACES, LLC/DR. CHRISTOPHER JOHNSON

OUR FINANCIAL POLICY

I understand that ***payment is due at the time of service.*** If you have insurance and we are a participating provider we will file the insurance claim, however you are responsible for your co-payment at the time of service. If we are not a participating provider, as a courtesy, we will file for payment with the insurance company for treatment that exceeds $250.00. (This limit does not apply to participating plans.)

If for any reason the insurance company does not honor their contract and payment is not forthcoming or if the insurance company does not pay the entire claim within 45 days, then I will be responsible for the full remaining balance 60 days after the date of service.

I also understand that if after the insurance pays there is a balance and I do not pay off the bill in 60 days from the date of service, there will be a 1% interest charge applied monthly until the balance is paid in full. Collection measures will be pursued if necessary.

Medicare, (under Section 1862(a)(1) of the Medicare law), and some health insurance plans will only pay for services that it deems to be “reasonable and necessary”. If Medicare determines that a particular service is not reasonable or necessary or my insurance company determines that a service was not authorized or not covered under my plan, Medicare or my insurance company will deny payment. Payment then will be my responsibility.

Signature Date:

Printed Name:

Witness' Signature:

If a personal representative on behalf of the patient signs this form complete the following - I certify that I am 18 years old or older and I signed this form for the patient for the following reasons(s):

Name:

Relationship:

ADVANCED FACES, LLC/DR. CHRISTOPHER JOHNSON

Please initial to confirm whom we may discuss your medical and financial information with:

☐ My Husband: ____________________

☐ medical ☐ financial

☐ My Wife: ____________________

☐ medical ☐ financial

☐ My Mother: ____________________

☐ medical ☐ financial

☐ My Father: ____________________

☐ medical ☐ financial

☐ My Mother-in-Law: ____________________

☐ medical ☐ financial

☐ My Father-in-Law: ____________________

☐ medical ☐ financial

☐ My Children: ____________________

☐ medical ☐ financial

☐ Other (Friends or Partners)

Please list specific names: ____________________

☐ medical ☐ financial

When calling to discuss your upcoming appointment or financial information may we:

☐ Leave a detailed message on your home phone

☐ Leave a detailed message on your cell phone

☐ Leave a detailed message on your work phone

☐ DO NOT leave any information but person calling and contact number

Signature: ____________________