Florida Center for
Plastic and Cosmetic Surgery

Jeff DeMercurio, M.D.
Florida Center for Plastic and Cosmetic Surgery

Today's Date: _____

Name: _____ _____ _____
First MI Last

□ Male □ Female □ Single □ Married □ Divorced □ Widowed □ Separated

Birthdate: _____/_____/_____ Age: _____ Social Security # _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____Email: _____

Occupation: _____ Employer: _____

Referring Dr: _____ Primary Doctor: _____

Reason for today's office visit (briefly explain):_____

What genre or types of music do you prefer:_____

May we text for appointment confirmations: Please circle: YES NO

How did you hear about us? Facebook_____ Instagram _____ Google_____ Patient (name) _____

Dr. Referral_____ Other (please list)_____

Emergency Contact (HIPPA):_____

Relationship: _____ Telephone #: _____

***PLEASE PROVIDE RECEPTIONIST WITH PHOTO ID AND INSURANCE CARDS (if applicable) ***

Insurance Co Name: _____ Policy # _____
Policy Holder Name: _____ Date of Birth of Policy Holder: _____

Personal Medical History: ***DO YOU HAVE A PACEMAKER? _____

Abdominal Bleeding	_____	Diabetes	_____	MRSA	_____
Asthma	_____	Eye Problems	_____	Neurologic Disease	_____
Blood Clots/Bleeding Disorder	_____	Heart Disease	_____	Non-Relevant medical history	_____
Breast Cancer	_____	Heart Murmur	_____	Other Relevant Medical History	_____
Cancer _____	_____	Hepatitis	_____	Psychiatric Condition	_____
Chemical/Radiation Therapy	_____	High Blood Pressure	_____	Reflux	_____
Chest Pain	_____	HIV	_____	Skin Cancer	_____
Congestive Heart Failure	_____	Hypercholesterolemia	_____	Stroke	_____
COPD	_____	Kidney Problems	_____	Thyroid Disorder	_____
Cystic Fibrosis	_____	Malignant Hyperthermia	_____	Tuberculosis	_____

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Are you currently under of a physician for Neuro/Psychiatric Problem(s)? Y N If yes, reason?_____

PERSONAL SURGICAL HISTORY:

SURGERY TYPE	HOSPTIAL	DATE	ANESTHESIA COMPLICATIONS	SURGEON

Family History (which family member):

BRCA Positive _____ Hemophilia _____ Obesity _____
Breast Cancer _____ High Blood Pressure _____ Other Cancer _____
Diabetes _____ Non-Relevant Family History _____ Other Relevant Family History_____
Heart Disease _____ _____

Social History:

Do you smoke? Y N If so, how many daily? _____ Quit date, if applicable:_____
Drink Alcohol? Y N How often? _____ Recreational Drugs? Yes No Exercise Daily? Y N

Current Height: _____ **Current Weight**: _____

MEDICATIONS:

Please list Medications/Dosage & Frequency taking: (Include all Prescriptions, OTC Medications & Vitamins):

MEDICATION NAME	DOSAGE	FREQUENCY

ALLERGIES:

Penicillin	Y	N	Codeine	Y	N	Tape Allergy	Y	N
Sulfa	Y	N	Tetanus	Y	N	Aspirin	Y	N
"Mycins"	Y	N	Demerol	Y	N	Latex Allergy:	Y	N

Other: _____

Have you ever received a transfusion? Y N If yes, what year? _____
Have you ever been tested for HIV? Y N If yes, what year? _____
Dentures: Y N Hearing Aid: Y N

Have you experienced any problems or complications with the following types of anesthesia?

Local anesthesia? YES NO If yes, please tell us what happened: _____
General anesthesia? YES NO If yes, please tell us what happened: _____

Florida Center for
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WOMEN PATIENTS ONLY:

Are you pregnant or suspect you may be pregnant? YES NO

Number of pregnancies _____ Number of children _____ Did you breast feed? YES NO

Release of Medical Information/Personal/Family Contacts: ***Florida Center for Plastic and Cosmetic Surgery will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list the names and relationships of those you authorize us to discuss your personal health information with. IF a name is not listed here, we will not provide any information to that person.***

*****PLEASE INCLUDE THOSE WHO WILL COME TO APPOINTMENTS WITH YOU*****

_____	_____	_____
Contact Name	**Relationship**	**Phone #**
_____	_____	_____
Contact Name	**Relationship**	**Phone #**

HIPAA-Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledge the receipt of Florida Center for Plastic and Cosmetic Surgery's Notice of Privacy Practices or acknowledgement that a copy of this notice is available for your convenience. The Notice describes how my health information may be used or disclosed. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling 386-317-0444 or by requesting one at the following office:

Jeffrey DeMercurio, M.D.
1425 Hand Ave Suite C
Ormond Beach, FL 32174

Adult Patient/Guarantor: _____Date: _____

Photo Release: I hereby authorize Dr. Jeffrey DeMercurio and/or his assistants to take pre-operative, intra-operative, and post-operative photographs, and/or videotapes. I additionally consent for photographs and videotapes of my interview. I understand that such photographs shall become the property of Florida Center for Plastic and Cosmetic Surgery and will be retained by Florida Center for Plastic and Cosmetic Surgery.

I understand that treatment will not be given if pre-treatment, intra-operative, and post-operative photographs are not taken as these are a part of every medical examination and a critical part of my patient chart.

I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing, insurances, and/or certifying purposes by the American Board of Plastic Surgery, Inc.

I certify that I have read the above Authorization and Release and fully understand its term.

Adult Patient/Guarantor: _____Date: _____

Florida Center for
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Financial Policy

Florida Center for Plastic and Cosmetic Surgery's financial policy requires our office to collect payment for your office visit at the time services are rendered. We accept cash, cashier's check, money order, debit card, Apple Pay, and all forms of credit cards. We ask that you remember the ultimate responsibility for full payment for our services rest with the adult patient or guarantor. If your account becomes delinquent and it becomes necessary for the account to be referred to an attorney or collection agency or suit, the patient or guarantor will be responsible for paying all patient charges, reasonable attorney fees, collection expenses, and court costs.

Patient Consent for Use of Credit cards, Debit Card, and Financing

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Florida Center for Plastic and Cosmetic Surgery, LLC to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing company when they request such information to process an account and assist with payment.

I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this noncredit card challenge agreement is irrevocable.

Cancellation: As a courtesy to our patients, we may have a waiting list for appointment availability. As a policy, we ask that you contact our office at least 48 hours prior to your scheduled appointment if you need to cancel or reschedule so that we may offer the appointment to another patient. As we understand that things come upon our lives at this time, we do not at this time charge for no-shows and/or last-minute cancellations we wish to not execute for the future. We appreciate our patients and would like to thank you for your consideration of our policies.

Adult Patient/Guarantor: _____Date: _____

Florida Center for
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Cosmetic Patients:

Cosmetic consultations are $75.00. This fee/payment is applied towards the surgery and/or the procedure if performed. If injectables are performed this day, there will be no consultation fee. The cost for an injectable is often determined during the consultation with Dr. DeMercurio and his assistant, depending on the number of units or syringes used. The patient is responsible for paying in full for the treatment immediately afterwards. Every patient is given an individual assessment for an injectable; therefore, the amount differs from one patient to another. If the patient comes back for an assessment and Dr. DeMercurio and patient agree that more product is needed to achieve satisfactory results, additional charges will be incurred and required to be paid in full at that time. The treatment fees you pay for are not a guarantee of results. The practice of medicine and surgery is not an exact science. Although good results are expected, there cannot be any guarantee of warranty, expressed or implied, by anyone as to the results that may be obtained.

Surgery Center and/or office surgical suite:

In the interest of safe surgery, laboratory, pathology, and diagnostic tests (up to date mammogram, chest x-ray and/or EKG) may be ordered and are the financial responsibility of the patients as well as the surgeon's fee, anesthesia, and facility fees for the procedure(s) as agreed upon. Medications are not provided by Florida Center for Plastic and Cosmetic Surgery. The fee quoted to you is an estimate and is based on the standard time needed to perform the procedure(s) properly. If the operation room time is extended for medical reasons, additional fees will be billed by the facility and anesthesiologist. Excess operating room time is the exception and not the rule. If there are any additional procedures needed, there will be additional fees. The fees are non-refundable, and you are financially responsible for payment of the additional fees.

Treatment and Complications: The practice of medicine and surgery is not an exact science. Although good results are anticipated, there can be no guarantee or warranty, expressed or implied, by anyone as to your results. Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. These will result in additional charges for which you are responsible.
When necessary, most revision surgery is not performed sooner than six months to one year ***after*** surgery. This allows time for all swelling to resolve and healing to be completed. The surgeon's fee for revision surgery will be evaluated on a case-by-case basis and be determined solely by Dr. DeMercurio.
However, you will be responsible for the cost of the operating room, anesthesia, and other cost including but not limited to, lab work, pathology, x-rays, EKG, prescriptions, medical clearance, supplies and any consulting doctor's professional fees.

I have read and understand the above Financial Policy. I have had the opportunity to address questions about this Policy, and all my questions have been answered to my satisfaction. I agree to be bound by the terms of this Policy. I further agree that, if I default on any obligations under this Policy, I will be responsible for attorney fees, court costs, pre-judgment interest allowed by law, and expenses of collection.

Adult Patient/Guarantor: _____ Date: _____

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Insurance Patients Only:

It is the policy of this office to collect the patient's deductible and out of pocket expenses 2 weeks prior to surgery if they have not been met for the calendar year before surgical procedures are performed. For procedures covered by your insurance, we will submit a claim to your insurance company, and once the company has paid all it will pay on the claim, the adult patient (18 years of age or older), or guarantor is responsible for any remaining balance. We participate in numerous insurance programs to accommodate our patients. While we are pleased to be able to provide this service, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each plan has different policies regarding how often services may be rendered and, even more importantly, where those services may be performed. We ask you to inform us if your coverage has any special requirements, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. We have found that many insurance plans provide payment at levels significantly lower than our fees. We take great care in setting our charges well within the acceptable norms for similar services in this area. Insurance companies no longer abide by these norms, rather they establish their own reimbursement schedules. It is our desire that you receive the maximum benefit possible from your health insurance ln order to achieve this we need your assistance in providing us complete and accurate personal and insurance information on the attached form.| **Insurance Deductibles (if applicable), co-payments (if applicable), and cosmetic surgical fees must be paid 2 weeks prior to surgery. For your convenience, we accept cash, cashier's check, money order, personal check, debit card, and major credit cards. No personal checks will be accepted within 7 days of surgery. A deposit of $1000 is required to schedule surgery. This deposit amount is applied to your total balance which is due in full two weeks prior to your surgical date at your pre-operative visit. There will be a non-refundable fee for booking and scheduling the surgery of $500. Should there be a cancellation, a medically acceptable reason must be provided in writing by your physician. Otherwise, the fee is forfeited. While this may appear to be a charge for services which were not provided, this fee is necessary to reserve time in the operating room and in the practice, which are done when surgery is scheduled. If you reschedule your surgical date, a $200 reschedule fee will be charged if not rescheduled two weeks prior to surgical date. You will not receive any kind of coded receipt for insurance purposes, as these services are understood to be cosmetic procedures not deemed medically necessary.**

Insurance Authorization and Assignment: I hereby authorize Jeffrey DeMercurio M.D., LLC to release information requested by my insurance company. I also authorize Jeffrey DeMercurio, M.D., LLC to release information to any hospital or physician to which I may be referred by this office. In addition, I authorize Jeffrey DeMercurio, M.D., LLC to request and obtain my medical records from my insurance company, hospitals, and/or physicians who have treated me. I hereby authorize assignment and payment directly to Jeffrey DeMercurio, M.D., LLC from major medical benefits or legal settlements and/or judgments due me. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I understand I will be responsible for any fees attached to this account to recover any uncollected balances.

Adult Patient/Guarantor: _____Date: _____

Medicare ONLY PATIENTS: I authorize any holder or medical information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Jeffrey DeMercurio, M.D., LLC for services rendered me by its physician(s).

Adult Patient/Guarantor: _____Date: _____