603 South Boulevard Tampa, FL 33606

Moriah Moffitt, M.D.

Cosmetic Plastic Surgery
813-414-0908

1715 N. Westshore Blvd Suite 100 Tampa, FL 33607

New Patient Registration Form

Patient Name: _____

Address: _____

City:_____State:_____Zip:_____

DOB: _____

Phone: _____

Email: _____

Reason for Visit: _____

How did you hear about Dr. Moffitt?: _____

_____

_____

Emergency Contact: _____Phone:_____
Emergency Contact Relationship:_____

Pharmacy Name: _____
Pharmacy #: _____

Have you consulted with any other surgeon regarding the surgery(s) you are interested in?

_____

Patient History Form

Allergies to Medicine: _____

Current Medication: Aspirin [ ]
Others:_____
_____
_____

Past Surgical History: (please include dates)
_____
_____
_____
_____

Have you ever been hospitalized? Yes [ ] No [ ]
Reason: (please include dates)
_____
_____
_____

Please check all that apply to you:

[]Glaucoma []Diabetes []Heart []Stroke []Lung Disease []Kidney

[]Cancer, Location:_____[]Chemo []Radiation

Family History:

Father	Mother	Brother/Sister	Children
Age_____	Age_____	Age(s)_____	Age(s)_____
Health_____	Health_____	Health_____	Health_____
Deceased[]	Deceased[]	Deceased[]	Deceased[]

List Diseases that run in your family:
_____
_____
_____

Social History

Occupation:_____
Employer:_____

Marital Status: Married[] Single[] Divorced[]

Use of Tobacco: No[] Yes[]-Packs Per Day:_____

Use of Alcohol: No[] Yes[]-Socially[] Binges[] Drugs[]_____

Review of Systems

Have you had or do you have problems with any of the following:

HEENT
Vision[] Swallowing[] Headaches[] Sinus[] Nose Bleeds[]
Loss of hearing[]

HEART
Shortness of Breath[] Chest Pain[] Blood Pressure[]
Ankle Swelling[] Heart Attack[] Rheumatic Fever[] Hear Murmur[]

LUNGS
Bronchitis[] Chronic Cough[] Cough Up Blood[] Emphysema[]
Pneumonia[] Asthma[] Shortness of Breath[]

GI
Stomach[] Ulcers[] Bloody Bowel Movements[] Vomit Blood[]
Appetite[] Black Bowel Movements[] Indigestion[] Hepatitis[]
Gallbladder[]

GU
Discharge[] Swelling/Tenderness[] Blood in Urine[]
Pain/Difficulty Urinating[] Incontinence[]

NEURO
Paralysis[] Dizzy Spells[] Tingling/Numbness[] Memory Loss[]
Blackout or Spells[] Seizures or Convulsions[]

SKIN
Bruising[] Bleeding[] Lumps or Bumps[] Unusual Moles[]

BREAST
Discharge[] Lumps[] Nipple Changes[] Other[]
For Women Only

Date of Last Mammogram_____
Last Breast Exam _____
LMP (Last Menstrual Period) _____

Any Problem With Pregnancies_____
#Pregnancies_____ #Living Children_____
#Miscarriages_____ #Full Term_____ #Premature_____
#Vaginal Deliveries_____ #C-Sections_____

Moriah Moffitt, M.D.
Consent For Photography

I authorize Moriah Moffitt, MD to photograph and agree that she may use the photographs for purposes of scientific use such as teaching, publication or research. I understand that my identity will be hidden. *I understand that the main purpose of the photographs are for my medical chart that will remain in the hands of Moriah Moffitt, M.D.*

Yes[] No[]

It is CLEARLY understood that any identifiable photographs will not be shown to the lay public or to other patients.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Guardian if Patient is a Minor Date

Moriah Moffitt, M.D.
Notice of Privacy Practices

This notice describes how your health instruction may be used and disclosed and how you can access this information. Please review it carefully.

At the practice of Moriah R. Moffitt, M.D. we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy. The terms of this notice are as follows:

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may share your medical information with our business associate, such as a transcription service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

in an emergency, we may disclose your health information to a family member or another person responsible for you care. We may release some or all of your health information when required by law. if this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of you health information to another practice. We will mail your files to you. You also have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement i your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Jill Bosley, at 813-414-0908.

This notice goes in effect as of April 14, 2003.

Acknowledgement: I have read a copy of the Moriah R. Moffitt, M.D. Notice or Privacy Practices.

Signed_____ Date_____

Print Name_____

If signing as a parent or guardian, please note the name of the patient_____

Moriah Moffitt, M.D.
Financial Policy

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE
Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Moriah Moffitt, M.D. accepts cash, personal checks (in-state only), Cashier Checks, Money Orders, VISA, MasterCard, and Discover. There is a service charge for returned checks.

INSURANCE
As a courtesy to our patients, our office will submit charges for medical treatment to the patients insurance company. However, the patient is primarily responsible for paying any and all medical expenses incurred at this office.

We may attempt to verify in advance that the patients insurance company will pay for the specific medical procedures. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will not pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his/her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible, in addition to whatever amounts the insurance does not pay.

Your insurance card and referral, if required, must be presented for your initial visit, otherwise full payment will be due. Members are responsible for getting pre-approval from the primary care physicians for each visit. We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment responsible to be sure all charges are paid whether by you or by your insurance carrier.

Regarding Health Reimbursement Accounts (HRA), after all insurance payments have been made; the remaining balance is your patient responsibility and is due within 30 days of receipt of your EOB (explanation of benefits).

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the consultation/appointment and 72 hours prior to a scheduled surgery. We reserve the right to charge for missed or late-cancelled appointments and/or surgeries.

I have read and understand Moriah Moffitt, MD's Financial Policy. I agree to assign insurance benefits to the Moriah Moffitt, MD practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collections agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

ADDITIONAL INFORMATION:

DISABILITY FORMS: There will be a $25.00 service charge for those requiring disability forms due to surgery for their place of work. This will be due before any forms are sent.

RETURNED CHECK FEE:
Insufficient funds are subject to prosecution under the Laws of the State of Florida. There will be a $25.00 service charge on any returned checks.

Signed(patient or guarantor): _____Date:_____

Print Name: _____