DELOZIER
COSMETIC SURGERY CENTER

Joseph B. DeLozier III M.D., F.A.C.S.
209 23rd Avenue North, Nashville, TN 37203
Phone (615) 565-9000 Fax (615)-565-9005

Date_____

Patient Full Name_____
Last First M.I

Patient Preferred Name (if different than above) _____

Patient Address_____

City _____ State _____ Zip Code_____

Home # (___)_____ Cell # (___)_____ Work # (___)_____

Sex *M* or *F* Birth Date___/___/___ Age_____ Social Security #_____

Place of Employment_____ Occupation_____

Marital Status _____ Spouse's Name (if applicable) _____

E-Mail Address _____ May we contact you via e-mail? Yes or No

What would you like to discuss with Dr. DeLozier today?_____

How did you hear about our practice? ***Facebook***_____ ***Instagram***_____ ***Google***_____

*Is there someone we may thank for your referral?*_____

Medical History

Patient Name: _____ Date of Birth:_____

Primary Care Provider:_____

Phone Number: _____ Fax Number: _____

Pharmacy Name:_____ Pharmacy Phone #: _____

Pharmacy Address:_____

Medication allergies with associated reactions:_____

_____

Do you have a latex allergy? _____ Do you have a tape allergy? _____

Height: _____ Weight: _____

Do you smoke? _____ How much? _____

List any nicotine products used (ie: tobacco, vaping, e-cigarettes, patches, gum):_____

Do you drink alcohol? _____ How much? _____

What is your daily pain score? (0=no pain, 10=severe pain)_____

Medications

Do you take a blood thinner? _____ (ie: Coumadin/warfarin, Lovenox, Xarelto, Pradaxa, Plavix)

If so, which one? _____ For what condition?_____

Who prescribes and manages your blood thinner? _____(if different from above)

Phone Number: _____ Fax Number:_____

Please list your current medications (include any over-the-counter medications, vitamins, etc.)

Have you taken any prescription or over-the-counter weight loss pills in the last three weeks? _____

If so, please list_____

Do you currently have or have you ever had any of the following conditions? (circle)

Heart attack	Pneumonia	Cancer
Chest pain	Other disease of lung	Healing problems
High blood pressure	Stroke	Staph/MRSA infection
High cholesterol	Sleep apnea or snoring	Visual problems
Heart murmur	Diabetes Type 1	Hearing impairment
Other heart disease	Diabetes Type 2	Migraines
Blood clots	Hypothyroidism	Fever blisters
Pulmonary embolus	Fibromyalgia	Hepatitis B
Bleeding or clotting disorder	Lupus	Hepatitis C
Emphysema/COPD	Other autoimmune disorder	HIV/AIDS
Asthma	Arthritis	Anemia

If you circled yes to any of the conditions, or if you have a condition *not* listed, please explain:

_____

_____

_____

_____

Please list <u>all</u> surgeries that you have ever had:

Patient Disclosures

Patient Name: _____ Date of Birth:_____

May we leave a detailed message on your voicemail? _____ May we send a text message?_____

Emergency contact: _____ Phone:_____

May we discuss/disclose your account of medical information with members of your family or other persons known to you? If yes, you **must** list their name(s) below. We will only discuss information with those listed below:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

By signing below, I authorize the discussion of my plan of care with the individuals listed above.

Patient signature: _____

Name of *Primary* Insurance: _____

Subscriber's Name _____ Subscriber's SS # _____

Relationship to patient: self spouse parent other Sex M or F Birth Date ___/___/___

Name of *Secondary* Insurance (if applicable):_____

Subscriber's Name _____ Subscriber's SS #_____

Relationship to patient (circle): self spouse parent other Subscriber's Birth Date ___/___/___

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Patient Agreement

Limitation of Practice: Patient understands that the practice of Joseph B. DeLozier, III, MD, PLLC is limited to **Plastic and Reconstructive Surgery**.

Patient Consent: Patient hereby gives consent, if needed, for drawing blood samples for diagnosis or in case of accidental puncture or exposure to medical personnel during my course of treatment either in the offices or in the hospital. These tests may include AIDS testing.

Tennessee Controlled Substance Monitoring Database (CSMD): Joseph B. DeLozier, III, MD, PLLC abides by the rules and regulations set forth by the State of Tennessee regarding the CSMD as required by law. Patient herby gives consent for the practice to access any and all records held by the Department of Health relating to Schedule II-V controlled substances dispensed to the patient.

Privacy Policy

All patients have a right to review our Notice of Privacy Practices. Any employee of the practice can provide you a copy of the Notice of Privacy Practices. If you would like to restrict access or request modifications be made to your Personal Health Information, please request the required form from a member of our staff.

Collection Policy

Insurance Claims Filing

In all cases, the patient is responsible for payment of their account. As a courtesy, Joseph B. DeLozier, III, MD, PLLC will file a claim to the patient's insurance coverage.

Assignment and Release: Patient hereby authorizes and assigns applicable insurance benefits to be paid directly to the physician; Patient is financially responsible for non-covered services. Patient authorizes release of information necessary to process insurance claims. Patient authorizes photographs to be restricted for medical, education or insurance purposes and information released to other practitioners in good faith effort for my medical care.

Medicare: Patient requests that payment of authorized Medicare benefits be made either to the patient or on the patient's behalf to Joseph B. DeLozier, III, MD, PLLC and their associates for any services furnished the patient by that physician. Patient authorizes any holder of medical information about the patient to release to the Center for Medicare and Medicaid Services (CMS) or its agents any information needed to determine these benefits payable for related services. This form is not to be used by the patient for Medicare reimbursement.

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Managed Care Plans and Referrals

Managed care plans (e.g. HMO's) require specialist and sub-specialists to obtain a referral number before the physician can see a patient. The patient is responsible for obtaining a referral number, not this office. Failure to have a referral number prior to service will result in reduced benefits by the managed care plan. Therefore, the patient is responsible for any balance not paid by the coverage plan.

Co-Payments

In all cases, the patient is responsible for making co-payments at the time of the patient visit in the form of cash or check. If a co-payment is not made at the time of the patients visit, Joseph B. DeLozier, III, MD, PLLC reserves the right to require co-payment to be made prior to all future patient visits.

Maximum 30-Day Period for Unpaid Balances

Patient Balances are due 30 days after insurance coverage payment has been made. In the alternative, the patient must make acceptable payment arrangements by contacting the Billing Department at Joseph B. DeLozier, III, MD, PLLC. Balances may be paid via cash, check, Visa, or MasterCard.

Unpaid Balances

If for any reason the patient cannot make scheduled payments, the patient must immediately contact the Office at Joseph B. DeLozier, III, MD, PLLC to make acceptable arrangements. Joseph B. DeLozier, III, MD, PLLC reserves the right to refer all unpaid accounts to collection agencies. Any fees associated with collection, including collection agency contingency fees and court costs, will be added to the patient's account balance. After accounts are place with collection agencies, all patient visits and procedures will be on a cash only basis.

Service Charge

Joseph B. DeLozier, III, MD, PLLC reserves the right to assess a service charge, not to exceed $20 per month, to a patient account for any unpaid balance over 30 days after the insurance coverage has been paid. No service charges will be assessed to patient account where the patient has made payment arrangements with the Billing Department and payments are being made as agreed.

Provider Signature _____ Date _____
Patient Signature _____ Date _____

All questions concerning these policies should be directed toward the administrator.