

THE LOMBARDI PLASTIC SURGERY CENTER

Restorative Health Alliance, LLC

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PATIENT INFORMATION

Date

Patients Last Name

First Name

M.I.

Suffix(i.e., Jr., Sr.)

Street Address

City

State

Zip Code

(_____) _____
Area Code Home Phone

(_____) _____
Area Code Cell Phone

Date of Birth

Age

M F
Sex

_____-_____-_____
Social Security Number

Emergency Contact (Name)

(Relation)

(_____) _____
Emerg. Contact #

Name & Address of Patients Employer

(_____) _____
Work Telephone

Occupation

Email Address

Referral Source (How did you hear about our office.)

Where can we reach you to confirm?

Can we leave a message on your answering machine?

Are you interested in receiving information via email?

Home Phone Cell Phone Work

Yes No

Yes No

Reason for visit:

Botox Dysport Filler Laser Hair Removal Laser Resurfacing

Breast Augmentation Breast Lift Breast Reconstruction Breast Reduction

Height: _____ Weight: _____ Bra Size: _____

Leg Veins Scar Revision Face Lift Eyelids Liposuction

Abdominoplasty full/mini Suspicious Lesion Wound _____
(Please Specify)

Suture Removal – Date Sutured: ____/____/____

Post-OP Visit/Hospital _____ - Date of Surgery: ____/____/____

Other – Please List _____

Past Medical History:

None Asthma Cancer Coronary Artery Disease(CAD) Diabetes

Heart Disease High Blood Pressure Peripheral Vascular Disease/Circulation

Stroke (CVA) Other – please list _____

Past Surgical History:

None Yes – Please list procedures and date: _____

Allergies:

No Known Drug Allergies

Penicillin Sulfa Codeine Aspirin

Other – Please List _____

Food Allergies Only – please list _____

Current Medications:

None Yes – Please List Names and Dosage _____

Social History:

Tobacco Use: No Yes – Cigarettes Packs/day _____ Year
Started _____

Alcohol Use: No Yes – Frequency: Daily Weekends Monthly Rarely Never

Family History:

None
High Blood Pressure _____ Heart Disease _____
Cancer _____ Diabetes _____
Asthma _____ Stroke _____
Kidney Disease _____ Other _____

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I hereby authorize Anthony S. Lombardi, MD, P.C. to release any information concerning my healthcare, condition and treatment for the purpose of evaluating, administering and appealing claims for insurance benefits. I also hereby assign and authorize payment of insurance benefits directly to Anthony S. Lombardi, MD, P.C. I understand that I am responsible for any amount not covered by insurance. I also understand that if I fail to pay any amount that I am responsible for, I will be charged no less than 1.5% interest per month compounded monthly. I also understand that for Worker's Compensation and No fault cases, if payment is not received, I am responsible to make full payment directly to the physician. Patient acknowledges and agrees that if the doctor must utilize the services of a collection agency or attorney to collect fees owed, that patient is also responsible for reasonable collection fees, attorney fees and costs of suit not to exceed 20% of the balance owed.

_____ Signature of Patient or Responsible Party, if minor Date _____

HIPAA

PATIENT ACKNOWLEDGEMENT FORM

This form is your acknowledgement that we have informed you how to get additional information on how we may use and disclose health information about you. This notice informs you to the fact that every patient has the right to review the Notice of Privacy Practices prior to signing this form. This notice is the outcome of HIPAA (Health Insurance Portability and Accountability Act of 1996), mandated by the federal government. The act will become law by April 14, 2003. The Notice of Private Practices insures that your personal health information is kept private between insurance companies, billing companies, doctors, hospitals and drug companies. HIPAA does not change the quality of your healthcare, it enforces your rights to the privacy of your health information.

The Notice contains a Patient Rights section describing your rights under the law. The terms of our notice may change, if we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to the restrictions, but if we do we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The Practice provides this form to comply with government regulations.

The patient understands that:

Protected health information may be disclosed or use for treatment, payment or healthcare operations.

The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review that Notice.

The practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information by the Practice does not have to agree to those restrictions.

The patient may revoke this consent in writing at any time and all future disclosures will the cease.

The Practice may condition receipt of treatment upon the execution of this consent.

This Acknowledgement by:

Please Print- patient name

X _____
Signature /Guarantor

Witness

Date