DEEPAK K. NAIDU, MD
PLASTIC SURGERY

201 E. Kennedy Blvd Suite 410
Tampa, FL 33602
Phone: 813.434.1620
Fax: 813.434.1621
info@DeepakNaiduMD.com
www.DeepakNaiduMD.com

Date:________________

Confidential Information: The information herein will not be released, except when you have authorized us to do so. This information will be used by Dr. Naidu in his decisions regarding your care.

Name:____

Address:____

City/State/Zip:____

Home Phone: _______________________ May we leave a voice mail? ❑Yes ❑No

Mobile Phone: _______________________ May we leave a voice mail? ❑Yes ❑No

May we send text message appointment reminders? ❑Yes ❑No

Email:____

May we send appointment confirmation and reminder emails? ❑Yes ❑No

DOB:_____________ Sex: ❑M ❑F Marital Status:_____________ SSN:__________________

Height:____________ Weight:___________

Occupation:___________________________________

Family Doctor (name & phone)____

Emergency Contact:____

Phone:_____________________ Relationship:___________________

With whom may we share your medical information?

Name:_________________________________Phone:_________________________________

Relationship:____________________________

Do you have an Advance Directive? ❑Yes ❑No

How did you hear about Dr. Naidu?

❑ Physician Referral ❑ Facebook ❑ Twitter ❑ Google/Internet ❑ Our Website

❑ Walk-in ❑ Advertisement ❑ Other _________________

❑ Referred By Current Patient. Who may we thank?____________________

What brings you to our office? Please be as specific as possible:________________________________

____

____

How long has this concerned you?____

Have you had any previous treatment or procedures for this? (If so, how and when was this treated?)

____

____

Do you have or have you ever had any of the following? (Please check yes or no)

	YES	NO		YES	NO
Anemia	❑	❑	Hepatitis/Liver disease	❑	❑
Arthritis	❑	❑	High blood pressure	❑	❑
Asthma	❑	❑	Irregular heart beat	❑	❑
Back problems	❑	❑	Kidney problems	❑	❑
Blood clots in legs	❑	❑	Migraine headaches	❑	❑
Blood disorders	❑	❑	Muscular disorder	❑	❑
Bleeding problems	❑	❑	Nose/throat problems	❑	❑
Breathing difficulty	❑	❑	Pneumonia	❑	❑
Cancer	❑	❑	Psychiatric condition	❑	❑
Chest pain	❑	❑	Skin cancer	❑	❑
Diabetes	❑	❑	Stomach/intestinal problems	❑	❑
Ear/eye problems	❑	❑	Stroke	❑	❑
Epilepsy/seizure disorder	❑	❑	Thyroid problems	❑	❑
Heart problems	❑	❑	Urinary problems	❑	❑
Heart murmur	❑	❑	HIV/AIDS	❑	❑
Heart palpitations	❑	❑			

List any hospitalizations and/or previous surgeries, including dates:_____________________________

____

____

Are you allergic to or have you ever had any reaction to any medication or drug, local anesthetic, or

general anesthetic? If so, please list medication and type of reaction:___________________________

____

Are you taking any medications regularly (including over-the-counter pain medications, birth control pills, herbal products, vitamins, etc.)?

Currently taking:____

____

Previously taken:____

____

Are you now or have you ever taken a prescription or over-the-counter medication for allergies, stuffiness, difficulty breathing, sinus problems, or other nasal problems? If so, please list:

____

____

Do you currently smoke? ❑Yes ❑No

If yes, how many packs per day?_________________ How many years?_______________

Have you ever smoked? ❑Yes ❑No

If yes, how many packs per day?_________________ How many years?_______________

Do you drink alcohol? ❑Yes ❑No

If yes, how much?______________________________ How often?_____________________

Any other recreational drug use? ❑Yes ❑No

If yes, please describe:____

Have you ever had exposure to radiation? ❑Yes ❑No

Have you ever had exposure to excessive sun? ❑Yes ❑No

Do you or a family member have difficulty with prolonged bleeding when cut? ❑Yes ❑No

Do you or a family member bruise easily? ❑Yes ❑No

Do you have a problem with excessive scarring or keloid formation? ❑Yes ❑No

Have you or a family member ever had a problem with anesthesia? ❑Yes ❑No

Is your general health good? ❑Yes ❑No

Have you ever had psychiatric problems, a nervous breakdown, or been under the care of a psychiatrist, psychologist, or mental health counselor? ❑Yes ❑No

If you are a female patient:

Have you ever had a mammogram? ❑Yes ❑No

If yes, when was your last one?_______________ What were the results?__________________________

Have you ever had a breast exam? ❑Yes ❑No

If yes, when was your last one?_______________ What were the results?__________________________

Have you ever been pregnant? ❑Yes ❑No If yes, number of pregnancies?_________________

Have you had a cesarean section in the past? ❑Yes ❑No If yes, date(s)?_________________________

Any additional information you wish to provide to Dr. Naidu? ____________________ -______________

____

____

I acknowledge that all of the information I have provided is truthful and accurate to the best of my knowledge and belief, and that I have not withheld any information that may be necessary for my medical care.

Patient Signature: ____ Date: _____________________

Patient Name:____

Patient Financial Policy

- Consultation with Dr. Naidu is $75.00, and is due at the time of your consultation. This fee will be credited toward your surgical procedure if you book your surgery on the day of your consultation.
- Missed appointments are costly to us and to other patients, who could have been seen during the time we reserved for you. Cancellations are requested 24 hours prior to your scheduled appointment. Excessive abuse of missing scheduled appointments may result in discharge from the practice.
- All payments are due at the time services are rendered, unless prior arrangements have been made. We accept cash, checks (in state only), VISA, MasterCard, and Discover. There will be a $30.00 service charge on returned checks. Non-sufficient funds are subject to prosecution under the laws of the State of Florida.
- In the unlikely event of a dispute over financial renumeration for products or services already provided by Deepak K. Naidu, MD Plastic Surgery, I waive my right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines so that my health information may be shared with any third parties involved.
- Booking your surgical procedure requires a deposit of $500. This will be credited towards the surgeon fee.
- Payment of your outstanding balance is due at the preoperative exam or 2 weeks prior to the surgery date, whichever comes first. If full payment is not provided by 5 business days before your scheduled procedure, the surgery will be canceled.
- We consider your preoperative examination as a definitive final consultation prior to your operation. If your surgery is canceled at least 2 weeks before your surgery date, you will receive a full refund of your $500 deposit. Surgery canceled 2 weeks or less in advance will forfeit 100% of deposit. This is done to maintain the continuity of a very valuable and busy surgical schedule. We reserve a considerable amount of discretion in implementing this difficult but necessary policy.
- Hospitals and surgical centers will bill you directly for facility and anesthesia fees, and may require separate deposits. Please consult the financial policy of the hospital or surgical center regarding fees, deposits, refunds, cancellation fees, etc.
- Plastic surgery is an art, and occasionally revisions are necessary. If revision surgery is indicated within one year of the original procedure date, the surgeon fee may not be charged; however, facility and anesthesia fees will still apply for the procedure. Dr. Naidu reserves the right to determine if a revision is warranted, or if a separate, different procedure is being requested. We will do our very best to make sure you are satisfied with your surgical results.
- We do not have in-office payment plans, but we do refer our patients to CareCredit® at www.carecredit.com. We accept the following CareCredit® options: 6 months deferred interest, 24- or 36-month fixed payment plans.

I ____________________________ acknowledge that I read, understand, and agree to the Patient Financial Policy of Deepak K. Naidu, MD Plastic Surgery. I also agree that, if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for cost of collections.

Signature: ______________________________________ Date: _____________________

NOTICE OF PRIVACY PRACTICES

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

At Deepak K. Naidu, MD Plastic Surgery. we will always keep your health information secure and confidential. A new law, The Health Information Portability and Accountability Act or HIPAA, requires us to continue maintaining your privacy, while providing you with a copy of this notice.

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 we may involve or consult in your care is permitted under HIPAA.

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

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

We may use your information to contact you. For example, we may send you newsletters or other information by mail or email. We may also want to call and remind you about your appointments. If you are not home, with your permission, we may leave this information on your voicemail 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 your care, if you have given us permission. 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, and is still protected under HIPAA.

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, telephone number, or email you prefer. You have the right to transfer copies of your health information to another practice. We will mail your files for you. You also have the right to see and receive a copy of your health information, with a few exceptions. Please provide us a written request regarding the information you want to see. If you also would like a copy of your records for your personal file, we may charge you a reasonable fee for the printing of your files.

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

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, Elaine Adams at 813-434-1620.

This notice goes into effect as of January 30, 2012.

Acknowledgement
I have read a copy of Deepak K. Naidu, MD Plastic Surgery's Notice of Privacy Practices.

Date:_______________

Signed_______________________________________ Print Name_______________________________

Photography Authorization & Release

I understand that, as part of my care and treatment, photographs will be taken prior to and following procedures. I understand that this is part of the normal course of treatment, and that these photographs will become part of the medical record. They will be kept confidential, except for medical, educational, or scientific purposes, including but not limited to: medical journals and textbooks, scientific presentations and teaching courses, and for the purpose of informing the medical profession about plastic surgery procedures or techniques.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please initial in the boxes marked Yes or No for each item)

YES	NO	USAGE
		in office “photo albums” for prospective patients.
		in office seminars for prospective patients.
		on our website for prospective patients.
		in print or online advertisements.

I understand that such uses may also include marketing on behalf of Dr. Naidu, for which Dr. Naidu may receive direct or indirect remuneration. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the images may display features that identify me, especially with facial images. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must mail or deliver my written revocation to Dr. Naidu at 201 E. Kennedy Blvd Suite 410, Tampa, FL, 33602. A revocation shall not affect any release of information made prior to the revocation, based on this Authorization.

The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by applicable federal and/or state confidentiality rules.

A copy of this Authorization is as valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Naidu and/or Deepak K. Naidu, MD Plastic Surgery from all liability, including liability for negligence, that in any way arises out of:

> any and all rights that I may have or may have had in the images of me that I have authorized to be used and disclosed in this Authorization; and
>
> any claim that I may have or may have had relating to such use and disclosure of those images of me, including any claim for payment in connection with distribution or publication in any medium.

This Authorization is made as a voluntary contribution in the interests of public education, and I certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact Dr. Naidu's office at 813-434-1620.

Patient Name:_______________________________________

Patient Signature: ____________________________________ Date: __________________________________

Witness:____ Name:__________________________________

Patient – Provider Email Agreement

E-mail offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over scheduling office visits or telephone calls. Please remember that there are important differences: e-mail is not the same as calling our office, you will not know for certain when your message will be read, and you may not know if we are even available. However, we do believe that the ease of communication that e-mail affords is beneficial to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us using e-mail.

- E-mail is never, ever, appropriate for urgent or emergency problems. Please use the telephone or go to the Emergency Department for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail also include requests for prescription refills, referral or appointment scheduling requests, and billing or insurance questions.
- E-mails should not be used to communicate sensitive medical information, including information regarding sexually transmitted diseases, HIV/AIDS, mental health, developmental disabilities, or substance abuse.
- E-mail is not confidential. It is similar to sending a postcard through the mail. Staff may read and reply to your e-mail to respond to routine, non-clinical matters. If sending e-mails from work, your employer has a legal right to read your e-mail, if he or she chooses.
- E-mail will become a part of the medical record, when applicable; a copy may be added to your file.
- E-mail is not a substitute for seeing Dr. Naidu. If you think that you might need to be seen, please call and schedule an appointment.
- E-mails addressed to Dr. Naidu may be forwarded to the office staff for handling, if appropriate.

Finally, either myself or Dr. Naidu can revoke permission to use the e-mail system at any time.

Please initial one:

_____ I **DO** want to communicate with Dr. Naidu's office electronically. I have read the above information and understand the limitations of security on the information that is transmitted. I understand that my doctor may not legally be able to communicate with me electronically about my specific condition, if I live outside of the state in which my doctor is licensed.

_____I **DO NOT** want to communicate with Dr. Naidu's office electronically.

Name: ____

Signature: _____________________________________ Date: ____________________

E-mail Address: _________________________________