CASTELLON
PLASTIC SURGERY CENTER

Patient Registration Form

Date: _____ Patient Referred By: _____

PATIENT INFORMATION

Patient's Name: _____ Age: _____ Date of Birth: ____/____/_____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Preferred Contact: ☐ Cell ☐ Home
Social Security #: _____-____-_____ E-Mail: _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Spouse Name: _____ Phone Number: _____
Has this office ever seen or treated any member of your family? ☐ No ☐ Yes
If yes, whom: _____ _____
(Name) (Relationship)
Family Physician: _____ Phone: _____

EMPLOYMENT INFORMATION

Patient's Occupation: _____ Employer: _____
Work Address: _____
City: _____ State: _____ Zip: _____ Work Phone: _____

FINANCIAL INFORMATION

Person Financially Responsible: ☐ Patient ☐ Parent ☐ Spouse ☐ Other (see below)
If parent, or "other", please complete the following:

Primary Insurance Company_____
Insured Party: _____ Relation to Patient: _____
Social Security #: _____-____-_____ Date of Birth:_____
Employer: _____
Is this a Cobra contract: ☐ No ☐ Yes

Secondary Insurance Company_____
Insured Party_____ Relation to Patient: _____
Social Security #: _____-____-_____ Date of Birth_____
Employer: _____
Is this a Cobra contract: ☐ No ☐ Yes Group: _____

PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO GET YOUR PRIMARY CARE REFERRALS FOR YOUR VISITS WITH CASTELLON PLASTIC SURGERY CENTER. OTHERWISE YOU WILL BE RESPONSIBLE FOR THE BILL AT THE TIME OF THE VISIT.

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

PHARMACY INFORMATION

Name: _____ Location: _____ Phone: _____

REASON FOR CONSULT: _____
Have you consulted with any other doctors, including plastic surgeons, about this? ☐ No ☐ Yes
If yes, please list their names: _____

Patient Name:_____

MEDICAL HISTORY

Weight: _____ Height: _____ General Health: ☐ Good ☐ Fair ☐ Poor

If not "Good", please explain:

_____

For female patients only:

Age period began: _____ Number of pregnancies: _____ Did you breast feed: ☐ No ☐ Yes

Breast lump or discharge: ☐ No ☐ Yes Date of last mammogram: _____ Current bra size: _____

Drug Allergies: _____

List any medications you are taking, including non-prescription drugs, vitamins and herbals:

_____

Are you currently under the care of a Pain Management Physician? No Yes

If yes, please provide the name of that physician: _____

Past Medical History - Have you ever had the following: *please circle*

High Blood Pressure	No	Yes	Arthritis	No	Yes
Diabetes	No	Yes	Anemia	No	Yes
Heart disease	No	Yes	Tuberculosis	No	Yes
Stroke	No	Yes	Glaucoma	No	Yes
Asthma	No	Yes	Bleeding tendency	No	Yes
Cancer	No	Yes	Mitral Valve Prolapse	No	Yes
AIDS or HIV	No	Yes	Stomach Ulcer	No	Yes
Hepatitis	No	Yes	Kidney disease	No	Yes
Thyroid disease	No	Yes	GI disease	No	Yes

List any surgeries with dates: _____

_____

_____

Social History: Smoking (type & amt per day) _____ Quit date: _____ Alcohol (type & amt per day) _____

Family History: Has any blood relative ever had the following: *please circle*

Breast Cancer	No	Yes	Melanoma	No	Yes
Heart disease	No	Yes	Diabetes	No	Yes
Stroke	No	Yes	Bleeding disorder	No	Yes
Kidney disease	No	Yes	Lung disease	No	Yes

PERTINENT INFORMATION: *please circle.*

Have you ever reacted badly to being put to sleep for surgery?	No	Yes
Has any member of your family ever reacted badly to being put to sleep?	No	Yes
Have you required unusually large amounts of local anesthetics for medical or dental procedure?	No	Yes
Have you ever had a bad reaction to a local anesthetic (Novocain, etc.)?	No	Yes
Are you allergic to adhesive tape?	No	Yes
Have you or anyone in your family been diagnosed with Malignant Hyperthermina?	No	Yes
Are you a slow or poor healer?	No	Yes
Do you form large scars or keloids?	No	Yes
Do you have any skin diseases, hives, eczema or rash?	No	Yes
Do you have frequent infections or boils?	No	Yes
Have you taken steroid medications, cortisone or ACTH?	No	Yes
Do you have or have you had any significant emotional problems?	No	Yes
Have you ever had psychiatric care?	No	Yes
Have you ever been advised to see a psychiatrist?	No	Yes
Do you have high blood pressure?	No	Yes
Have you ever taken Redux or PhenFen?	No	Yes

REVIEW OF SYMPTOMS

Patient Name:_____

Do you have now or have you had within the past year:

General	Weight Gain/Loss	No	Yes
Eyes	Dry eyes	No	Yes
	Vision changes	No	Yes
ENT	Mouth sores	No	Yes
	Ringing in ears	No	Yes
	Sinus headaches	No	Yes
CV	Chest pain	No	Yes
	Rapid heart rate	No	Yes
	Swollen hands/feet	No	Yes
RES	Persistent cough	No	Yes
	Coughing blood	No	Yes
	Wheezing	No	Yes
	Shortness of breath with activity	No	Yes
	Difficulty breathing lying down	No	Yes
GI	Persistent diarrhea	No	Yes
	Bloody stools	No	Yes
	Nausea, vomiting	No	Yes
	Constipation	No	Yes
	Bloating/gas	No	Yes
	Abdominal pain	No	Yes
MSK	Joint or muscle pain	No	Yes
	Muscle weakness	No	Yes
Skin	Painful breasts	No	Yes
	Breast lumps	No	Yes
	Nipple discharge	No	Yes
HEME	Easy bleeding	No	Yes
	Easy bruising	No	Yes
ENDO	Night sweats	No	Yes
	Hot/Cold intolerance	No	Yes
LYMPH	Swollen lymph nodes	No	Yes
NEURO	Seizures	No	Yes
	Frequent headaches	No	Yes
	Dizziness	No	Yes
	Numbness	No	Yes
PSYCH	Depression	No	Yes
	Mood swings	No	Yes
	Sleep disturbances	No	Yes
	Bipolar Disorder	No	Yes
RENAL	Kidney Stones	No	Yes
	Bloody Urine	No	Yes

Do you have a gift certificate from Castellon Plastic Surgery Center you would like to use? Yes No

Financial Agreement

"Services that are performed that are paid with a credit card or debit card are not eligible for credit card challenge. I will not challenge credit card payments once the service is provided, as per this agreement. The practice encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I, the patient, agree that this non credit card challenge agreement is irrevocable." Reisman

X_____ _____

Signature of patient or parent if minor — Date

_____ _____

Witness — Title

Health Insurance Portability and Accountability Act (HIPAA)

Receipt of Privacy Practices

I have received my notice of privacy practices from the office of Castellon Plastic Surgery Center, Mauricio J. Castellon, MD, FACS.

X_____ _____

Signature of patient or parent if minor — Date

_____ _____

Witness — Title

PRACTICE INFORMATION & BILLING

If you would like to designate a person or persons to whom we may discuss billing information, appointment information or health care information we cannot do that without your written permission. This is in accordance with HIPAA guidelines. You may revoke this authorization at any time. And you may limit what information is to be shared for example, only billing or only health care. If you would like only certain information to be shared, please check below.

☐ **Billing Information** ☐ **Appointment Information** ☐ **Health Care Information**

I, _____ authorize Dr. Castellon and/or staff to discuss my information with _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X_____ _____

Signature of patient or parent if minor — Date

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PLASTIC SURGERY CENTER

Authorization to Release Medical Records

Patient Name: _____
Date of Birth: _____
Social Security #: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above-named patient.

Information to be released or accessed: ☐ **Billing Information** ☐ **Appointment Information** ☐ **Medical Records**
Information is to be used for:

_____

The information designated above may be released,
TO:

_____
Doctor, Hospital, Attorney, Insurance Company, Self, etc.

_____
Street Address

_____
City, State, ZIP

_____
Telephone Number Fax Number

FROM:

_____
Doctor, Hospital, Attorney, Insurance Company, Self, etc.

_____
Street Address

_____
City, State, ZIP

_____
Telephone Number Fax Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used of disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has be taken in reliance upon this authorization. This authorization will expire (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature: _____ Date: _____
Patient or Legally Authorized Representative

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship to Patient

CASTELLON
PLASTIC SURGERY CENTER

Patient Photographic Authorization and Release

I authorize, permit, and allow **MAURICIO J. CASTELLON, M.D., FACS**, or members of his staff, the use of any photographs of myself for medical records "in chart" only.
Medical photographs will be taken before, during and after a surgical procedure or treatment. These pictures will be used for your "medical chart" only but **MUST** be taken for reference before and after procedure(s) as well as the protection of MD and the patient. Please sign below to confirm you understand and consent to "in chart" only photographs.

X_____ _____
Signature of patient or parent if minor — Date

_____ _____
Patient Name — Date of Birth

_____ _____
Witness — Title

I authorize, permit, and allow **MAURICIO J. CASTELLON, M.D., FACS**, or members of his staff, the use of any photographs and/or videos of myself concerning my plastic surgery treatments at the discretion of Dr. Castellon, or members of his staff, for media presentations or for any purpose which Dr. Castellon deems appropriate to inform the medical profession or the general public about plastic surgery methods. The media may include, but are not limited to: medical journals, textbooks, pamphlets, newspapers, magazines, social media, website and television. Presentations may be given to various groups locally, nationally, or internationally for education purposes.

I understand that I will not be identified by name in any publication. I also understand that in some circumstances the photographs and/or videos may portray features which shall make my identity recognizable. I release and discharge Dr. Castellon and all parties acting under his license and authority from all rights that I may have in the photographs and/or videos and from any claim that I may have relating to such use and publication of the photographs and/or videos. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above authorization and release and fully understand its terms.

I hereby declare that I am eighteen years of age or older, or the patient's legal guardian, and I have the full right to make this release and to grant herein granted.

_____ _____
Signature of patient or parent if minor — Date

_____ _____
Patient Name — Date of Birth

_____ _____
Witness — Title

Mauricio J. Castellon, MD, FACS | 1499 S. Harbor City Blvd, Ste 301, Melbourne, FL 32901 | Tel: 321.729.9909 Fax: 321.728.0288 | www.drcastellon.com

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Payment Policy

Thank you for choosing us as your plastic surgery provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Credit/Debit card policy. "Services that are performed that are paid with a credit card or debit card are not eligible for credit card challenge. I will not challenge credit card payments once the service is provided, as per this agreement. The practice encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I, the patient, agree that this non credit card challenge agreement is irrevocable." Reisman

9. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

10. FMLA/Disability Forms. There is a $50 fee to fill out FMLA, Disability, or any other forms. Payment will be due before the completed forms are returned to you.

11. Cosmetic Consultation Fee. There is a $50 scheduling fee for new cosmetic surgery consultations with Dr. Castellon. This fee is non-refundable and services are considered rendered upon scheduling the appointment.

Our practice is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. **I have read and understand the payment policy and agree to abide by its guidelines:**

_____ _____

Signature of patient or responsible party **Date** **Signature of witness** **Date**