HANEMANN
PLASTIC SURGERY

Name: _____ Date: _____

What Procedure are you interested in? _____

Patient Height: _____ Patient Weight: _____

HABITS

Smoke: Y N Amount:_____ Coffee/Tea/Soda: Y N Amount: _____
Alcohol: Y N Amount:_____ Daily Exercise: Y N Amount:_____

Medications (list dose or number of pills per day)

Prescription Drugs

_____
_____
_____

Non-Prescription (Vitamins; Herbs)

_____
_____
_____

Regular Aspirin Use: Y N Dosage & Frequency:_____
NSA (Advil, Motrin, Ibuprofen): Y N Dosage & Frequency:_____
***Drug Allergy:** Y N List Drug(s) & type of reaction:_____

Latex Allergy: Y N Tape Allergy: Y N

Family History

Have any blood relatives ever had any of the following:

Abnormal Bleeding:	Y	N	Coronary Surgery:	Y	N	Kidney Disease:	Y	N
Abnormal Clotting:	Y	N	Diabetes:	Y	N	Tuberculosis:	Y	N
Anesthetic Problems:	Y	N	Heart Attack:	Y	N	Other Illness:	Y	N
Cancer:	Y	N	Hypertension:	Y	N			

Please describe questions with "Yes" answer :_____

Personal History

Have you ever had any of the following:

Cancer:	Y	N	Sleep Apnea:	Y	N	Chest Pains/Angina :	Y	N	Abnormal Clotting:	Y	N
Recent Fever:	Y	N	Hear Aids:	Y	N	Asthma:	Y	N	Blood Thinner Medication:	Y	N
Weight Change:	Y	N	Dentures:	Y	N	Shortness of breath:	Y	N	Diabetes:	Y	N
Contact Lenses:	Y	N	High Blood Pressure:	Y	N	Hepatitis:	Y	N	Anxiety:	Y	N
Eye Glasses:	Y	N	Heart Attack:	Y	N	Acid Reflux:	Y	N	Depression:	Y	N
Dry Eyes:	Y	N	Abnormal Heart Rhythm:	Y	N	Anemia:	Y	N	Fainting Spell:	Y	N
Snoring:	Y	N	Atrial fibrillation:	Y	N	Abnormal Bleeding:	Y	N	Weakness/Numbness:	Y	N
Arthritis:	Y	N	Osteoporosis:	Y	N	Other:	Y	N			

Please describe questions with "Yes" answer:_____

Have you ever received a Transfusion? Y N If Yes explain:_____
Have you ever been tested for HIV? Y N If Yes, What year_____ Test results: Pos Neg
Previous Surgery: Type of Procedure & Year:_____

Indicate the Type(s) of anesthesia received in the past. List any complications/reactions you experienced:

Local Anesthesia: Complication/Reaction:_____
General Anesthesia: Complication/Reaction:_____
Spinal/Epidural: Complication/Reaction:_____

Primary Care Physician (Name):_____ (Phone):_____ Date Last Seen:_____

For Women Only:

Number of Pregnancies:_____ Number of Children:_____ Breast Feed?_____ How Long?_____ Last Period:_____

Authorization for Disclosure of Information

I authorize Dr. Hanemann to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment to those individuals who, in Dr. Hanemann's sole determination, are required to receive such information *for the purpose of medical treatment, medical quality assurance and peer review*.

Patient Signature:_____ **Date:**_____

HANEMANN

PLASTIC SURGERY

Patient Information

Date:_____ Social Security No.:_____ Referred By:_____

Patient's Name:_____ Date of Birth:_____ Age:_____

Marital Status: S M W D Sep. Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Home Telephone:_____ Cell #:_____ Work Telephone:_____

Patient's Employer:_____ City:_____ State:_____ Zip:_____

Email Address:_____

Spouse's/Parent's Name:_____ SS#:_____ Date of Birth:_____

Spouse's Telephone:_____ Cell#:_____ Work Telephone:_____

Spouse's/Parent's Employer:_____ Occupation:_____

Employer's Address:_____ City:_____ State:_____ Zip:_____

Insurance Information

Name of Insurance Co.:_____ Contract #:_____ Group No.:_____

Name of Insured as it Appears on Card:_____ Date of Birth:_____ SS#:_____

Name of Secondary Insurance Co.:_____ Contract #:_____ Group #_____

Name of Insured as it Appears on Card:_____ Date of Birth:_____ SS#:_____

In Case of Emergency Notify (other than Responsible Party)

Name:_____ Phone:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Explanation of Payment Policy and Insurance Filing Procedures

I hereby authorize Hanemann Plastic Surgery to release any and all information acquired in my examination and treatment to my insurer listed above. If I am covered by Blue Cross, Medicare, and/or Medicaid I will furnish my insurance card and signature. If I am covered by other insurance, I will furnish the necessary forms to this office.

I hereby assign and authorize payment directly to the above named clinic. Any medical and surgical benefits otherwise payable to me, should an insurance payment be received that is less than the physician's usual charge for the services provided, I will be responsible for the difference.

I also agree to pay all cost of collection including, but not limited to reasonable attorney's fees, and waiver all claims of exemption under the law of the state of Louisiana. There is a $25 fee charged for all checks returned for insufficient funds.

I authorize treatment by Hanemann Plastic Surgery physicians and personnel.
****Form must be signed and dated by patient or responsible party.**

Date:_____ Signature:_____

Michael S. Hanemann Jr., MD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses And Disclosures We May Make Without Written Authorization**. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

To avoid a serious threat to your health or safety or the health or safety of others.

As required by state or federal law such as reporting abuse, neglect or certain other events.
As allowed by workers compensation laws for use in workers compensation proceedings.

For certain public health activities such as reporting certain diseases.

For certain public health oversight activities such as audits, investigations, or licensure actions.

In response to a court order, warrant or subpoena in judicial or administrative proceedings.

For certain specialized government functions such as the military or correctional institutions.

For research purposes if certain conditions are satisfied.

In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.

To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. **Disclosures We May Make Unless You Object**. Unless you instruct us otherwise, we may disclose your information as described below.

To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition, and location in our facility. We may also disclosure your religious affiliation to clergy.

3. **Uses and Disclosures With Your Written Authorization**. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. **Your Rights Concerning Your Protected Health Information**. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a

reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Changes To This Notice**. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. **Complaints**. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. **Contact Information**. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer: Michael S. Hanemann Jr. MD
Phone: 225-766-2166
Address: 5233 Dijon Dr.
Baton Rouge, LA 70808
E-mail: hanemannmd@yahoo.com

8. **Effective Date**. This Notice is effective September 23rd, 2013

Michael S. Hanemann Jr., MD
5233 Dijon Dr.
Baton Rouge, LA 70808
225-766-2166

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have reviewed a copy of Michael S. Hanemann Jr., M.D. P.A's Revised **Notice of Privacy Practices**.

_____ _____

PATIENT or GUARDIAN SIGNATURE **DATE**

_____

PATIENT NAME (PLEASE PRINT)

ASSIGNMENT OF BENEFITS (AOB)

I, the undersigned, do hereby authorize the assignment of all medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, Worker's Compensation insurance, and any liability settlement payments to Michael S. Hanemann, Jr., M.D.

_____ Initial I, the undersigned, do acknowledge that if my insurance contract requires a co-payment, there will be a co-payment due. I hereby authorize Michael S. Hanemann, Jr., M.D. to release all information necessary to secure the payment for said benefits. I understand that the benefits represented to me are not a guarantee of payment by my insurance company. I acknowledge I am ultimately responsible for all charges incurred and any balance remaining after insurance has paid.

_____ Initial If your injury is work related, we will file charges with your employer's insurance carrier. We will accept reimbursement from the carrier as payment in full for the treatment you receive. If your employer does not accept responsibility for your injury, you will be asked to pay for the charges you incur at our office.

_____ Initial If your injury resulted in a litigation process, we must receive a letter of representation from the attorney who is representing your claim. Payment in full is due three weeks prior to surgery.

_____ Initial If you are a Medicare patient, we will file claims for your services directly with Medicare and any supplement insurance that you may have. If you do not have supplemental insurance you will be responsible for paying any unmet deductible and the 20% co-insurance.

WAIVER OF LIABILITY

_____ Initial I have been informed by the office staff and fully understand that the services performed, or the supplies received, may not be covered by my insurance carrier or the secondary insurance carrier, regardless of whom files for payment. I realize that anything not covered by my insurance company will be my full responsibility.

_____

Signature Patient/Parent or Legal Guardian

_____

Print Patient's Name

_____

Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have been offered the option to receive and review a copy of Michael S. Hanemann, Jr., M.D.'s **Notice of Privacy Practices**.

_____ _____

PATIENT NAME (PLEASE PRINT) **DATE**

_____

PATIENT SIGNATURE

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

Patient Name: _____
PLEASE PRINT

Do we have your permission to:

Call you/send mail to you at **home?** Y____ N ____

If Yes, may we leave the following information on your **home** answering machine/voice mail**:**

Appointment information Y____ N ____

Billing Information Y____ N ____

Call you at **work?** Y____ N ____

If Yes, may we leave the following information on your work answering machine/voice mail:

Appointment information Y____ N ____

Billing Information Y____ N ____

I give my permission to share appointment information with the person(s) listed below

Name:_____

Relationship: _____

I gave my permission to share billing information with the person(s) listed below:

Name:_____

Relationship: _____

_____ _____

PATIENT SIGNATURE DATE