RICHARD CASHIO, M.D.
Plastic Surgery

New Patient Forms

Patient Demographic Information

Name____
Last First Middle

Address ____

____ Apt No. ______________

City________________________________ State________ Zip______________

Home Phone______________________ Cell______________________ Work______________________

Any restrictions for contacting you? ☐Yes ☐No Email address ______________________________

How did you hear about our office? ☐ Facebook ☐ Our Website☐ Physician ☐ Other ______________________

Age_____ Birth Date ____ / ____ / ____ Social Security Number ____ – ____ – ____ ☐ Female ☐ Male

Marital Status ______________________ Referred by______________________ Family Physician ______________________

Cardiologist______________________________ Referring Physician ______________________________

Employer______________________________ Occupation ______________________________

Work Phone ______________________________ Ext ______ Is it okay to contact you at work? __ Yes __No

Emergency Contact ______________________________ Relationship to Patient ______________________

Home Phone______________________ Work Phone______________________ Other Phone______________________

Primary Health Insurance Company ______________________________________

Policy # ______________________ Group #______________________ Ins. Phone______________________

Insured Name ______________________ Date of Birth______________________ Employer______________________

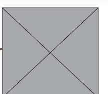
Secondary Health Insurance ______________________________________

Policy # ______________________ Group #______________________ Ins. Phone______________________

I understand that the office visit charges are payable on the day service is rendered. I authorize Richard Cashio Jr., M.D. to bill my insurance company. Regardless of insurance coverage I am responsible for all bills being paid in a timely manner. I understand that my contract is between Richard Cashio Jr., M.D. and myself.

No show/Surgery Cancellation Policy- I understand if I schedule a surgery and do not show for scheduled surgery I will be charged a fee of $50.00. This fee will not be charged if the patient calls the office and reschedules office visit or surgery within 48 hours of scheduled procedure. If there are any questions regarding this policy please speak to the office staff.

Signature ______________________________________ Date ______________________



RICHARD CASHIO, M.D.
Plastic Surgery

DATE ____________________

PATIENT NAME ____________________

Patient Medical History

Family Medical History: (Please note Mother, Father, Brother or Sister next to each item)

☐ Hypertension ___ ☐ Kidney Disease ___ ☐ Colon Cancer ___ ☐ Skin Cancer ___ ☐ Stroke ___ ☐ Ulcerative Colitis/Crohn's Disease ___

☐ Heart Disease ___ ☐ Liver Disease ___ ☐ Breast Cancer ___ ☐ Ovarian Cancer ___ ☐ Sickle Cell Anemia ___ ☐ Diabetes ___

☐ Lung Disease ___ ☐ Thyroid Disease ___ ☐ Lung Cancer ___ ☐ Uterine Cancer ___ ☐ Bleeding Disorder ___ ☐ None

Medical Problems: (Check ALL that apply)

General Symptoms

☐ Fever ☐ Chills ☐ Nausea/Vomiting ☐ Easily Fatigued ☐ Recent Weight Loss ____________ lbs ☐None

Head and Neck

☐ Headaches ☐ Dizziness ☐ Neck Masses ☐ Facial Drooping ☐ Previous Head Injury ☐ Sleep Apnea ☐ None

Eyes and Ears

☐ Blurring ☐ Double Vision ☐ Hearing Loss ☐ Sinus Problems ☐ Glaucoma ☐ Temporary Blindness ☐ None

Endocrine

☐ Heat Intolerance ☐ Cold Intolerance ☐ Infertility ☐ Irregular Menses ☐Thyroid Enlargement/Pain ☐ None

Breasts

☐ Pain ☐ Tenderness ☐ Lumps ☐ Nipple Discharge ☐ Asymmetry ☐ None

Respiratory

☐ Bronchitis ☐ Asthma ☐ Shortness of Breath ☐ Chronic Cough ☐ Lung Blood Clots ☐ Use of Home Oxygen ☐None

Cardiovascular

☐ Chest Pain ☐ Heart Murmur ☐ Heart Failure ☐ Previous Heart Attack ☐ Claudication (pain in legs when walking) ☐ None

Gastrointestinal

☐ Reflux (heartburn) ☐ Bleeding Ulcers ☐ Blood in Stool ☐ Diarrhea ☐ Constipation ☐ Changes in Stool ☐ None

Genitourinary

☐ Painful Urination ☐ Groin Hernias ☐ Incontinence ☐ Blood in Urine ☐ Frequent Urination ☐ Flank or Pubic Pain ☐ None

Hematologic/Lymphatic

☐ Bleeding Disorder ☐ Anemia ☐ Blood Clots ☐ Easy Bruising ☐ Previous Transfusions ☐ Enlarged Lymph Node ☐ None

Musculoskeletal/Neurologic

☐ Joint Pain ☐ Joint Swelling ☐ Seizures ☐ Tremors ☐ Weakness/Paralysis ☐ Syncope (fainting spells) ☐None

Psychiatric

☐ Depression ☐ Mood Changes ☐ Nervousness ☐ Sleep Disturbances ☐ Bipolar Disorder ☐ None

Skin

☐ New Lesion ☐ Changing Lesion ☐ Rash ☐ Bleeding Lesion ☐ Itchy Lesion ☐ None

RICHARD CASHIO, M.D.
Plastic Surgery

DATE ______________________________

PATIENT NAME ______________________________

DOB ______ AGE ______ HEIGHT ______ WEIGHT ______

Patient Medical History (Continued)

Reason For Visit ______________________________

Primary Care Physician ______________________________

Referring Physician (if applicable) ______________________________ Advance Directive ☐ Yes ☐ No

Medical Problems	Treating Physician

Previous Surgical Procedures	Surgeon	Month/Year

Current Medications (dose and frequency — continue on back as necessary)	Ordering Physician
Do you take Aspirin or any blood thinners? ☐ Yes ☐ No	

List all medication allergies

____

Social History

Tobacco – packs per day: How long? Quit/When? Alcohol – number of drinks per day/week:

Do you or have you used illicit drugs ☐ Yes ☐ No Which drugs? How long and how much?

RICHARD CASHIO, M.D.
Plastic Surgery

PATIENT NAME ______________________________

DOB ______________________________

SS# ______________________________

Patient Consent and Authorization

CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, do hereby present myself (or the patient) for care or treatment at the office of Richard V. Cashio, Jr. M.D., and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of my physician and it is the responsibility of the practice and its staff to carry out the instructions of such physician. I understand that the physician furnishing services to me is an employee of the hospital, however, other services such as radiology, laboratory, and pathology may be provided by independent practitioners. All physicians expect payment in full upon receipt of a bill and I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcomes of care or treatment if I do not follow the care, service or treatment plan.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Richard V. Cashio, Jr. M.D., the physician accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Richard V. Cashio, Jr. M.D. for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent, or legal guardian, do hereby authorize Richard V. Cashio, Jr. M.D., the practice's officers and his employees, to release to any third party payor (such as an insurance company or government agency; Example: Blue Cross/ Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AIDS related complex) treatment information and records, in accordance with the policy of Richard V. Cashio, Jr. M.D. and any applicable State or Federal Statues, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release Richard V. Cashio, Jr. M.D. from all liability that may arise from the release of the information requested.

FLORIDA LAW: Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

FOR MEDICARE AND MEDICAID PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Richard V. Cashio, Jr. M.D. I understand that I am responsible for any health insurance deductibles and coinsurance.

____________ (initials) **MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES:** Medicare does not cover some inpatient, outpatient, and emergency services. Items not covered include,but are not limited to, medications typically self-administered, annual testing and physicals.

ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY): My signature only acknowledges my receipt of this message from Richard V. Cashio Jr., M.D. as dated below and does not waive any of my right to request a review or make me liable for any payment.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH MAY BE ON FILE AT THE OFFICE OF RICHARD V. CASHIO, JR. M.D.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to pay the account of Richard V. Cashio, Jr. M.D. in accordance with the regular rates and terms of the physicians. The undersigned will pay all costs and expenses including reasonable collection fees (which may include agency, attorney, interest or court fees) incurred or paid by the hospital or Richard V. Cashio, Jr. M.D. in the collection of this obligation by suit or otherwise. Furthermore, I hereby authorize Richard V. Cashio, Jr. M.D. and/or his successor/designee as my attorney-in-fact to take measures in my behalf as may be necessary to collect such claims or insurance proceeds and to endorse any checks made payable to me for such claims or insurance proceeds by signing my name as attorney-in-fact for me to any such checks and/or insurance claim forms.

Patient's Signature ______________________________

Patient's Representative/Policy Holder or Spouse ______________________________ Relationship ______________

Witness ______________________________ Date ______________

Patient unable to sign due to: ______________________________

RICHARD CASHIO, M.D.
Plastic Surgery

PATIENT NAME ______________________________

DOB ______________________________

Patient Medical Release

You may release my medical information to the following:

Name ______________________ Relationship ______________________

Phone ______________________

Name ______________________ Relationship ______________________

Phone ______________________

Name ______________________ Relationship ______________________

Phone ______________________

Name ______________________ Relationship ______________________

Phone ______________________

Signature of Patient ______________________ Date ______________________

RICHARD CASHIO, M.D.
Plastic Surgery

PATIENT NAME ______________________________

DOB ______________________________

Photographic, Video and Computer Imaging Informed Consent

I ______________________________, hereby grant permission to Richard V. Cashio Jr., M.D., for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing, and/or certifying purposes by The American Board of Plastic Surgery, Inc.. I authorize these photographs and/or images be used in prospective patient education and in any advertising. I understand that complete confidentiality of my identity is assured.

PATIENT COMPUTING IMAGING

In the course of consultation and discussion with certified medical professionals, I may have been shown or may be shown or provided with certain brochures, pictures of actual patients or pictures on an electronic computer imaging device. I do understand that those pictures and any alterations of such pictures seen are solely for the purpose of illustration, discussion, and to provide improved communication with medical professionals. I do understand that the outcome of any type of surgical procedure is directly related to my individual characteristics and health. I further understand and acknowledge that because of the obvious significant differences in how living tissues react to surgery, there may be no relationship between the electronic images created, an my actual final surgical result. Use of computer imaging system offers an opportunity for me to discuss my desires and to allow improved communication with the medial staff.

I certify my understanding that there is NO WARRANTY, expressed or suggested, as to my own final appearance after elective surgery by the use of these photographic and electronic images.

Signed ______________________________ Date ______________________________

(Patient or legal Guardian, if patient is a minor child)

Signed ______________________________ Date ______________________________

(Witness)

Signed ______________________________ Date ______________________________

(Physician)

Exceptions/Exclusions ______________________________

HIPAA Notice of Patient Privacy Practices

Effective Date: April 1, 2003

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.

If you have any questions about his notice, please contact the Office Manager

Section A: Who Will Follow This Notice?
This Notice describes Richard Cashio MD Plastic Surgery P.L.

• Any health care professional authorized to enter information into your medical chart.
• All departments and units of Richard Cashio MD Plastic Surgery
• Any member of a volunteer group we allow to help you while you are in our offices
• All Employees, staff and other personnel of Richard Cashio MD Plastic Surgery

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or practice operations purposes described in this notice. This list may not reflect recent acquisitions or sales of entities, sites, or locations.

Section B: Our Pledge Regarding Medical Information
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the services you receive while under our care. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or maintained by Richard Cashio MD Plastic Surgery.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe our rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:
• Use our best efforts to keep medical information that identifies you private;
• Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
• Follow the terms of the notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You
The following categories describe different way that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Richard Cashio MD Plastic Surgery personnel who are involved in taking care of you in the office, an outpatient setting or the hospital. Different departments of Richard Cashio MD Plastic Surgery also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside Richard Cashio MD Plastic Surgery who may be involved in your medical care after you leave Richard Cashio MD Plastic Surgery, such as family members, clergy or others we use to provide services that are part of your care.

Payment: We may use and disclose medical information about you so that the treatment and services you receive at Richard Cashio MD Plastic Surgery may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment/procedures you received at Richard Cashio MD Plastic Surgery so your health plan will pay us or reimburse you for the treatment/procedures. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose your medical information to your credit card company and/or our attorney to provide proof of treatment if a dispute is made with your credit card company.

Health Care Operations: We may use and disclose medical information about you for Richard Cashio MD Plastic Surgery's operation. These uses and disclosures are necessary to run Richard Cashio MD Plastic Surgery and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services Richard Cashio MD Plastic Surgery should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other Richard Cashio MD Plastic Surgery personnel for review and learning purposes. We may also combine the medical information we have with medical information from other entities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the practice.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities: We may use information about you to contact you in an effort to raise money for Richard Cashio MD Plastic Surgery and its operations. We may disclose information to a foundation related to Richard Cashio MD Plastic Surgery so that foundation may contact you to raise money for Richard Cashio MD Plastic Surgery. We would release only contact information, such as your name, address and phone number and the dates you received treatment or services at Richard Cashio MD Plastic Surgery. If you do not want Richard Cashio MD Plastic Surgery to contact you for fund raising efforts, you must notify us in writing.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave Richard Cashio MD Plastic Surgery. We will generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Section D: Special Situations

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injury or illness.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized bylaw. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime if, under certain limited cumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at Richard Cashio MD Plastic Surgery; and

• In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.**Coroners, Medical Examiners and Funeral Directors:** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of Richard Cashio MD Plastic Surgery to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, or authorized persons or foreign heads of state who conduct special investigation.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution or the law enforcement official.

Section E: Your Rights Regarding Medical Information About You
You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy some of the medical information that may be used to make decisions about your card. Usually, this includes medical and billing records, but does no include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy medical information in certain circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by Richard Cashio MD Plastic Surgery will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Richard Cashio MD Plastic Surgery. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information the:
• Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
• Is not part of the medical information kept by or for the practice
• Is not part of the information which you would be permitted to inspect and copy; or
• Is accurate and complete

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2002. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operation. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both: and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise the above rights, please contact the office manager or Director of Practice Operations to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our offices. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you return for treatment or health care services, we will offer you a copy of the current notice in effect.

Section G: Complaints
If you believe your privacy rights have been violated, you may file a complaint with Florida Hospital-Memorial Division, Attn: Office Manager 61 Memorial Medical Parkway, Suite 2802 Palm Coast, FL 32164, or with the Secretary of the Department of Health and Human Services at Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsythe St., S.W., Atlanta, GA 30303-8909. Voice Phone (404) 562-7886, Fax (404) 562-7881. TDD (404) 331-2867. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

RICHARD CASHIO, M.D.
Plastic Surgery

Acknowledgment of Receipt

By signing this Written Acknowledgment of Richard Cashio MD Plastic Surgery P.L. Notice of Patient Privacy Practices (“Acknowledgment”), I hereby expressly acknowledge my receipt of Notice of Patient Privacy Practices.

____
Patient, or Legal Representative, Signature

____
Printed Patient, or Legal Representative, Name (or label)

____
Date

Acknowledgment NOT obtained because:

Patient, or legal representative, declined Notice of Patient Privacy Practices;

Other (briefly describe) ________________________________

____

____
Employee Signature

____
Employee Printed Name

____
Date

61 Memorial Medical Parkway, Suite 2802, Palm Coast, Florida 32164 | 386.313.1982 | www. RichardCashioPlasticSurgery.com

Dr. Richard Cashio is Board Certified by the American Board of Plastic Surgery.

RICHARD CASHIO, M.D.
Plastic Surgery

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name ______________________________ Date of Birth ______________________________

Physician ______________________________ Medical Record No. ______________________________

I am entitled to Medicare benefits: ☐ No – Return form to the front desk ☐ Yes – proceed to Section I

Section I

Select the ONE statement that is true for you:

☐I am over 65 and married… Proceed to section II

☐ I am over 65 and not married (includes widowed)
… Proceed to section III

☐ I am under 65, Disabled and currently employed
… Proceed to section IV

☐ I am under 65, Disabled and unemployed
Disability Date: ____________________ … Proceed to section IV

Section II

Select the one statement that is true for you:

☐ My spouse and I are both fully retired
The date of my retirement: ____________________
The date of my spouse's retirement: ____________________
… Proceed to section V

☐ I work full or part-time (my spouse is retired) for a company with:
☐ LESS than 20 employees… Proceed to section V
☐ MORE than 20 employees… Proceed to section IV

☐ My spouse works full or part-time (I am retired) for a company with:
☐ LESS than 20 employees… Proceed to section V
☐ MORE than 20 employees… Proceed to section IV

Section III

Select the one statement that is true for you:

☐ I am fully retired…
Date of my retirement: ____________________
… Proceed to section V

☐ I work full or part-time for a company with:
☐ LESS than 20 employees… Proceed to section V
☐ MORE than 20 employees… Proceed to section IV

Section IV

Select the one statement that is true for you: *(This does not apply to supplemental plans or employer plans offered during retirement.)*

I have health care coverage through my employer: ☐No ☐Yes

I have health care coverage through someone else: ☐ No ☐ Yes

If YES, list name of guardian and relationship:

____

… Proceed to Section V

Section V

Is this visit related to an injury due to a fall?

☐ YES – Did the accident occur in:
◊ your home ◊ public location ◊other
Date of Accident:____________________

OR

Is this visit related to an illness/injury due to an automobile accident?

☐Yes – Date of Accident:____________________

Return to front desk and present your automobile insurance card.

☐ No… Proceed to Section VI

Section VI

Indicate which statements apply to you.

☐ I am entitled to Worker's Compensation for this service.

☐ I am entitled to Black Lung benefits.

☐ I am entitled VA benefits.

☐ I am entitled ESRD benefits.

☐ I am entitled COBRA benefits.

☐ I am entitled to other Federal benefits. (UMWA, Gov't research programs, Hospice) Please explain: ____________________
____
____

Patient Signature ______________________________ Date ____________________

Staff Signature ______________________________ Date ____________________

61 Memorial Medical Parkway, Suite 2802, Palm Coast, Florida 32164 | 386.313.1982 | www. RichardCashioPlasticSurgery.com

Dr. Richard Cashio is Board Certified by the American Board of Plastic Surgery.

RICHARD CASHIO, M.D.
Plastic Surgery

PATIENT NAME ______________________________

DOB ______________________________

MSP Questionnaire Review Signature Form (Continued)

Appointment Date	**To be completed by the patient at each appointment:** I have reviewed the information on the Medicare Secondary Payor Questionnaire that I completed at a previous visit. I attest that all information is correct or I have indicated changes to my health insurance coverage to the best of my knowledge.	**This section is to be completed by the medical practice personnel only.** I have obtained a legible copy of each insurance card and a driver's license. I have determined whether Medicare is the primary or secondary payer for today's visit.

Please return this form, your insurance cards and your drivers licenses to the front desk personnel.

RICHARD CASHIO, M.D.
Plastic Surgery

Coinsurance Notice to Medicare Patients

Dear Medicare Patient:

We would like to take this opportunity to inform you that this physician practice is a provider-based clinic. This provides increased continuity of care and improved reimbursements, thus allowing Florida Hospital Flagler to continue to provide quality medical care and services.

Your visits to this office are billed by a Central Billing Office, which is a service of Florida Hospital Flagler. You will be registered in this office as an outpatient of Florida Hospital Flagler. Any services you receive will still be billed by Florida Hospital Flagler to Medicare and any secondary insurance companies. If you have any questions regarding your service provided at this office, please call 386-671-4500 to speak with a Billing Representative.

In accordance with Medicare's laws and regulations, you will incur a co-insurance liability to Florida Hospital Flagler that you would not have incurred if this office were not provider-based. Your actual co-insurance liability will depend upon the actual services furnished by this office. For example, co-insurance balances for an average follow up visit for an established patient (99213) would be approximately $12.06 for the hospital charge and $8.32 for the physician charge.

After the hospital and physician have been reimbursed by Medicare, co-insurance balances will be billed to secondary insurers. If co-insurance is still owed to Florida Hospital Flagler and/or physician, you will be billed. You may request an estimate of this amount of co-insurance liability by contacting your physician's office.

I have read the foregoing and understand that I will incur a liability to Florida Hospital Flagler for Medicare coinsurance as permitted by law.

____ ____________________
Signature of Patient or Authorized Representative Date

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Dr. Richard Cashio is Board Certified by the American Board of Plastic Surgery.