



BALTIMORE CENTER FOR
FACIAL PLASTIC SURGERY^{LLC}

6535 NORTH CHARLES STREET
PAVILION NORTH SUITE #250
BALTIMORE, MARYLAND 21204
410.828.4123

Welcome to the Baltimore Center for Facial Plastic Surgery!

Please complete the following forms and bring them to your appointment. Completion of this information in advance of your visit plus arriving 15 minutes prior to your scheduled appointment time will speed your check in process. Please have the forms completed before you arrive, or you may not be seen on time.

If you would like us to bill your insurance for the visit and your insurance company requires a referral from your primary care physician, please be sure you bring the referral form with you. If your referral is not in our office at the time of your scheduled visit, you might not be seen that day and it is likely you will need to reschedule.

If you have never been to the Physicians Pavilion North on the GBMC campus, please refer to our website for a map and feel free to call us for directions. If you must cancel your appointment and reschedule, we ask you do so at least 24 hours prior to your appointment as a courtesy.

We look forward to seeing you!

RANDOLPH B. CAPONE, MD, FACS
DIRECTOR



BALTIMORE CENTER FOR
FACIAL PLASTIC SURGERY

PATIENT INFORMATION

Name	DOB	SS#
Address		
City	State	Zip
Phone (home)	(work)	(cell)
E-mail Address		
Emergency Contact		Phone #
Referring MD Name		Phone #
Primary MD Name (if different)		Phone #

HEALTH INSURANCE INFORMATION

Primary Policy Holder		
Relationship to patient		
Insurance Co.		
Policy#		Group#
SS#	DOB	Effective Date

Secondary Policy Holder		
Relationship to patient		
Insurance Co.		
Policy #		Group #
SS#	DOB	Effective Date

ASSIGNMENT OF BENEFITS

I understand that I am responsible for the accuracy of the information on this form. If for any reason payment cannot be received from my insurance company(s) or coverage of services is denied, I will be directly responsible for all fees incurred with the Baltimore Center for Facial Plastic Surgery, LLC and/or Randolph B. Capone, MD. I authorize payment of medical benefits to the provider for all services rendered if the provider is a participating provider with my insurance. I also authorize the release of any medical or other information necessary for the processing of claims.

AUTHORIZED SIGNATURE

DATE



BALTIMORE CENTER FOR
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RANDOLPH B. CAPONE, MD, FACS
DIRECTOR

Name:

Appointment Date:

Aesthetic Interests (please check all that apply):

- Facial Rejuvenation and Enhancement (eyelids, face, neck, brow)
- Injectables (Botox™, Dysport™, Restylane™, Perlane™, Radiesse™, Fat Transfer)
- Cosmetic Consultation Skin Care Lip Augmentation
- Laser Hair Removal Hair Restoration Skin Cancer
- Nasal Deformity Chin Surgery Ear Deformity
- Nasal Obstruction / Congestion / Sleep Apnea Scar Revision
- Cleft Lip or Cleft Palate Deformity
- Facial Trauma / Sports Related Injury
- Other _____

How did you hear about  The Baltimore Center for Facial Plastic Surgery?

- My Doctor _____ A Friend _____
- Our Website Family Member _____
- Magazine Ad Mass Media (TV, radio)
- Brochure Yellow Pages
- Other _____

Thank you!



BALTIMORE CENTER FOR
FACIAL PLASTIC SURGERY LLC

RANDOLPH B. CAPONE, MD, FACS
DIRECTOR

Name:

Date of Birth:

Appointment Date:

HEALTH HISTORY

CURRENT & PAST MEDICAL CONDITIONS: _____

PAST SURGICAL HISTORY: _____

SOCIAL HISTORY: _____
Occupation- _____
Tobacco use- _____
Alcohol use- _____
Marital Status- _____

CURRENT MEDICATIONS & VITAMINS: _____

ALLERGIES: _____

NOTIFICATION OF MEDICAL INFORMATION DISCLOSURE AND PRIVACY PRACTICES.

Please review the following information carefully.

The Baltimore Center for Facial Plastic Surgery, L.L.C., has implemented the following policies and procedures so the confidentiality of you or your minor / child's personal and medical information remains confidential. Dr. Capone and all other employees working in the practice will keep any information related to you or your family in a confidential manner.

- A. The Baltimore Center for Facial Plastic Surgery, L.L.C. and Dr. Randolph Capone are generally authorized to disclose the information in your or child's medical records to the extent needed for the following purposes:
1. For the purpose of providing treatment to you or your child. This would include, for example, sharing information with employees and contractors of Dr. Capone, or with other health care providers who are treating you or your minor child or consulting in you or your minor child's care such as:
 - Physician/Non-Physician Providers (i.e. Physical Therapist, Nutritional Counselors, etc.) who work outside of this practice.
 - Medical Facilities (i.e. hospitals, outpatient surgery centers).
 - Laboratories for the purposes of running medical tests.
 - Other health care providers such as pharmacies, durable medical equipment suppliers, and ambulance services.
 - School Health Departments.
 - School Nurses.
 - Insurance companies (or third party administrators) for the purpose of obtaining payments, reviewing medical necessity, and/or general case management.
 - State or Federal agencies that require the submission of specific health related information.

This information will be submitted by means of the U.S. Postal Service, private delivery services, fax, internet, voice mail and/or personal communications.

2. For the purpose of arranging payment for you or your child's care. This would include, for example, your insurer or other third-party payer who is responsible for paying all or part of the cost of you or your minor child's care.
 3. For the purpose of Dr. Capone's "health care operations." This would include such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and the provision of legal and auditing services.
- B. A Specific Authorization for Release of Medical Records that you may sign for you or your child authorizes Dr. Capone to make a specific disclosure that is not covered under section A. above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose you or your minor child's records. However, the record release policy for Baltimore Center for Facial Plastic Surgery, L.L.C. requires that a separate Authorization For be completed for each medical record transfer request.
- C. Other that activity that has already occurred, you may revoke any further authorization provided to Dr. Capone by giving the Baltimore Center for Facial Plastic Surgery a written notice of revocation at any time.
- D. Dr. Capone may use or disclose your protected health information in the following situations when required by law without your authorization. These situations include, but are not limited to : as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you for you or your minor child and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

- E. Dr. Capone may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- F. You have the following rights with respect to you or your minor child's medical records/information:
 - 1. You have the right to request restrictions on the use and disclosure of you or your minor child's medical records/information; however Dr. Capone is not required to agree to restrictions not guaranteed by law. You will be informed if Dr. Capone will not agree to a requested restriction.
 - 2. You have the right to receive confidential communications of you or your minor child's health information and to direct the place and manner of communication.
 - 3. You have the right to inspect and copy you or your minor child's medical records. (Dr. Capone is entitled to charge you a reasonable fee related to the cost of copying your records). Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
 - 4. You have the right to seek to amend you or your child's medical records, and if Dr. Capone does not agree with your request, to note your objection in the medical record.
 - 5. You have a right to receive an accounting (list) of disclosures of you or your minor child's medical records/information made by Dr. Capone. (Except for those disclosures that fall within the scope of Dr. Capone's "health care operations" or disclosures made for payment or treatment purposes.)
 - 6. You have the right to receive a paper copy of this Notice.
- G. Dr. Capone is required by law to maintain the privacy of protected health information, and to provide patients with this Notice of its duties and practices, as well as changes to those practices, as well as changes to those practices. Patients will be provided with revised Notices, as appropriate.
- H. If you as a patient or guardian believe that his or her privacy rights have been violated, the patient may wish to notify Dr. Capone, or contact the Secretary of the U.S. Department of Health and Human Services. To notify Dr. Capone please call our office and ask to speak with our designated Privacy Complaints Contact Person, Timothy A. Rumrill, at (410) 785-0333.
- I. Dr. Capone reserves the right to change his privacy practices and this Notice, and to make new policies effective for all protected health information that he maintains.

-Updated July 1, 2009-

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By my signature below, I acknowledge that I have received a copy of
The Baltimore Center for Facial Plastic Surgery's Notice of Privacy Practices.

Patient Name

Name of Patient's personal representative (if applicable)

Relationship of personal representative to Patient (if applicable)

Signature of Patient or Patient's personal representative

Date