John M. Rowley, M.D.
Palo Verde Plastic Surgery

Palo Verde Plastic Surgery
4545 E Chandler Blvd, Suite 110 ; Phoenix ,AZ 85048
Phone: 480-759-3001 • Fax: 480-759-1341

PATIENT DEMOGRAPHICS

PLEASE FILL OUT COMPLETLEY AND PRINT CLEARLY

FULL LEGAL NAME: _____ **DOB (MM/DD/YYYY):** _____

AGE:_____ **GENDER:** ☐ Female ☐ Male **SOCIAL SECURITY NUMBER:** _____

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

MAILING ADDRESS: _____ **Apt/Suite:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

☐ **HOME PHONE:** _____ ☐ **CELL PHONE:** _____

☐ I agree to allow Palo Verde Plastic Surgery to leave a detailed messages /test results on my voicemail at the above number(s) (Please check at least one phone number above)

☐ I do NOT wish for Palo Verde Plastic Surgery to leave a detailed messages/test results on my voicemail.

EMAIL ADDRESS: _____

PREFERRED PHARMACY: (Name, location, and cross streets): _____

EMPLOYER : _____ **EMPLOYER** PHONE: _____

EMERGENCY CONTACT INFROMATION

EMERGENCY CONTACT:_____ **PHONE NUMBER:** _____

RELATIONSHIP TO PATIENT _____ **PERMISION TO LEAVE MESSAGE** ☐ YES ☐ NO

PHYSICIAN & REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN(PCP):_____ **PHONE NUMBER:** _____

REFERRING PHYSICIAN: _____ **PHONE NUMBER:** _____

HOW DID YOU HEAR ABOUT US? (please provide name or platform) ☐ Insurance_____

☐ Family Member _____ ☐ Friend _____

☐ Social Media _____ ☐ Other: _____

RESPONSIBLE PARTY (If other than patient)

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

FULL LEGAL NAME: _____ **DOB:** _____

SOCIAL SECURITY NUMBER: _____ **GENDER:** ☐ Female ☐ Male

MAILING ADDRESS (If different from above):_____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____ ☐ VM OK? ☐ Yes ☐ No

Employment Status: ☐ Employed ☐ Self-Employed ☐ Not Employed ☐ Retired ☐ Student

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PATIENT DEMOGRAPHICS

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INSURANCE

FOR US TO BILL YOUR INSURANCE COMPANY PROPERLY PLEASE FILL OUT FORM COMPLETELY.

PRIMARY INSURANCE: _____ ID #: _____

GROUP # _____

POLICY HOLDER NAME: _____ RELATIONSHIP TO PATIENT:_____

DOB (MM/DD/YYYY): _____ SOCIAL SECURITY NUMBER : _____

SECONDARY INSURANCE: _____ ID #: _____

GROUP # _____

POLICY HOLDER NAME: _____ RELATIONSHIP TO PATIENT:_____

DOB (MM/DD/YYYY): _____ SOCIAL SECURITY NUMBER : _____

RELEASE and ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION: Giving us permission to leave a voicemail , text message or email which includes what may be protected health information (i.e.: test results ,appointment reminders etc.) UNLESS STATED OTHERWISE, WE Will POTENTIALLY MAIL INFORMATION TO THE ADDRESS YOU PROVIDE.

I, the undersigned have insurance coverage and assign directly to Palo Verde Plastic Surgery all medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance unless assignee has executed an agreement with my insurance provider or plan. I understand that if such agreement has been executed, I am responsible to pay any deductible and/or co-payment and non-covered services under the terms of my insurance. I understand that I am financially liable in the event of non-payment. I authorize payments of medical benefits to the provider for services rendered , or to be rendered in the future, without obtaining my signature on each claim submitted , and I will be bound by the signature as though personally signed the claim. I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.

By Signing below , I have read ,understand and agree to all the above and that the information I have given is correct.

PATIENT/RESPONISBLE PARTY PRINTED: _____

PATIENT/RESPONISBLE PARTY SIGNATURE: _____

DATE: _____

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PATIENT MEDICAL HISTORY

PLEASE FILL OUT COMPLETLEY AND PRINT CLEARLY

FULL LEGAL NAME: _____ **DOB (MM/DD/YYYY):** _____

Height:_____ **Weight:**_____ **Race:**_____ **Ethnicity**_____ **Language**_____

Do You have an Advance Directive? ☐ **Yes** ☐ **No**

****PLEASE PUT DOWN ALL PERSCRIBED, OVER THE COUNTER AND SUPPLEMENTS****

MEDICATIONS	DOSAGE	MEDICATIONS	DOSAGE

DATE	SURGICAL PROCEDURE(S)
ANESETHSIA PROBLEMS? (If yes, please list below):	

ALLERGIES

Do You Have ANY of the following Allergies? **Latex :** ☐ Yes ☐ No **Tape :** ☐ Yes ☐ No

Please list all Medication & Food Allergies (Including Reactions)

Med/Food Name	Reaction

WOMEN'S HEALTH HISTORY	
Contraception Type	
Date & result of Last Mammogram	
**Bra size	

****Breast Surgery Patients are Required to Answer**

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MEDICAL CONDITIONS							
☐	High blood pressure	☐	Intestinal Problems	☐	Varicose Veins	☐	Wound Healing Issues
☐	Heart Murmur	☐	Thyroid Problems	☐	TB	☐	Easy Bruising
☐	Coronary Artery disease	☐	Emphysema	☐	HIV	☐	Seizure
☐	Heart Failure	☐	Chronic Bronchitis	☐	Liver Disease	☐	Headaches
☐	Arrythmia	☐	Asthma	☐	Hepatitis	☐	Psychological Disorders
☐	Stroke	☐	Diabetes	☐	Blood Clots	☐	Drug Abuse
☐	Lung Problems	☐	Kidney Problems	☐	Bleeding Tendencies	☐	Other (please list below)
☐	Cancer	☐	Cholesterol	☐	Sleep Apnea		
☐	Arthritis	☐	Circulation Problems	☐	Chronic Back Pain		

**** List all other medical conditions here:**

_____

_____

Are you currently under Pain Management Care ? ☐ Yes ☐ No
Provider Name: _____ **Provider Phone:**_____

	FAMILY MEDICAL CONDITION	RELATION: (Mother, Father, Brother, Sister, PGF, PGM, MGM, MGF)
☐	Diabetes	
☐	High Blood Pressure	
☐	Heart Disease	
☐	Stroke	
☐	Mental Illness	
☐	Cancer	

Social History

Do you use Nicotine? ☐ Yes ☐ No - (if never smoked, please move to Alcohol/Drug Use)

Vape? ☐ Yes ☐ No **Cigarettes?** ☐ Yes ☐ No Other Nicotine Products: _____
Current: Packs/ day_____ # of Years _____ **Past**: Quit Date:_____ Packs/day_____# of Years _____

Alcohol/drug Use

Do You Drink Alcohol? ☐ Yes ☐ No
How Often? ☐ 1 or less a month, ☐ 2-4 times per month ☐ 2-3 times a week, ☐ 4 or more a week

PATIENT/RESPONISBLE PARTY PRINTED: _____

PATIENT/RESPONISBLE PARTY SIGNATURE: _____

DATE: _____

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Authorization for Release and Disclosure of Protected Health Information

PLEASE FILL OUT COMPLETLEY AND PRINT CLEARLY

Consent related to the Privacy Notice:
I hereby give my consent to John M Rowley, MD and/or "this practice" to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.
I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing.

Please allow those listed below access to my Protected Health Information (PHI):

Name: _____ Relationship:_____

Name: _____ Relationship:_____

PATIENT/RESPONISBLE PARTY PRINTED: _____

PATIENT/RESPONISBLE PARTY SIGNATURE: _____

DATE: _____

Consent to Obtain External Prescription History

The purpose of this consent is for permission to obtain your medication history. Patient medication history is a list of prescription medicines that our providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribution to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record.

Medication history is very important in helping healthcare providers treat your symptoms and/or illnesses properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history may not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements and/or herbal remedies that patients take on their own may not be included. By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

I certify that I have read and fully understand the above Notice of Privacy Practices and Consent to obtain External Prescription history. That by signing below, I am consenting fully and voluntarily to allow Palo Verde Plastic Surgery to obtain my medication history and acknowledge that I have read and fully understand Notice of Privacy Practices.

PATIENT/RESPONISBLE PARTY PRINTED: _____

PATIENT/RESPONISBLE PARTY SIGNATURE: _____

DATE: _____

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Financial and Cancellation Policies

Thank you for choosing Palo Verde Plastic Surgery , Dr. John M Rowley. We are committed to building a successful physician-patient relationship. Your clear understanding of our Patient Financial and Cancellation Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

Appointment:
ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE : Payment is required at the time services are rendered unless other arrangements are made in advance. This includes applicable coinsurance, copayments, and deductibles for participating insurance companies. We accept cash, check (returned checks will be charged a $35.00 fee), VISA, MasterCard, Discover, American Express and A bank issued Cashier's Check.

Please Note: Patients with an outstanding balance 60 days or more overdue must make payment arrangements prior to scheduling appointments. We do use a collection agency to pursue past due accounts.

Consultation Fee: There is a $75 consultation fee for any cosmetic procedure (surgery, Botox, Juvéderm etc.). Insurance based consult that our billed to insurance are subject to your benefits, co-pay, deductible, or co-insurance amount.

Insurance:
We bill participating insurance companies as a courtesy to you. Benefits and eligibility will be confirmed prior to any procedure done by Dr. Rowley. To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. An estimate will be given to you for the procedure. Because this is an estimation, after your claim is paid by the insurance company, you may receive a refund or a bill from us. You are expected to pay your deductible, copayments, and coinsurance. Although requirement for prior authorization will be verified prior to any procedure, please be aware that some services provided may be non-covered and considered not reasonable and unnecessary under your insurance plan. It is your responsibility to know your coverage. If payment is not received from your insurance company, you may be expected to pay the balance in full. If your insurance requires a referral for you to see a specialist, it is your responsibility to obtain the referral from your primary care physician. Again, it is your responsibility to notify us of any insurance coverage changes.

Missed Appointments/Late Cancellations:
Missed appointments represent a loss to us, to you and to other patients who could have been seen in the time set aside for you. Appointment Reminders will be provided but are not guaranteed , we require a 48 business hours' notice of cancellation. Failure to adhere to our policy will result in you being charged $200 fee. Failure to pay cancellation/no show fees may result in denial to schedule an appointment until the amount due is paid in full. Excessive cancellations or missed appointments may result in discharge from the practice.

Lab and Pathology:
You may receive separate billing statements from an outside lab or pathologist for review of skin tissue removed or biopsied during your visit. These providers could have different arrangements with your insurance company that may lead to additional bills. Should you have questions regarding those bills, please contact their office directly.

FLMA/Disability/Time off Forms:
There is a $45.00 fee for any FMLA/Disability/Time off forms that are requested from our office. A $25.00 fee will be charged for each additional form. Attorney fees may vary in price per request

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Cosmetic Surgery

As you prepare to have/approach your surgery, you most likely have questions regarding payments for services. It is important to get the information necessary to answer those questions PRIOR to your surgery to avoid any misunderstanding and/ or confusion.

PLEASE NOTE: We will **NOT** submit any claims for a cosmetic procedure on your behalf to any insurance carrier. You are completely responsible for the full amount. Patients will be responsible for necessary charges associated with their service(s) rendered. The fees charged for this service(s) do not include any potential future cost for additional service(s) that is elected to have performed to optimize or complete the patient's desired outcome. Additional cost may occur should complications develop from the service. Subsequent services that are performed with the intent of revision will also be the patient's responsibility.

Surgery Payments:

1. We collect a surgery deposit when surgery is scheduled.
2. We do not offer financing or payment plans.
3. The surgery balance will be taken at your pre-op appointment in full for Surgeon fee ,equipment and assist (if needed).
4. The Surgery Center you are scheduled at will collect their fee.
5. Anesthesia group will contact you to collect their fee.
6. Included in your surgical fee is all the pre- and post- operative visits for from the date of surgery.
7. NOT included in the surgical fee : laboratory fees, radiology fees, prescriptions, or other testing procedures
8. Insurance Coverage: Majority of Cosmetic procedure are not covered by insurance plans.

Payment Options:

1. Money order or Cashier's Check
2. Credit Cards: Visa, Master Card, Discover or American Express
3. Cash

Cancellation/Reschedule Policy:

We understand that a situation could arise which would require you to postpone your surgery. However, please understand that a cancellation/postponement affects many individuals including the healthcare professionals scheduled for your procedure as well as other patients. Therefore, we would ask that as soon as you become aware of the need to cancel/postpone your surgery, you notify our office at once.

Cancel/Reschedule

- **14 business days** prior to your surgery lose your deposit and must put down another deposit to reschedule.
- **7 business days** prior to your surgery lose your deposit and must pay all the Surgeon fee.

Once payment is received, we will provide a new quote and secure your revised surgery date with a fresh deposit.

I have read and fully understand the financial ,cancellation and rescheduling policy outlined above. My signature below signifies that I agree to abide by these terms and accept full financial responsibility as described.
I acknowledge that this policy is in place to respect the time and resources of Dr. John M. Rowley and the team at Palo Verde Plastic Surgery.

PATIENT/RESPONISBLE PARTY PRINTED: _____

PATIENT/RESPONISBLE PARTY SIGNATURE: _____

DATE: _____

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Authorization for the Use of Photographs

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery in connection with the plastic surgery procedure(s) performed by Dr. John Rowley. The photographs will be taken by one of the members of the Dr. John Rowley's medical staff.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information but will not affect the health care services I presently receive, or will receive, from Dr. John Rowley.

I understand that I am providing this authorization as a voluntary contribution and that such photographs shall become the property of Dr. John Rowley for the purpose of informing the medical profession or the public about plastic surgery procedures and methods.

I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it won't have any effect on any actions taken prior to my revocation.

I release and discharge Dr. John Rowley, and all parties acting under his license and authority, from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I authorize the anonymous use of my photographs for Dr. John Rowley, Palo Verde Plastic Surgery in the situations I have checked below:

	In office to show patients	For the Internet/Social Media	Printed Materials
Photos of my Face	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Photos of my Body	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

I certify that I have read the above Authorization and Release and fully understand its terms.

PATIENT PRINTED: _____

PATIENT SIGNATURE: _____

DATE: _____

*I have read the above Authorization and Release. I am the parent, guardian, or conservator of, a minor. I am authorized to sign this authorization on his/her behalf *:

RESPONISBLE PARTY PRINTED: _____

RESPONISBLE PARTY SIGNATURE: _____

DATE: _____

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Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions regarding this notice, please contact Arizona Community Physicians Business Office by mail or phone. Our contact information is listed above.

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.

This Notice of Privacy Practices is **NOT** an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION: Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We will abide by the patient's request not to disclose PHI to a health plan for services which the patient has paid out of pocket and requests the restriction.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues as required by law, communicable diseases, health oversight, immunizations to schools, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request.

Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500

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USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION: Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. The same authorization/restrictions that were used while you are alive will remain in place for up to 50 years after your death. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS: The following are statements of your rights with respect to your protected health information: **You have the right to inspect and have a copy of your protected health information (fees may apply).** Pursuant to your written request you have the right to inspect or have a copy your protected health information whether in paper or electronic format. The records will be provided within 30 days of request. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Patient Requesting Medical Record Copies. There may be fees associated with requesting copies of medical records, such as copy fees, and/or shipping and handling fees.

You have the right to request a restriction of your protected health information - You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications - You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

You have the right to request an amendment to your protected health information - You may ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.

You have the right to receive an accounting of certain disclosures - You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law for up to six years prior to the date of the request.

You have the right to receive notice of a breach - We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.