

Practice Authorizations and Policies

**Dean P. Kane, MD, FACS, PA (Practice) no longer participates with medical insurance companies. Both “insurance-pay” and “self-pay” procedures are offered. I remain personally and fully responsible for immediate payment of all fees.** Should I / we wish to submit a claim for reimbursement of “insurance-pay” services from my insurer, I will request a receipt within 30 days of the services rendered. Payment for cosmetic services are irrevocable.

initial

I / we understand that I / we personally guarantee to be financially responsible to pay for any and all charges not covered by my insurer. As a guarantor, I /we fully accept the medical services provide to me / the patient. I also remain totally responsible to the bill if my insurer including Medicare or HMO’s, PPO’s and the like deny payment as deemed not necessary, not reasonable, cosmetic or otherwise. In the event collection efforts are required to obtain payment of the charges incurred by me / the patient, I / we agree to pay any costs incurred in the collection of this account including but not limited to court costs, private processing service fees and the like. All persons executing this form are guarantors and agree that their obligation to pay is joint and several in nature.

initial

I / we understand that “failure to show” (FTS) for an appointment imposes a great burden on the Practice. **Forfeiture of a pre-paid service or a FTS fee will be collected for the date missed prior to new services provided.**

initial

**The practice of medicine and surgery is not an exact science. I / we acknowledge that no guarantees have been made to me as to the results of any treatment, procedure or product.** Although good results are desired, there cannot be any guarantee or warranty expressed or implied on the result(s) that may be obtained. Dissatisfaction with any result does not constitute a basis for reimbursement, refund or cancellation of payment. Regret, remorse, anguish or any other show of apology does not express any admission of fault or constitute a show of guilt, liability, error or blame. Should complications or dissatisfaction occur, additional surgery or other treatments may be necessary. Your insurer may not cover the cost of complication(s), side-effect(s) or revisional therapy for elective cosmetic procedures. You should expect additional fees and these fees may be non-refundable. Risk of complications and side-effects may occur with primary and any additional procedures. I agree to be personally and fully responsible for all fees..

initial

Services performed that are paid for with a credit card, debit card or with financing, are not eligible for post-care payment challenges. I agree that this credit, debit card or financing challenge agreement is irrevocable. Your Protected Health Information will be used if required to recover a practice expense claim. I agree and authorize the use of my credit card on file to pay for unpaid services.

initial

**Red Flag Rules and Anti-Fraud Regulations are followed.** We require a minimum of 1 (one) current photo-identification such as a driver’s license and a second non-photo ID for proof of identity.

initial

I / we consent to the **use or disclosure of my individually identifiable health information (“Protected Health Information”)** as defined in this offices “Notice of Privacy Practices” by Dean P. Kane, MD, FACS, PA in order to carry out treatment, payment, or health care operations. A “Notice of Privacy Practices” is available for my review.

initial

I / we acknowledge that it is the policy of the practice of Dean P. Kane, MD, FACS, PA to follow **all federal and state laws and reporting requirements regarding Identity Theft.** I / we will provide all necessary documents to prove the authenticity of my identity. Should there be any claim or concern of Identity Theft, I / we will report or the incident will be reported to the appropriate authorities. Should I / we wish to defer these policies, all products, services and surgery may be provided with a cash payment only.

initial

I / we hereby authorize Dean P. Kane, MD, FACS, PA and his associates to **take photographs, slides, videotapes and other documentary images, quotations or testimonials during my care.** Digital Imaging or HIPPA protected information other than medical documentation will be requested under separate authorization.

initial

It is the policy of Dean P. Kane, MD, FACS, PA to **protect your digital communication to and from our practice** to the best of our ability. I / we acknowledge that current technology may not fully conceal and / or protect the confidentiality of your identity with email, social media or other digital contact. I will not hold Dean P. Kane, MD, FACS, PA, Dean P. Kane, MD, FACS nor any employees or contractors responsible for a breach in such communication.

initial

I / we are aware that many **prescription medications sold by this “Practice” maybe available by at local pharmacies.** I have chosen to purchase said medications at the “Practice” location for my convenience.

initial

I / we are made aware that the Dean P Kane, MD, FACS, PA follows **2017 Maryland Heroin and Opioid Prevention, Treatment, and Enforcement** Initiative has mandated an Opioid Education, Discovery and Consent process for those patients who receive peri-operative controlled substances prescriptions.

initial

I / we acknowledge that this Practice has **recommended me / us to obtain an executed Power of Attorney and Advanced Directives** with an appropriate attorney..

initial

By signing below, the undersigned certifies that the foregoing paragraphs have been read in full, are understood and agreed upon by the undersigned.

initial

By signing below, the undersigned certifies that ALL information provided to the Practice is truthful and up-to-date.

Signature:\_\_\_\_\_Date:\_\_\_\_\_

**Refusal to sign acceptance to the above items indicates non-compliance by the patient / surrogate / guarantor to the policies of this practice and elective, non-emergency services will not be provided.**

## **HIPAA, HITECH and the Omnibus Final Rule Notice of Privacy Practices – Summary**

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 required HHS [Health and Human Services] to adopt national standards for electronic health care transactions. At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated into HIPAA provisions that mandated the adoption of Federal privacy protections for individually identifiable health information. The Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009 (HITECH) provides additional requirements beginning in 2013. Both are provided to you as a Notice of Privacy Practices (NPP).

### **A. HIPAA:**

1. Protected Health Information maybe used or disclosed for treatment, payment or healthcare operations
2. The patient has a right to request restrictions on identifiable "data."
3. The unique and identifiable data that maybe used or disclosed is listed below.

B. Dean P Kane, MD, FACS, PA also known as the Center for Anti-Aging Medicine and Cosmetic Surgery complies with the HIPAA Privacy Standards by requesting a patient signature for each patient visit on the Encounter Form (superbill) authorizing that Protected Health Information (PHI) maybe used or disclosed for treatment, payment or healthcare operations. A review of our Notice of Privacy Practices is available in our library. A copy of our Notice of Privacy Practices is available in upon request.

C. PHI includes: name, address, email, dates, social security number, medical record number, health plan beneficiary number, account number certificate number, license number, vehicle identifiers, facial photographs, telephone numbers, device identifiers, URL's, IP addresses, biometric identifiers, geographic units and other unique identifiers or codes.

D. PHI may be disclosed by a Covered Entity without the individual's consent or authorization when:

- a. Used for Research if requested by:
  - i. A Privacy Board
  - ii. A Institutional Review Board
- b. Used for facility directories (for clergy and other visitors), or to update family members and those involved in the individual's care, provided the patient is given an opportunity in advance to object.
- c. In the certain limited circumstances, such as those required by law or public health activities.
- d. Limited patient information (demographics and dates of service), are used for marketing and fund raising activities.
- e. Disclosures of PHI may be made to Business Associates where a Business Associate Contract is in place, eg medical insurance company.
- f. Your Protected Health Information will be used if required to recover a healthcare expense claim to include and not limited to your medical insurance, banking, finance companies and credit card companies.
- g. Your Protected Health Information will be used for this office to contact you regarding appointments, medical and emergency care. Please provide secure and confidential contact information on the demographic form. Should this information change or become discovered, please inform us immediately and provide another form of contact. All efforts will be made to preserve your privacy in accordance with HIPAA rules.

### **E. Individual Access to Protected Health Information:**

- a. Only the patient or surrogate may request to review their medical record and only when a Release of Medical Information Authorization is signed.
- b. Any contested information will be reviewed by Dean P Kane, MD, FACS and added to the medical record as a addendum

### **F. Patient Rights:**

- a. The individual has a right to inspect and copy his or her PHI, in whole or in part, for as long as the covered entity maintains the information.
- b. The patient has the right to amend the PHI as above
- c. Any person who believes that a Covered Entity is not complying with the applicable requirements of HIPAA may file a complaint with the Secretary of HHS. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless the time limit is waived by the HHS Secretary for good cause shown.

### **G. HITECH:**

- a. You have the right to be notified following a breach os unsecured PHI.
- b. If you pay "out-of-pocket" for products or services, you have the right to restrict disclosures of PHI to your health plan.
- c. Any other uses and disclosures of your PHI will be made only with your authorization.
- d. Any notes from a social worker, psychologist, psychiatrist or other mental health professional will require a separate authorization for release of PHI.
- e. Any PHI used for marketing purposes including subsidized treatment will require your authorization.
- f. You have the right to "opt-out" of any fund raising communications.
- g. You must authorize the "sale" of your PHI.
- h. Providers may charge a reasonable cost-based fee when providing medical records.

### **H. HIPAA Final Rule Summary 2014**

- a. Breaches of PHI are reportable unless there is a "low probability of PHI compromise."
- b. A patient may request their physician not to disclose PHI to a health plan for those services for which the patient has paid for out-of-pocket, unless it is required for treatment purposes or in the rare event the disclosure is required by law.
- c. Limited marketing communications may be provided without the patient's authorization.
- d. It is prohibited to sell PHI.

I. Our receptionist is designated as the contact person to receive requests, amendments and complaints in writing and provide privacy practice information when requested.

J. Authorization is requested for specific use or disclosure of PHI not for TPO (treatment, payment, operation).

# THE CENTER FOR COSMETIC SURGERY &



DEAN P KANE, MD, FACS, PA  
LAURI P KANE, RD, MPH, SCD

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## NOTICE OF PRIVACY PRACTICES:

### ACKNOWLEDGEMENT OF NOTIFICATION

By signing this form, you acknowledge having been offered the *Notice of Privacy Practices of Dean P Kane, MD, FACS, PA*. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. While a summary is found on the reverse side of this form, we encourage you to read the *Notice of Privacy Practices* in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our practice in writing.

If you have any questions about our *Notice of Privacy Practices*, please contact our practice in writing.

I acknowledge having been offered the *Notice of Privacy Practices of Dean P Kane, MD, FACS, PA*.

Signature: \_\_\_\_\_  
(patient/parent/conservator/guardian)

Date: \_\_\_\_\_

### INABILITY TO OBTAIN ACKNOWLEDGEMENT OF NOTIFICATION

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

- ☐ Patient refusal
- ☐ Other:

Signature of Dr. Kanes representative: \_\_\_\_\_ Date: \_\_\_\_\_

# THE CENTER FOR COSMETIC SURGERY &



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## Patient Demographic Information

Today's Date: \_\_\_\_\_ Who or How were you referred?: \_\_\_\_\_

*Person, eBlast, Website, Google, Bing, MSN, Magazine, Newspaper, Seminar, TV, Radio, Facebook / Social Media, Word of Mouth, other.*

Name: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_  
Street Apt City State Zip

**Preferred Contacts:** Please circle how you wish to be contacted: **Home, Cell, Work, Text, email, Pharmacy** (see HIPAA Authorization)

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Pharmacy #: \_\_\_\_\_ / e-RX: \_\_\_\_\_

eMail: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Employer Name: \_\_\_\_\_

### **With whom may we discuss your personal health information and medical care?**

**Emergency Contact:** \_\_\_\_\_  
Name Relationship Phone #

**Medical Disclosure Contact:** \_\_\_\_\_  
Name Relationship Phone #

**Other Disclosure Contact(s):** \_\_\_\_\_  
Name Relationship Phone #

**Other Disclosure Contact(s):** \_\_\_\_\_  
Name Relationship Phone #

Current regulations demand the presentation and copy of 2 forms of identification both unique to the you. One form will required photo identification (Driver's License or Passport). Your best second form of ID may is your Health Insurance Card. If you cannot comply, all services will be provided with cash payment only.  
For those individuals who require the use of another person's ID or credit information, current regulations demand that this individual be with you with all forms of ID. I trust you will understand the difficulties imposed upon medical practices today. Thank you for your understanding. Dean P. Kane, MD, FACS, PA

Above named Patient Signature (and Responsible Adult if under 18 years old)

Date

Demographic 101717

# Base Medical Data

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for choosing our office for your consultation! Please check or fill in the following information so I may better help you.

Sex: M F; Height: \_\_\_\_\_, Weight: \_\_\_\_\_ . Reason for Visit: \_\_\_\_\_

Your job description:

List ALL your physicians:

Circle, list and explain all that apply:

**Social Support:** Single, Divorced, Separated, Widowed, Married: live with friend, other:

**My ethnic background** includes: Caucasian, N. European, Irish, Mediterranean, Middle Eastern, African-AA, Hispanic, Am-Indian, West-Indies, East-Indian, Asian  
Other: Jehovah's Witness

**Allergies:** None Penicillin Sulfa IV Iodine Latex/Fruit **Other/ Reaction:**

**Tobacco / Nicotine (Nicorette, etc):** Never. Yes, I now smoke \_\_\_\_\_ packs / day. I stopped smoking \_\_\_\_\_ years ago. **2<sup>nd</sup> hand?** Y N

**FAMILY or PERSONAL History:** Malignant Hyperthermia, Other:

**YOUR Personal Medical History:** Circle and / or explain ALL that apply: **NONE**

Accutane **N Y**: when \_\_\_\_\_  
AIDS / HIV **N Y**  
Flu / Ebola exposure past 21 days **N Y**  
Malignant Hyperthermia **N Y**

Anemia (Low blood)  
Autoimmune Disease: RA, Scleroderma  
Lupus  
Asthma / COPD  
Bleeding or Clotting Disorders  
Hypertension (High Blood Pressure)  
Low Blood Pressure **BP:** \_\_\_\_\_ / \_\_\_\_\_

Low Blood Sugar  
Diabetes mellitus  
GERD / Reflux / Hiatal Hernia  
**Motion Sickness** / Glaucoma  
Heart Disease / Heart Failure  
Heart Attack / Stroke / bypass / stent  
Peripheral Vascular (arterial) Dis  
Heart Valve / MVP problems  
Hepatitis, Liver Disease  
Kidney Failure  
Osteo/degenerative Arthritis  
Seizure

Skin Cancer  
Sun Response: tan, no response, burn  
Thyroid Disease  
Venous Disease: clots, phlebitis, DVT PE  
Behavior Issues: anxiety, depression,  
Body dysmorphic synd, dementia,  
Gender change, suicidal syndrome  
Implant(s) / Prostheses: breast, joints  
Body Piercing(s): tongue, nipples, labia  
Infections: Yeast, Viral cold sores  
Bacterial, MRSA  
Snoring, sleep apnea, B/C-PAP

**Skin-Cold syndromes:** Sickle Cell,  
Raynauds Synd, AutoImm Dis.

**Stem Cell therapy**  
Other:

## Review of Systems:

**# Pregnancies** \_\_\_\_\_, **# Births** \_\_\_\_\_, **# Miscarriages** \_\_\_\_\_, **# Abortions** \_\_\_\_\_

**Anesthesia Concerns:** **None**, Malignant Hyperthermia or List:

**Recreational Drugs:** **N Y**: (circle): cocaine, crack, meth, heroin, narcotic, marijuana, other:

**Alcohol:** wine, beer, liquor: \_\_\_\_\_ ounces / week.

**Chronic Narcotics / Sedatives use:** eg: codeine, codones, oxycontin, suboxone, methadone, valium, xanax, Ativan, other:

Are you planning or involved in a law suit regarding any areas of medical concern? **N, Y (if yes, explain):**

List ALL prior **SURGERY, COSMETIC PROCEDURES and INJURIES:** **NONE**

tonsil & adenoids, tubal ligation, appendectomy, lap/open gall bladder, caesarean section, D&C, CABG, stent, Gastric Bypass / Lap Band, neck / back surgery, other:

List ALL **MEDICATIONS:** **NONE**

**Hormones:** HRT, Estrogen, Testosterone Birth Control:

**Acne:** Spironolactone

**Coagulant:** Tamoxifen

**Erectile Drugs:** Viagra; Cialis, Levitra

**Cholesterol:**

**Blood Pressure:**

**Anti-Coagulants:** Coumadin Plavix

**Auto-Immune:** Humira, Remicade, Rituxan, Herceptin, other:

**Heart Meds:** Nitroglycerine:

**Herbals, Teas or Supplements?** Circle or List: **NONE**

Inhibits: MAOI & SSRI: **St. Johns Wort** (incr photosensitivity & induces cytoP450 which decr Rx activity!); Yohimbe; Licorice root;  
GABA & Serotonin stimulation = Sedation: 5 Hydroxy Tryptophan; **Valerian**; **Kava** (hepatic dysfunction); Melatonin

Anti-coagulants: Arnica; Bromelain; Black Mushrooms; Clove oil; **Ginkgo biloba**; **Ginseng** (hypoglycemia); Ginger; **Garlic** (decr BP); Bilberry; Dong Quai; Feverfew;

**Vitamin E**; Honeysuckle; Wintergreen; **Aspirin**; **Ibuprofen**; **Naprosyn**; **Chondroitin/Glucosamine**; **Saw Palmetto**; **Fish Oil / Essential Fatty Acids**; **Co-Q-10**;

**Other NSAIDS:**

Stimulants: **Phentermine**; Ma Huang; MetaLife; MetaBoost; **Ephedra** (halothane potentiates CV effects); Other Weightloss Supplements:

Liver Dysfunction / Immunosuppression / inhibits cytoP450 which potentiates Rx: **Echinacea**; **Goldenseal**; Milk Thistle;

Other: Aloe (dermatitis, low K)

**Multi-Vitamin, Other OTC's:**

**Any incorrect or missing information may adversely affect my care and my results.**

**I hereby confirm that all the information provided is complete and accurate to the best of my knowledge.**

☐ **I hereby confirm that there has been "NO CHANGE" in my medical condition since last documented in this record.**

Signed:

Date: