



*The Center for Plastic & Cosmetic Surgery  
410 Pellis Road; Suite 2A; Greensburg, PA 15601  
(724) 836-0400  
Michael S. Kluska, DO*

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE  
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION**

**Read before signing the Acknowledgment and Consent**

This acknowledgment of notice and consent authorizes The Center for Plastic & Cosmetic Surgery, LLC, to use and disclose health information about you for treatment, payment, and health care operations purposes.

**Notice of Privacy Practices:** The Center for Plastic & Cosmetic Surgery, LLC, has a Notice of Privacy Practices, which describes how we may use and disclose your protected information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

**Amendments:** We reserve the right to change our Notice of Privacy practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

**How to contact our Privacy Officer**

Address to: The Center for Plastic & Cosmetic Surgery, LLC  
Attn: Privacy Officer;  
410 Pellis Road; Suite 2A; Greensburg, PA 15601  
Telephone: 724-836-0400  
Fax 724-836-6422

**Acknowledgment and Consent**

I have received the Notice of Privacy Practices for The Center for Plastic & Cosmetic Surgery, LLC. The Center for Plastic & Cosmetic Surgery, LLC, is authorized to use and disclose health information about \_\_\_\_\_ (patient name) for treatment, payment, and health care operations purposes consistent with its Notice of Privacy Practices.

\_\_\_\_\_  
Patient's Signature \_\_\_\_\_  
Witness

Personal representative information (if applicable)

\_\_\_\_\_  
Name of personal representative \_\_\_\_\_  
Relationship to Patient



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**GOOD FAITH EFFORTS TO OBTAIN  
ACKNOWLEDGMENT OF RECEIPT OF NOTICE**

*For office use only when efforts to obtain acknowledgment of receipt of notice are unsuccessful.*

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**Name of Patient**

**Personal representative information** (if applicable):

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**Name of Personal Representative**

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**Relationship to patient (or other authority)**

I provide the above named \_\_\_patient \_\_\_ personal representative with the Notice of Privacy Practices for The Center for Plastic & Cosmetic Surgery, LLC.

Describe how notice was provided:

\_\_\_ Offered copy and individual refused to accept delivery

\_\_\_ Offered copy and individual accepted delivery

\_\_\_ Other \_\_\_\_\_

Describe efforts to obtain signature on acknowledgment of notice form:

\_\_\_ Patient/personal representative was asked to sign form and refused.

\_\_\_ Other: \_\_\_\_\_

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**Signature of Office Personnel**

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**Date**



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**AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION**

**Read entire document before signing**

*This authorization gives The Center for Plastic & Cosmetic Surgery, LLC, permission to use/or disclose information about you.*

***Right not to sign.*** *You may refuse to sign this authorization. Refusal to sign this authorization will not effect your ability to obtain treatment by The Center for Plastic & Cosmetic Surgery, LLC, except in the case of health care that is solely for the purpose of creating health care information for disclosure to a third party (for example, research-related care).*

***Right to revoke.*** *You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, you must submit a written revocation to the privacy officer at the following address:*

*The Center for Plastic & Cosmetic Surgery, LLC  
Attn: Privacy Officer  
410 Pellis Road; Suite 2A  
Greensburg, PA 15601*

***Re-disclosure.*** *Health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by the federal privacy rule or another privacy law.*

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*I give permission to The Center for Plastic & Cosmetic Surgery, LLC to contact me via the telephone and give permission for the following information to be left on my answering machine. I understand that a message left on the answering machine may be overheard by others present at that time.*

*DO NOT LEAVE ANY MESSAGE ON THE ANSWERING MACHINE*

*Leave Office Name and/or Office Staff Name with phone number.*

*Leave Office Name/Number for Appointment and Recall Information*

*Leave Office Name/Number for Referral Information*

*Consent for Dr. Kluska or Office Staff to contact you via cell phone.*



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**PLEASE LIST BELOW WHO WE ARE PERMITTED TO DISCUSS YOUR MEDICAL CONDITION WITH AND WHAT INFORMATION MAY BE RELEASED:**

1. Spouse Name: \_\_\_\_\_

Covered Health Information: \_\_\_All Information \_\_\_Test Results \_\_\_Referral Status  
\_\_\_Appointment Status \_\_\_Other \_\_\_\_\_

2. OTHER PERSONS

1. Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Covered Health Information: \_\_\_All Information \_\_\_Test Results \_\_\_Referral Status  
\_\_\_Appointment Status \_\_\_Other \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Covered Health Information: \_\_\_All Information \_\_\_Test Results \_\_\_Referral Status  
\_\_\_Appointment Status \_\_\_Other \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Covered Health Information: \_\_\_All Information \_\_\_Test Results \_\_\_Referral Status  
\_\_\_Appointment Status \_\_\_Other \_\_\_\_\_

**Expiration of Authorization**

Provide a date of the expiration of this authorization. (Example: 1 year, 2 years, 5 years, or indefinite)

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

**You do have the option to cancel this authorization at any time with written consent.**

*I have read and understand this authorization and authorize use and disclosure of health information about the named patient as described in this authorization.*

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

Personal Representative Information (if applicable):

\_\_\_\_\_  
Name of Personal Representative  
Parent

\_\_\_\_\_  
Relationship

04/28/10



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## **NOTICE**

Effective September 25, 2009

If your insurance company denies pre-authorization once we have done the initial request, we will not be able to complete an appeal.

This can be very time consuming and must be completed by you, the patient, by contacting your member services. The phone number is on the back of your insurance card.

We will be happy to provide you with any information you may need to complete the appeal.



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## **NOTICE**

Effective May 1, 2008, there will be a \$5 fee charged for each form that needs to be completed by our staff. The fee is due at the time the forms are presented.

All forms must have the patient's section complete before we can complete our part. Please allow five business days for completion.

These forms can be very time intensive and is extra work for the staff.

Your cooperation is greatly appreciated in this matter.

04/28/10

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**PATIENT INFORMATION**

(Please Print)

**PLEASE COMPLETE ALL SECTIONS OF THIS FORM**

Date \_\_\_\_\_

Account # \_\_\_\_\_

**PATIENT'S NAME**

Last

First

Middle

Address \_\_\_\_\_

Social Security # \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Family Physician \_\_\_\_\_

Male/Female

Referring Physician \_\_\_\_\_

Pt. Home Phone \_\_\_\_\_

Pt. Work Phone \_\_\_\_\_

Employed \_\_\_ Full-Time Student \_\_\_ Part-Time Student \_\_\_

**Pt. Cell Phone** \_\_\_\_\_

Patient Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_

**Pt. E-Mail Address** \_\_\_\_\_

If Patient is Minor, Person Responsible:

Guarantor's Name \_\_\_\_\_

**PATIENT'S EMPLOYER**

Guarantor's Date of Birth \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Parent's or Spouse's Employer \_\_\_\_\_ Social Security# \_\_\_\_\_

Relative whom we can contact in event of emergency

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Last First Middle

Address \_\_\_\_\_

(Number & Street) (Town) (State) (Zip)

**Injury Information**

Type of Accident \_\_\_\_\_ Date of Accident \_\_\_\_\_ Time \_\_\_\_\_

**Insurance Information**

Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**\*Payment is expected upon completion of your visit.**

How will you be paying at your visit? ( ) Cash/Check ( ) Credit Card

If you have any questions or anticipate problems with payment, please call or see the receptionist upon completion of this form.

**PRIMARY INSURANCE INFORMATION**

Does your insurance require a signed claim form? \_\_\_\_ Yes \_\_\_\_ No (If yes, please give the form to the receptionist.)

Insurance Co. Name \_\_\_\_\_ Insured's Name \_\_\_\_\_

Street \_\_\_\_\_ (if different than patient)

City/State/Zip \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

ID# \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Group # \_\_\_\_\_ Street \_\_\_\_\_

Medical Assistance # \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Other Information \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

**CONSENT TO TREATMENT**

This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all diagnostic procedures and/or such medical, surgical, lab, or x-ray treatment, which in the judgment of my attending physician or his authorized agent may be considered necessary or advisable.

Signature \_\_\_\_\_

Relationship \_\_\_\_\_

**FINANCIAL AGREEMENT - MEDICARE**

I request that payment of authorized Medicare/Medigap benefits is made on my behalf to Michael S. Kluska, DO, for any services furnished me. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Beneficiary or his/her representative's signature \_\_\_\_\_

**FINANCIAL AGREEMENT**

I understand that charges will be made today for the physician's service, consults, surgery, etc. I understand that I am financially responsible for all charges and that payment is expected at the time of service unless other arrangements are made with the billing office. I authorize my insurance carrier to pay medical benefits directly to Michael S. Kluska, DO, for services rendered; however, I am responsible for any outstanding balance after such payment. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereof, and all proceeds of insurance are assigned to this office where applicable, but without it assuming responsibility for the collection thereof.

**Notice:** Do not sign this agreement before you read and agree to the conditions set forth above. You are entitled to a copy of the agreement at the time you sign.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_

*Are you required to have your procedures Pre-certified?* Yes \_\_\_\_ No \_\_\_\_

How did you hear about Dr. Kluska?  
\_\_\_\_ Web \_\_\_\_ Phone Book \_\_\_\_ Newspaper \_\_\_\_ Friend \_\_\_\_ Other \_\_\_\_\_



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**Photographic Consent**

Date \_\_\_\_\_

The undersigned consents and authorizes Michael S. Kluska, DO, to obtain pre-operative, operative, and postoperative photographs as deemed necessary for the complete documentation and illustration of the case involved.

It is understood that these photographs may appear in medical publications or conferences in the interest of medical education, knowledge, or research.

Although I give permission for the publication of details and pertinent photographs concerning my case, it is understood that I will not be identified by name

\_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Signed)

I have read the above authorization and release. I am the parent or conservator of \_\_\_\_\_, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

04/28/10