Donald Ray Revis, Jr., M.D., P.A.
Board Certified by The American Board of Plastic Surgery

Personal Information

Last Name__________________ First Name_________________ Middle Initial______
Address ____
City ____________________________ State _____ Zip Code_________________
Home Telephone _____________________ Business Telephone __________________
Cell Phone __________________________
Employer __________________________Occupation___________________________
Business Address ____
City ____________________________ State _____ Zip Code_________________

Email Address ____
Birth Date _______________ Age_____ Male/Female _____ SSN _______________
Marital Status - Single____ Married____ Widowed____ Divorced____ Separated_____
Name of Spouse (if applicable) ____
Person to notify in the event of an emergency ______________________________
Relationship _______________________ Telephone _____________________
Address ____
City _________________________ State _____ Zip Code_______________

I am interested in discussing the following with Dr. Revis:

____

____

I was referred to Dr. Revis by ____

I understand that payment for services are due at the time such services are rendered. By signing this document, I agree to pay for services at the time they are rendered.

Signed:___________________________________ Date:________________________

4200 North Federal Highway • Ft. Lauderdale, FL 33308
www.SouthFloridaPlasticSurgery.com
(954) 630-2009

Donald Ray Revis, Jr., M.D., P.A.
Board Certified by The American Board of Plastic Surgery

Medical History

Have you ever had:

Diabetes	____	High Blood Pressure	____	Atherosclerosis	____
Heart Attack	____	Cancer	____	Heart Murmur	____
Chest Pain	____	Shortness of Breath	____	Fainting Spells	____
Alcoholism	____	Anemia	____	HIV+/AIDS	____
Anorexia	____	Arthritis	____	Asthma	____
Bronchitis	____	Dryness of the Eyes	____	Emphysema	____
Glaucoma	____	Chemical Dependency	____	Goiter	____
Gout	____	Angina	____	Hepatitis	____
Hernia	____	Herpes	____	Gonorrhea	____
Pneumonia	____	Facial Paralysis	____	Pacemaker	____
Stroke	____	Kidney Disease	____	Tuberculosis	____
Ulcers	____	Liver Disease	____	Cold Sores	____
Bulimia	____	Psychiatric Care	____	Varicose Veins	____
Jaundice	____	Suicide Attempt	____	Syphilis	____

Other:____

Prior Surgery and Dates:____
____

Have you experienced complications following surgery?___________________________
Have you experienced unsatisfactory medical care?______________________________
Have you seen another physician regarding the present issue?___ How many?_________
Are you presently under the care of another physician?

Doctor______________________ Reason_______________________________
Doctor______________________ Reason_______________________________

Have you ever received psychiatric care?______________________________________

Do you have any allergies? Yes___ No___

If yes, please list:

Drug_________________ Reaction_______________________ Date________
Drug_________________ Reaction_______________________ Date________
Drug_________________ Reaction_______________________ Date________

Are you currently taking any medications? ______ If yes, please list:

Drug_________________ Dosage_____________________________________
Drug_________________ Dosage_____________________________________
Drug_________________ Dosage_____________________________________
Drug_________________ Dosage_____________________________________

Are you taking any herbal products?____

Bleeding Problems:

Do you regularly take aspirin? _____ Why?______________________________
Do you have prolonged bleeding when cut?_____
Do you bruise easily?_____
Have you ever had a blood transfusion?_____ Why?________________________

4200 North Federal Highway • Ft. Lauderdale, FL 33308
www.SouthFloridaPlasticSurgery.com
(954) 630-2009

Have you ever had a reaction to a blood transfusion?______________________

Name of your personal physician____
Address___________________________________Telephone___________________
City_________________________ State______ Zip Code______________________

Date of last physical examination ____________________________ Normal?________

When was your last mammogram (if applicable)?_____________________________
What was the result?____

Are you pregnant?____

Do you have any family history of disease? (Please list relation and type of illness)_____
____
____

Do you use tobacco?_______ If so, in what form?______________________________
How often?____

Do you drink alcohol?______
How often?____

Do you use any illicit drugs? _____ If so, what kind(s)?__________________________
How often?____

When was your last tetanus shot?____

How tall are you?________ What is your present weight?_______________________
Has your weight changed significantly in the past six months?____________________

Do you have any dermal piercings? Yes___ No___

The above information is true and complete to the best of my knowledge. I have not withheld any information requested on this form.

Signed:_____________________________________ Date:________________________

Donald R. Revis, Jr., MD, PA

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient ID # (SSN):____________________**
(Print)

I hereby acknowledge that I have received a copy of Donald R. Revis, Jr., MD, PA's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

© Copyright 2002, HIPAA Made Easy, Inc.

Donald R. Revis, Jr., MD, PA
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: April 14, 2005

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. However, we reserve the right not to agree to the requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. A reasonable copying charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

© Copyright 2002, HIPAA Made Easy, Inc.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

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

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

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.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information 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.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health 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.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information 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.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

© Copyright 2002, HIPAA Made Easy, Inc.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Suzanne Afshar at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Donald R. Revis, Jr., MD, PA, or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Donald R. Revis, Jr., MD, PA
Suzanne Afshar
Privacy Officer
4200 N Federal Highway
Ft. Lauderdale, FL 33308
(954) 630-2009
Fax (954) 630-2094

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.

© Copyright 2002, HIPAA Made Easy, Inc.