



Suburban
Plastic
Surgery, S.C.

PATIENT REGISTRATION

Please Print

Patient Name _____ Birth Date _____ Sex _____
Last Name First Name Middle

Family Doctor _____ Referring Doctor _____

Patient S.S.# _____ Phone _____ Age _____ Marital Status: S M W D

Patient's Address _____
Street City Zip

Patient's Employer _____ Employer
 and Employer Address _____ Phone # _____

Spouse or Nearest Relative _____ Relationship _____ Phone _____

Address _____

Employer Address _____

Bill TO: (Please Complete - Even if Same as Above)

Responsible Person Name _____ Relationship to Patient _____

Street _____ Home Phone _____

City _____ State _____ Zip _____ S.S.# _____

Employer _____ Employer Phone _____

Patient's Relationship to Insured Self Spouse Child Other

Primary Insurance _____ Group _____ Plan _____

Policy Holder's Date of Birth _____ S.S.# _____ Policy # _____

Claims Office Address _____

Secondary Insurance _____ Group _____ Plan _____

Policy Holder's Date of Birth _____ S.S.# _____ Policy # _____

Claims Office Address _____

Medicare # _____ Public Aid # _____

Work Injury _____ Auto Accident _____
Date Date

Patient's Authorization to release medical information and claim payment authorization

I hereby authorize the above physician(s) to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance

Date

Patient (Parent or Guardian if minor)

I hereby authorize and direct payment check(s) for benefits due for the services rendered by the above named physician(s) to be made directly to him, regardless of my insurance benefits, if any. I understand that I am financially responsible for the fees for services rendered.

Date

Responsible person, policy owner (insured)





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HISTORY

Name: _____ MR: _____ Date: _____

Chief complaint: _____

MEDICAL AND SURGICAL PROBLEM

Diabetic	Yes	No	Heart Problem	Yes	No
Hypertensive	Yes	No	Respiratory Problem	Yes	No
Thyroid Disease	Yes	No	Vascular Problem	Yes	No
Gastrointestinal	Yes	No	Cancer	Yes	No
Arthritis	Yes	No	Seizure	Yes	No

Past Surgery: _____ Date: _____
 _____ Date: _____
 _____ Date: _____

Medication: _____

Allergy: _____

No. of Pregnancies: _____ Children: _____ Height: _____ Weight: _____

PERSONAL

Smoke	No: _____	Yes: _____	Amount: _____
Alcohol	No: _____	Yes: _____	
Recreational Drug	No: _____	Yes: _____	Type: _____
Work Related	No: _____	Yes: _____	
Accident	No: _____	Yes: _____	

Any family history of similar problem: _____

Consent to Treat: I, myself (or the patient named below), hereby consent for examination and treatment as necessary and appropriate for my condition or illness by Dr. Ramasamy Kalimuthu, resident and staff under the direction of Dr. Ramasamy Kalimuthu. I also consent to taking of photographs necessary to document the status and progress. I understand that the medical record and photographs are confidential and occasionally used for scientific and educational purposes. The document may be released to insurance companies or other physicians who are involved in my health and government agencies as necessary.

I also understand that in the event of a medical emergency while in this office, 911 will be called and every effort will be made to resuscitate.

I was given information about the physician who is treating me and necessary office information. I have read and understand the above terms of treatment and confirm that I am the patient or I am authorized to sign on the patient's behalf.

Patient Name: _____ Date: _____

Signature of patient or legal Guardian/Representative _____

Reviewed

Signature: _____

Dr. Ramasamy Kalimuthu

Patient Name _____

Date: _____

MEDICATIONS

4- way Cold Tablets		Congesprin		Madipren	
Advil		Cope		Mathotexate	
Alcohol		Coumadin		Meclomen	
Aleve		Darvon		Midol	
Alka-Seltzer		Darvon Comppound		Multivitiamins	
Amica		DayPro		Nalvadex	
Anacin		Disalcid		Naprosyn	
Anaprox		Doans Pills		Naproxen Sodium	
Ansaid		Drilan		Norgesic	
APC		Easprin		Nuprin	
Arthrotec		Ecotrin		Oruvail	
ASA		Empirin		Pamelor	
Asacol		Equagesic		Pepto-Bismol	
Ascriptin		Excedrin		Percodan	
Aspercream		Feldene		Persantine	
Aspergum		Fish Oil		Plavix	
Aspirin		Florinal		Relafen	
B C Power		Flublprofen Sodium		Robaxlsal	
Banquish		Ginger		Salsalate	
Bilberry		Ginko Blioba		Sine-Aid	
Bufferin		Goodys Headache		Sine-Off	
Cama Arthritis Pain Relief		Ibuprofen		Soma Compound	
Cayanne		Idomethacin		Synalgos - OC	
Celebrex		Indocin		Talwin	
Children's Aspirin		Kopak		Tamollfen	
Clinoril		Lodine		Ticlid	
Coricidin		Lovenox		Tolectin	
Trandate		Trental		Trillistate	
Vioxx		Vitamin C		Vitimin E	
Voltarten		Xorprin		Other	



**Suburban
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Ramasamy Kalimuthu, M.D., F.A.C.S.

Specializing in Plastic, Reconstructive, Cosmetic, Hand Surgery & Laser Surgery

Dear Patient,

As you may know, it has become increasingly difficult to satisfy our patients and at the same time deal with the demands of health insurance plans. More and more, due to insurance company policies, we are receiving denials for services we would like to provide. This causes both anxiety as well as disappointment for our patients.

Due to the large number of plans with different policies, it is not possible for us to know the specifics of your policy. To help provide better care for our patients and to avoid further administrative entanglements we recommend:

Please check with your Primary Care Physician before you visit. If required please obtain a referral before your visit.

We will send a letter to your primary care physician or insurance carrier outlining our recommendations. However, it is your responsibility to check with your primary physician or insurance company to obtain proper authorization for surgery. Please be sure you have the appropriate forms for the hospital and the doctor if they are required under your plan, this will prevent and delay in scheduling surgery.

It is your responsibility to file with your secondary insurance. If needed, and upon your request, we will provide an itemized bill for you to send with your primary explanation of benefits. We do not file any secondary claims, including secondary insurance for Medicare patients.

It is your responsibility to provide the co-payment and other fees that your carrier does not cover, unless prior arrangements have been made.

Thank you in advance for your cooperation and understanding.

Suburban Plastic Surgery



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I _____ give my permission to Dr. Kalimuthu and his office
(print name)
staff to contact and discuss any of my medical Problems with the following people:

Name	Relationship	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Password: _____
(Maiden name, pets name etc... above named person will have to know)

Date: _____ Signature: _____



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Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to *Ramasamy Kalimuthu, M.D. and*
(Name of Patient or Authorized Agent)

Suburban Plastic Surgery, S.C. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon my next office visit or by request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

CONSENT FORM DEFINITIONS *[to be printed on reverse side of form]*

“Health care operations” refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Underwriting, premium rating, and other activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

“Payment” means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, Social Security number, payment history, account number, and name and address of the physician.

“Treatment” means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider or another.

“Use” means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician’s practice that maintains such information.

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2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
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