Brett Kotlus MD
cosmetic and oculofacial
plastic surgery

PATIENT INFORMATION (PLEASE PRINT)			
❑ Mrs. ❑ Ms. ❑ Mr. ❑ Miss	Legal First Name:		Last Name:
Nickname (If preferred):		Marital status S / M / D / W	
SS#:		Date of Birth: / /	
Home #:	Cell #:		Work #:
Address:			
City:	State:		Zip:
Employer:		Pharmacy name/address:	
Occupation:		Pharmacy phone:	
Email:		❑ Please do not contact me about special promotions, offers & news.	
Primary Care Physician:		PCP Phone:	
Reason for Today's Visit:		**How did you hear about Dr. Kotlus:** (If person, list name)	

Check other services of interest or concern:
❑ Facial Rejuvenation/Resurfacing ❑ Spa Services ❑ Brow lift ❑ Brown spots ❑ Fat injections ❑ Eyelids
❑ Non-surgical face lift ❑ Liposuction ❑ Botox/Facial Fillers ❑ Facial implants ❑ Earlobe repair ❑ Nose

MEDICAL HISTORY				
Please list any allergies:				
Please list current medications (prescribed and over the counter):				
Are you pregnant or lactating? Y N	Do you smoke? Y N	Do you exercise regularly? Y N	Are you diabetic? Y N	Any heart condition? Y N
List additional information if applicable:				

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)			
Primary Insurance:		Secondary Insurance:	
Policy Holder:		Policy Holder:	
Holder's DOB:	Holder's SSN:	Holder's DOB:	Holder's SSN:
Relationship to Holder:		Relationship to Holder:	
Plan:		Plan:	
Policy #:		Policy #:	
Group #:		Group #:	

IN CASE OF EMERGENCY	
Emergency Contact:	Relationship:
Phone 1:	Phone 2:

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient/Guardian signature: *Date:*

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Patient Privacy Notice

Please read this information carefully.

This notice explains how your personal and medical information may be used and how you can gain access to it.

When you visit a medical office and see a physician and/or any other health care provider, a record is made. This record contains information such as:

- Demographic Information
- Home Address
- Birth Date
- How you say you feel
- Treatments you received
- Observations by health care providers
- Social Security Number
- Telephone Number
- Health Insurance Information
- Health conditions you have
- Diagnosis and care plans

Health Information Uses and Disclosures
IN ORDER TO SERVE YOU EFFICIENTLY, THERE ARE INSTANCES WHEN WE USE AND DISCLOSE (GIVE OUT) YOUR HEALTH INFORMATION:

Treatments
Your information will be provided to doctors, nurses and other health care workers that are involved in your care. This is necessary so that your plan of care can be carried out efficiently and effectively.

Payment
We will provide information about the care you received in our office to your insurance provider (s). On occasion, your health insurer may request details regarding procedure (s) performed during your visit. Some insurers require pre-approval for certain levels of care and we would provide the necessary information for that purpose as well. This process will help you receive benefits from your health insurer in a timely and concise manner.

Health Care Operations
To continually improve the quality of service we provide, we may use your information to conduct studies. The results are generally used to determine if our services are meeting the needs of our community. We may also contact you or send you a survey to collect comments on the service we provided to you.

Legal Requirements
If we are required by law or other regulation to release your information, we will do so. For example,

- Regulatory agencies that require information for audits, investigations and licensing due to administrative oversight.
- Reporting your information to all the necessary parties involved in a Workers' Compensation case as required by law.

I understand that this practice may not release my protected health information without my written consent, except in cases of Treatment, Payment or Healthcare Operations.
I understand that if I send electronic mail or text messages to the office or staff that my private health information may not be protected.
I understand that signing this document acknowledges that I have received a Patient Privacy Notice from the office of Dr. Brett Kotlus that indicates "use and disclosure" information as well as identifies and explains my patient rights.

Signed: _____

I give the practice permission to discuss my medical condition with the following people: