P: 813-579-3369 & F: 866-202-3227
www.wayneleemd.com

Brandon Office
1020 E. Brandon Blvd, Suite 101
Brandon, FL 33511

Tampa Office
3000 Medical Park Dr. Ste 140
Tampa, FL 33613

Patient History

Date:_____

Patient Name:_____ MI: _____

Address:_____City:_____State:_____Zip:_____

Phones: (Home):_____(Cell): _____

Email: _____

(If you would prefer not to receive email communication and promotion from WLMD, please leave the email line blank.)

Social Security # _____ _____

Driver's License #: _____State: _____Exp: _____

Age: _____Birthdate: (mm/dd/yy): _____/ _____/ Gender: M / F Ethnicity:_____(opt)

Height: _____ft _____in. Weight: _____lbs

Occupation: _____Employer:_____

Marital Status (please circle one): Single – Married – Widowed – Divorced – Separated

Spouse's Name: _____

Family Physician: _____

Other Physician: _____

Emergency Contact, Name: _____Relation:_____Ph: _____

Nearest relative not living with you:_____Relation:_____

Phone: _____

Address:_____City:_____State:_____Zip:_____

Reason for today's Visit:_____

Confidential Health Information Release

Name (Print):_____MI: _____

I authorize this medial office or its affiliates to leave confidential health information voicemail at the following phone number if I'm not available:_____Type of Ph: H / W/ Cell

I authorize this medical office or its affiliates to send confidential health information to the following address:

_____City:_____State:_____Zip: _____

Signature:_____Date:_____

Pharmacy Information

Pharmacy Name: _____ Location:_____

Phone Number: _____ Fax Number: _____

Patient Name:_____

Insurance Information

Primary Policy Holder (Name): _____

Relation to patient:_____

Subscriber Birthdate:_____/_____/_____Subscriber Social Security # ---------- _____

Primary Insurance Co:_____Phone: _____

Policy #:_____Acct #:_____Group #: _____

Secondary Insurance Co:_____Phone:_____

Subscriber Name:_____Relation to patient: _____

Policy #:_____Acct #:_____Group #: _____

Person Responsible for bill:_____Phone: _____

Past Medical History

Check below all illnesses that you have/had:

____ Allergies	____Asthma	____Bleeding Tendencies	____Diabetes	____Epilepsy
____ Diverticulosis	____Eczema	____Depression/Anxiety	____Emphysema	____Glaucoma
____ Eye Disease	____Reflux	____Gastroesophageal	____Glaucoma	____Hernia

____ Heart Disease	____Gout	____Heart Disease	____Hemorrhoids	____Thyroid
____ Kidney Disease	____Neuritis	____Liver Disease	____Tuberculosis	____Pancreatitis
____ Osteoarthritis	____Stroke	____Ulcers (Duodenal)	____Irritable Bowel Syndrome	
____ Ulcers (leg)	____Rheumatic Fever		____Hepatitis, Type: _____	
____ Obstructive Sleep Apnea		____High Blood Pressure	____Cancer/Tumors. Type: _____	

Sexually Transmitted Disease, Type: _____

Do you have a pacemaker?____Yes,____No Are you HIV positive?____Yes,____No

List all other illnesses you've had: _____

_____

Surgeries

Type	Month/Year	Surgeon/Hospital

Pregnancies

Number of Pregnancies:_____

Number of Children:

Males_____ Ages:_____ Females_____ Ages: _____

Patient Name: _____

Medications

Are you currently taking any medications: Yes_____No_____Please list all medications:

_____

_____

Are you currently taking any of the following blood thinners? Please circle.

Aspirin	Plavix	Warfarin (Coumadin)	Fish Oil		Fragmin
Coumadin	Dicumarol	Miradon	Clexane	Arixta	
Orgaran	Innohep	Argatroban	Reludan		Angiomax
Pradax	Plavix	Persantine Aggrenox			

Allergies

Pencilin (reaction):	Cephalosporin(e.g. Keflex)(reaction):
Sulfa (reaction):	Aspirin (reaction):
Codeine (reaction):	Morphine (reaction):
Latex (reaction):	Other (reaction):

Social History

Smoking: (circle) YES, NO, QUIT:_____ Types:_____Cigarettes,_____Cigars,_____Chewing Tobacco
Packs per Day:_____Years Smoked: _____
Alcohol: (circle) YES, NO, QUIT # of Drinks per Week: _____
Illegal Drugs: (circle) YES, NO, QUIT Type:_____Frequency:_____IV Drugs? Y/N
Exercise: (circle) YES, NO, QUIT Activity:_____Frequency:

Family Medical History

Have you or anyone in your family had problems with anesthesia? _____Yes,_____No
Check below if any of the following conditions have occurred on either side of the patient's family:

____ Allergies	____ Bone Disease	____ Diabetes
____ Breast Cancer	____ Kidney Disease	____ Tuberculosis
____ Melanoma Skin Cancer	____Thyroid Disease	____ Pulmonary Disease
____ Other Cancer	____ Congenital Deformities	____ Bleeding Tendencies
____ Gastrointestinal Disease	____ Heart Disease/Cardiovascular	____ Keloid Scars

Other (please list all):

_____

Patient Name: _____

Review of Symptoms

Constitutional: ____Weight Loss ____Fatigue ____Fever

Cardiovascular: ____Chest Pain ____Cyanosis ____Shortness of Breath

____ Ankle Edema ____Frequent Urination at Night

Respiratory: ____Cough ____Coughing Blood ____Wheezing

____Use of Oxygen ____Shortness of Breath

Musculoskeletal: ____Pain ____Tenderness ____Muscle Weakness

____ Joint Swelling

Endocrine: ____High Blood Sugar ____Excessive Thirst ____Intolerance of Heat or Cold

Hematology/Lymphatic: ____Anemia ____Bruise Easily ____Enlarged Lymph Node

Allergy/Immunologic: ____Itchy ____Frequent Infection Inhalant or Food Allergy GU:

____Burning ____Urinary Infections ____Urine in Blood

Eyes: ____Blindness ____Red Eyes ____Double or Blurry Vision Skin:

____Rash ____Lumps ____Sores ____Loss of Hair

Psych: ____Anxiety ____Sleep Disturbances ____Nervousness

____ Memory Loss

GI: ____Nausea ____Vomiting ____Diarrhea

____ Vomiting Blood ____Indigestion ____Difficulty Swallowing

Neuro: ____Paralysis ____Head Injury ____Head Aches

____ Numbness ____Blackouts

How were you referred to our office? Please check all that apply.

____ Physician Referral & Physician Name: _____

____ Hospital Affiliation & Name: _____

____ Patient Referral & Name: _____

____ Word Of Mouth ____Driving By ____E-Mail

____Website ____Facebook ____Tampa Bay Surgical Arts

____ Bella Medspa ____RealSelf ____Yelp

____ Citysearch ____Vitals ____Healthgrades

____ Merchant Circle ____Insider Pages ____Thumbtact ____Return 2 Fitness

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my healthcare, Wayne Lee MD Plastic Surgery, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plan for future plan for treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a Notice of Privacy Practices that provides more completed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Wayne Lee MD Plastic Surgery PLLC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance there on. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse treatment as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Wayne Lee MD Plastic Surgery PLLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Wayne Lee MD Plastic Surgery PLLC change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

_____

Patient Signature: Date:

Patient Name: _____

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

Member Name:_____ Date:_____

Member #: _____

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to **Wayne Lee MD Plastic Surgery PLLC** and **Dr. Wayne Lee** (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account. In the event the insurance carrier responsible for making medical payments to **Wayne Lee MD Plastic Surgery PLLC** and **Dr. Wayne Lee** for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including the Law Offices of Cohen and Howard) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

Patient Name:_____

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance
   policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third- party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: _____ Patient Signature:_____ Date:_____

Patient Name:_____

Authorization For & Release of Medical Photographs, Slides, and/or Videotapes

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

Medical photographs, slides, and videotapes may be taken before, during, or after surgical procedure of treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs, slides, and videotapes for a stated purpose.

Consent to Take Photographs, Slides, and/or Videotapes

I hereby authorize Wayne Lee MD Plastic Surgery and/or his associated or licensees to take pre-operative, intra-operative, or post-operative photographs, slides, and/or videotapes.

Consent for Release of Photographs, Slides, and/or Videotapes

I hereby authorize Wayne Lee MD Plastic Surgery and/or his associate or licenses to use pre-operative, intra-operative, or post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to show these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, advertising purposes, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment of any other consideration as a result of any use of the images.

Patient Signature: Date:

WAYNE LEE MD
Plastic & Reconstructive Surgeon
Where Art Meets Science

P: 813-579-3369 & F: 866-202-3227
www.wayneleemd.com

Brandon Office
1020 E. Brandon Blvd, Suite 101
Brandon, FL 33511

Tampa Office
3000 Medical Park Dr. Ste 140
Tampa, FL 33613

Patient Name:_____

Patient DOB:_____SSN:_____

I hereby authorize Wayne Lee MD Plastic Surgery, PLLC to *Release/Request* my medical Records *to/from*:

NAME:_____

Location
Address:_____

_____

Phone:_____Fax:_____

Email:_____

Reason For Request:_____

Date Needed:_____

Records Needed: (Please specify which medical records are needed for the above patient. For instance, Doctor's office visit notes, operative reports, prescriptions, lab work, diagnostic test results, x-rays, MRI Results, etc. Doing so will help with efficiency in processing the request. Thank you for your cooperation.)

_____

_____

_____

Patient's Signature_____Date:_____

Edited 3/2021