JUAN C. NOSTI, M.D., P.A

PLASTIC SURGERY

BREAST SURGERY
COSMETIC SURGERY OF THE FACE
BODY CONTOURING
HAND SURGERY

FELLOW AMERICAN COLLEGE OF SURGEONS – DIPLOMATE AMERCIAN BOARD OF SURGERY
DIPLOMATE AMREICAN BOARD OF PLASTIC SURGERY – CERTIFICATE OF ADDED QUALIFICATIONS SURGERY OF THE HAND

Re: Upcoming appointment on _____.

Time: _____ with Juan C. Nosti, M.D.

Dear _____:

Thank you for choosing our office for your medical care. We will work very hard to treat and manage your medical needs. In order to expedite your visit, we ask the following of you:

- Please bring your insurance card with you at the time of your visit and if you have a co-pay we will collect it at the time of your visit.
- Please complete the enclosed forms and bring them with you. If your paperwork has not been completed, please arrive 15 minutes before your appointment.
- If you have records from a referring physician, please bring those with you on the day of your appointment.

Sincerely,

Juan C. Nosti, M.D.

(913-262-5014- FAX (913-262-6198
GEORGETOWN MEDICAL BUILDING – 8901 W 74TH STREET STE 350 – SHAWNEE MISSION, KANSAS 66204
151 WEST 151ST STREET – OLATHE, KANSAS 66061

PATIENT INFORMATION

JUAN C. NOSTI, M.D., P.A.
PLASTIC AND RECONSTRUCTIVE SURGERY

Name _____
Last First M. Initial Date

Home Address _____
Street City State Zip Code

Phone _____ Age Sex
Home Work

Date of Birth Social Security # Marital Status

Insurance Carrier _____
Primary Secondary

Nearest Relative _____

Home Address _____

Patient/Parent Employer _____
Phone #

Spouse/Parent Employer _____
Phone #

Notify in Emergency _____

Address _____
Street City State Zip Code

Phone _____
Home Work

Responsible Billing Party _____
Relationship to Patient

Date of Birth Social Security #
(if other than patient)

PATIENT REFERRED BY _____

REASON BEING SEEN TODAY _____

Please have your insurance card(s), medication list, referral from your PCP and/or other necessary forms with you.

JUAN C. NOSTI M.D., P.A.

PLASTIC AND RECONSTRUCTIVE SURGERY

The following is a statement of our Financial Policy. Please read and sign prior to any services being rendered.

PARTICIPATING INSURANCE PLANS

In order to properly bill your insurance company and avoid untimely delays, we require that you provide your insurance information and allow us to keep a copy of your insurance card on file. For those plans that we are a participating provider, all co-payments and deductibles are due at the time of service. For those patients requiring a referral form from your primary care physician, please bring the referral form at the time of your visit or before any surgical procedures.

NON-PARTICIPATING INSURANCE PLANS

If you do not have an insurance plan where we are a provider, we require that payment be made at the time of service. We accept cash, check, Visa, MasterCard or Discover.

SECONDARY AND TERTIARY INSURANCE

We will be happy to file your second and third insurance if you provide the necessary information. If you do not provide us with the information, you will be responsible to file any claims with that insurance.

Thank you for your understanding of this financial policy. Please let us know if you have any questions.

MEDICAL AUTHORIZATION

I authorize Juan C. Nosti M.D., P.A. to furnish complete medical information to my insurance or its intermediaries regarding services rendered.

_____

Patient Signature/Parent/Guardian Date

Some insurance companies will not pay for certain procedures or office visits and will be your responsibility. We accept assignment with numerous insurance companies. Please verify your benefits with your insurance company. If you do not have insurance through one of these contracted insurance companies, then you are responsible for submitting claims and payment is due at the time of service.

I HAVE READ AND UNDERSTAND THE ABOVE, and hereby give my consent to Dr. Juan C. Nosti or designee to provide medical treatment to me encompassing diagnostic and therapeutic procedures.

_____

Patient Signature/ Parent/ Guardian Date

Name _____ Today's Date _____
Sex M_____F_____ Birth Date ____/_____/_____ Age_____

Today's Problem
What is the reason for seeing the doctor today?_____

Drug Allergies
Do you have any allergies to medications? ( ) Yes ( ) No
If yes, list the medication and the reaction._____
_____

Current Medications Including Vitamins and Supplements

Name	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please mark with a check if you are taking any of the medications mentioned below:

Alternative Medications that affect blood coagulation:

_____Alfalfa
_____Chinese Herbs
_____Horseradish
_____Licorice
_____Fenugreek
_____Capsicum
_____Feverfew
____Ginger
____Chamomile
____Fish Oil
____Vitamin E
____Passionflower
____ Gingko

Alternative Medication that affect blood pressure:

_____Black cohash
_____Capsicum
_____Celery
_____Ephedra
_____Horseradish
_____St. John's Wart
_____Fenugreek
_____Ginseng
_____Goldenseal
_____Hawthorn
_____Garlic
_____Licorice
_____Ginger

Alternative medications that affect cardiac function:

_____Black cohash
_____Ephedra
_____Fenugreek
_____Ginger
_____Ginseng
_____Goldenseal
_____Hawthorn
_____Licorice
_____Lobelia

Past Medical History
Surgeries (list dates)_____
_____

Hospitalizations (non-surgical)
_____
_____

Name_____ Today's Date__ _____

Review of Systems- Have you ever had any of the following?

1. **Constitutional**

_____Poor Health _____Fatigue _____Weight Loss (Due to Illness)

2. **Ear, Nose & Throat**

_____ Ear Problems _____Sinus Problems _____Throat Problems

3. **Eyes**

_____Blurred Vision _____Painful Eyes _____Irritation from Light

4. **Respiratory**

_____Asthma _____Chronic Cough _____Emphysema
_____Shortness of Breath _____Lung Infections _____Tuberculosis

5. **Cardiovascular (Heart)**

_____Chest Pain _____Heart Troubles _____Heart Murmur
_____High Blood Pressure _____Palpitations/fluttering of heart

6. **Gastrointestinal**

_____Ulcers/Heartburn _____Hepatitis _____Bowel Irregularity

7. **Genitourinary**

_____Kidney Disorder _____Urinary Tract Infection _____Prostate Disease

8. **Endocrine (Glands)**

_____Thyroid Disorder _____Diabetes

9. **Allergy/Immunology/Hematology (Blood Problems)**

_____Bleeding Disorder _____Frequent Infections _____Cancer
_____Anemia _____Blood Transfusion _____Arthritis

10. **Neurology**

_____Seizures _____Mental Disorder _____Stroke

Family History Have any relatives ever had any of the following? If so, whom?

Allergies_____ Cancer_____
Asthma_____ Diabetes_____
Reaction to Anesthesia_____ Bleeding Disorder_____
Heart Disease_____ Stroke_____
Thyroid Disease_____ Kidney Disease_____
Arthritis_____

Social History and Habits

Tobacco:_____NONE

_____Cigarettes _____Cigars _____Chew _____Pipes
_____packs per day/# per day Age started_____ Age stopped_____

Alcohol:

Present Use :_____Never _____Occasional _____Frequently _____Daily
Past Use: _____ Never _____Occasional _____Frequently _____Daily

Occupations: Current_____ Past_____
_____Married _____Single _____Divorced _____Separated _____Widowed

Juan C. Nosti, M.D., P.A.
Plastic and Reconstructive Surgery
Hand Surgery

Patient Consent to Leave Detailed Messages/Information

Dear Patient:

Juan C. Nosti, M.D., P.A. has adopted a policy that requires that the physician and staff obtain authorization from the patient to leave detailed messages for that patient. This policy is to protect the privacy of the patient and to protect the physician and staff of Juan C. Nosti, M.D., P.A. from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone asking the patient to return the call.

By completing the consent below, you are allowing Juan C. Nosti, M.D., P.A. and his staff to leave a message on an answering machine, voicemail or with a specified individual. You can specify what information is left and with whom. By signing, you are also consenting to the mailing or faxing of any results requested by you, your primary care physician or another physician involved in your care.

_____

I give my consent to Juan C. Nosti, M.D., P.A., physician and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary.

_____ on an answering machine or voicemail at home or cell phone

_____ on an answering machine or voicemail at work

_____ with _____ relationship_____

with _____ relationship_____

with _____ relationship_____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Witness Date

Notes_____

_____

JUAN C. NOSTI, M.D., P.A.
PLASTIC AND RECONSTRUCTIVE SURGERY

MAXILLOFACIAL SURGERY
COSMETIC SURGERY
HAND SURGERY

FELLOW AMERICAN COLLEGE OF SURGEONS
DIPLOMATE AMERICAN BOARD OF SURGERY
DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY

GEORGETOWN MEDICAL BUILDING
8901 W 74TH St., SUITE 350
SHAWNEE MISSION, KS 66204
913-262-5014

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

PATIENT: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

I _____, do hereby authorize disclosure to: _____

_____

ATTN: _____, the following information _____

_____

(Please return a copy of this consent with the requested information.)

I understand that my medical records, including drug or alcohol abuse information, may be protected by Federal Regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (i.e., probation, parole, etc.) and that in any event this consent automatically expires as described below.

SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES (expires in one year if left blank): _____

Executed this date: _____

_____

Witness **SIGNATURE OF PATIENT**

_____

SIGNATURE OF PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE

PATIENT INFORMATION SHEET
FOR
JUAN C. NOSTI, M.D., P.A.

THIS NOTICE DESRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

As a condition of providing treatment to you, our office must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and the health care operations.

You may revoke this consent at any time by notifying our office in writing, except to the extent our office has taken action and reliance of your consent.

Your protect health information may be used and disclosed to carry out treatment, payment, or health care operations.

Please refer to the "Privacy Notice" for a more complete description of the uses and disclosures that our office may use of your protected health information. You have the right to review the "Privacy Notice" prior to signing this consent.

Our office has reserved the right to change its privacy practices described in the "Privacy Notice". At any time, you may request a current copy of the "Privacy Notice" in writing or in person.

You have the right to request our office to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment or health care operations. However, our office is not required to agree to such restrictions.

I hereby consent to the use and disclosure by Juan C. Nosti, M.D., P.A., staff, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

_____

Signature

_____

Signature of Personal Representative of Patient

_____

Description of Representative's Authority to Act for Patient

Date: _____