Caroline J. Plamondon, MD
One Randall Square, Suite 408
Providence, RI 02904-7405
Tel: (401) 272-6602 Fax: (401) 273-2900

ACCOUNT INFORMATION: **Date:** _____

Patient's Name: _____ Guarantor's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ Phone (cell): _____

Phone (work): _____ E-mail Address: _____

Preferred Method of Contact (**circle one**): HOME ☐ CELL ☐ WORK ☐ E-MAIL ☐

Date of Birth: _____ Marital Status: _____ SS#: _____

Employer: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Employer's Phone: _____

Name of Emergency Contact: _____ Relationship: _____

Emergency Contact Phone (home): _____ Phone (cell): _____

INFORMATION FOR DEPENDENT PATIENT:

Patient's Name: _____

Date of Birth: _____ SS#: _____

PRIMARY CARE PHYSICIAN/PEDIATRICIAN:

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

PHARMACY:_____Phone:_____Address:_____

REFERRED BY: (Internet, Doctor, Patient, Relative, etc.)

Name: _____

INSURANCE INFORMATION:

Subscriber's Name: (policy holder) _____

Carrier's Name: _____

Plan Name: _____ Plan ID#: _____

Subscriber's SS#: _____ Subscriber's Date of Birth: _____

If you have secondary insurance, please provide name and plan information below:

_____

Please note: If you are co-insured or if your insurance only covers part of the surgical fees, you may be asked to pay this amount ahead of the surgery.
My signature below authorizes the release of any medical information necessary to process reimbursement claims.
I authorize payment of benefits to Dr. Caroline J. Plamondon.

Signature: _____ **Date:** _____

M E D I C A L H I S T O R Y

Caroline J. Plamondon, M.D.

Patient Name_____ Today's date_____

Age_____ Birthdate_____ Date of last physical examination_____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

General

- ☐ Chills
- ☐ Depression/Anxiety
- ☐ Eating Disorder *(Bulimia, Anorexia)*
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Gastrointestinal

- ☐ Appetite poor
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Reflux
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Vomiting
- ☐ Vomiting blood

Genito-Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Eye, Ear, Nose, Throat

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

Women

Are you pregnant? ____

Number of children ____

Cardiovascular

- ☐ Chest pain/Heart attack
- ☐ Heart murmur or leaking valve
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood sugar
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Drug or Alcohol dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Embolism
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis B or C
- ☐ Hernia
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers

☐ Psychiatric Care

If yes, Doctor's Name

_____

Medications

List **all** medications you are currently taking.

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

Past Surgeries

Year	Hospital	Reason

Past Hospitalization for Serious Illnesses

Year	Hospital	Reason

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates: _____

Health Habits

Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to the following:

Stress ☐ Hazardous Substances ☐

Heavy Lifting ☐ Other ☐

Occupation

Family Health

Check ✓ If, your blood relatives had any of the following:

✓	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

CAROLINE J. PLAMONDON, M.D., M.Sc., F.R.C.S.C.
ONE RANDALL SQUARE, SUITE 408
PROVIDENCE, RI 02904-7405
401-272-6602

INSURANCE WAIVER OF LIABILITY

Insurance regulations require that I inform you that your insurance company may possibly deny coverage for surgical procedures that have been requested by you or recommended to you by myself or other health care providers.

Most insurance companies' will either not pre-authorize surgery and/or may retroactively deny it. If this occurs, it is the policy of this office to bill you directly after appealing to your insurance company for you. It is recommended that you also appeal directly if your insurance company denies you coverage.

If your insurance company ultimately denies covering your surgery, you will be responsible for the surgical fee up to the reimbursement level normally provided by your insurance company.

INSURANCE DEDUCTIBLE FOR SURGICAL PATIENTS

In the event you become a surgical patient, we require **a copy of the front and back of your credit/debit card** to cover any deductible that your insurance plan may indicate. Our office will verify this amount of ahead of time through your insurance carrier. We will submit the claim to your insurance carrier on your behalf.

Upon receipt of notification from your insurance company, any outstanding deductible will be charged to the credit card you have provided us. You may also choose to write us a check which we will hold until we receive notification of payment from your insurance company.

By signing below, I acknowledge that I have read and agree to the above policies.

_____

Signature Date

_____

Witness Date

AUTHORIZATION FOR PHOTOGRAPHS

I authorize Caroline J. Plamondon, MD to take pre- and post-operative photographs. They are important aids in planning and performing surgery and become a permanent part of your patient record.

I also authorize Caroline J. Plamondon, MD to use these pictures for the purpose of teaching, as a tool to inform other patients, or as part of Dr. Plamondon's internet website. Photographs will always be used in an anonymous fashion. Body photographs never show the face; however, if the surgery involves part or the whole face, I still authorize Caroline J. Plamondon, MD to use the photographs as mentioned above.

Restrictions if any: _____

Signature _____

PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature _____

Name (print) _____Date:_____

CAROLINE J. PLAMONDON, M.D., M.Sc., F.R.C.S.C.
One Randall Square, Suite 408
PROVIDENCE, RI 02904
401-272-6602

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

THIS NOTICE TAKES EFFECT ON APRIL 14, 2003 AND REMAINS IN EFFECT UNTIL WE REPLACE IT.

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address above.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluation the performance of employees, conduction training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

COURT ORDERS AND JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

PUBLIC HEALTH ACTIVITIES: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We
may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

WORKERS COMPENSATION: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

LAW ENFORCEMENT: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoena or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

APPOINTMENT REMINDERS: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

ALTERNATIVE AND ADDITIONAL MEDICAL SERVICES: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

YOU HAVE A RIGHT TO:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information list at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you for each page, and postage if you want the copies mailed to you. Contact us using the information listed above for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

Questions and Complaints

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit or submit requests involving any of your rights in Section 4 of this notice by writing to the above address.

We will provide you with the address to file your complaint the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.