





**PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING**

**Assignment, Release and Financial Agreement:** I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I understand that I am financially responsible for non-covered services. I also authorize the physician to release any information required. I agree that I will not withhold or delay payment if my insurance company denies payment of any of my charges. I am financially responsible for a billing fee and understand that balances of 60 days may incur a billing fee of \$5.00 per month, with a minimum charge of \$1.00 monthly. I have also been informed of the \$25.00 fee (per RCW 62A.2-515&520) on checks returned for NSF. In the event it should become necessary to place any unpaid balance due for services rendered to me or my family for collection, I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fees and other costs the court determines proper.

**Medicare Authorization:** I authorize the doctor to release to the Federal Government or its designated agent information on this or related medical claims. I permit a copy of this authorization to be used in place of the original request payment of my insurance benefits be made to myself or to the doctor if assignment is accepted. Good for one year or Ending \_\_\_/\_\_\_/\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

REVIEW DATE / INITIAL:


## Patient Personal History

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name:**

**DOB:**

**History of Skin Cancer**  
If yes, please list type

Yes      No

**Family History of Skin Cancer**  
If yes, please list type

Yes      No

**Allergies to Medications:**

**Operations:**

**Family History (Illnesses):**

**Hobbies/Activities:**

**Illnesses/Symptoms**

**Please Explain Nature of Illness/Symptoms**

Blood bleeding disorders		Yes	No
Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Diabetes thyroid		Yes	No
Eyes glaucoma	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Ear/nose/mouth/throat		Yes	No
Lung disease/asthma	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Epilepsy/Seizures		Yes	No
Stroke/Neurological	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Kidney/Urinary		Yes	No
Liver/Hepatitis	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Heart disease/Angina		Yes	No
High blood pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Stomach/Gastrointestinal		Yes	No
Chronic viral infections	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Circulation disorder		Yes	No
Arthritis	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Skin		Yes	No
Psychiatric depression	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Pacemaker		Yes	No
Artificial joints	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Anticoagulants (including aspirin)		Yes	No

Tobacco    Yes    No      Alcohol    Yes       No      Amount: \_\_\_\_\_



An **Advance Directive** or **Living Will** states a person's healthcare decisions in the event that person becomes incapacitated and can no longer make these choices.

Regardless of your Advance Directive, it is the policy of Harbor Plastic Surgery Center to NOT honor Advanced Directives in our outpatient center. We will make every effort to resuscitate you, including calling paramedics.

However, if you are transferred to the hospital, we will bring a copy of your POLST with you. The hospital will follow your Advance Directive orders.

Do you have an Advance Directive?                      YES              NO

If Yes, have you provided Harbor Plastic Surgery Center with a copy of your POLST?      YES              NO

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



### Communication Agreement

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Your Healthcare Provider may need to contact you to discuss your health, review results of testing or to coordinate your care. Please review and answer a few questions regarding your preferences regarding this communication.

- 1. May we leave messages regarding your health information on your answering machine or voicemail at **home**?  **NO**  **YES**  **N/A**
- 2. May we discuss your medical care with **anyone** that answers the telephone at your home?  **NO**  **YES**  **N/A**
- 3. May we leave messages regarding your health information on your answering machine or voicemail at **work**?  **NO**  **YES**  **N/A**
- 4. May we leave messages regarding your health information on your **cellular** telephone voicemail?  **NO**  **YES**  **N/A**
- 5. Are there any members of your family, household or those coming with you to this appointment with which we should **not** discuss any of your health care issues?  **NO**  **YES**  **N/A**

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I AGREE that I am making this request for my convenience, without coercion or pressure by my healthcare provider or any other party. I understand that this request may result in someone other than me learning of my personal health information. I also understand that this agreement will be in place until I personally request in writing that it be cancelled. I will be responsible for completing a new request form to update contact numbers should they change. If my contact numbers should change, I give permission to send test results to me by mail.

Patient or legally authorized individual signature	Date

Printed name if signed on behalf of the patient	Relationship (parent or legal representative)

Please list additional phone numbers: \_\_\_\_\_  
\_\_\_\_\_

## **FINANCIAL & INSURANCE POLICY**

**IDENTITY THEFT PROTECTION:** I understand that according to Federal Identity Theft Protection I will be required to show valid picture identification. Valid identification must include the patient's picture and date of birth. Examples: A Washington Driver's License, Valid Passport, State Resident Identification Card, Work Permit or Green Card.

**INSURANCE COMPANY REFERRALS:** If your insurance carrier requires a referral, it will be the patient's responsibility to obtain that referral from their primary care physician. If a referral is required and not obtained prior to your procedure, the patient will be responsible for any non-covered charges.

**INSURANCE AUTHORIZATION:** Many insurance carriers require that procedures be authorized prior to your surgical procedure. This may require a written letter of documentation, pre-operative photos and possible diagnostic procedures. This process takes on average 25 business days for the insurance carriers to process. Please keep in mind that insurance carriers do not give guarantees of payment. They only document if your case meets their medical criteria for coverage. Our facility will assist you in this authorization process. **If you have not heard from our facility regarding preliminary status within 10 working days following your consultation, please contact our office at (253) 858-5040.**

**DEDUCTIBLES AND CO-PAYMENTS:** Co-Payments are due and payable at the time of your visit. You may be responsible for covering your annual deductibles prior to a procedure. Deductibles and Co-payments, by law, cannot be adjusted at the discretion of the surgeon or their office.

**YOUR BILL:** You will be billed separately for care provided in the clinic and in our ambulatory surgery center. You will be billed both a professional fee and a facility fee for procedures performed in the ambulatory surgery center. Your EOB will show the same codes on each of these bills, but one will be for professional services and the other for facility charges. You will be billed a professional fee only for work performed in the clinic. Your insurance company may process these at different times, resulting in up to 3 EOBs showing what your insurance company paid and what your responsibility is.

**PATIENT RESPONSIBLE BALANCES:** Once your insurance company has paid their portion of the bill and notified us of your balance, our billing service will send a statement to you. If you cannot pay the full balance upon receipt of your bill, contact our office immediately to see if you qualify for a payment plan. You will be sent 2 statements and if your payment has not been received within 90 days of the first statement, we will send the balance to a collection agency.

**RETURNED CHECK POLICY:** Patients will be responsible for a \$35.00 Service Fee for any check returned to our office by your bank as not valid for payment.

**BILLING SERVICE:** Direct all questions and concerns to our billing department at (253) 858-5040. Harbor Plastic Surgery Center accepts Mastercard, Visa, American Express and Discover. Payment arrangements can also be made through the billing department to assist you in any remaining balances indicated by your insurance carrier. Our billing personnel are available to assist you Monday through Friday 8:30 a.m. to 4:30 p.m.



**COSMETIC SERVICES:** Non-surgical cosmetic services must be paid in full at the time the service is rendered. All Cosmetic Surgery fees are payable in full three (3) weeks prior to the day of your surgical procedure.

**POST-OPERATIVE PERIOD:** Most major surgeries performed in our ambulatory surgery center have a 90-day global post-operative period. This means that all care that is directly related to your surgical office procedure is included in the initial surgical fee for the first 90-days following your procedure. Once this 90-day global period has passed, your future visits with your surgeon will be billed to your insurance company. **Exceptions** to this rule would be any care received that is not directly related to your surgical procedure (a different diagnosis) or a return to the operating room for more surgery. These exceptions will be billed to your insurance carrier for further payment. Any medical care provided after the 90-days will be submitted to your insurance carrier for reimbursement and you will be responsible for additional co-payments and any and all charges deemed by your insurance carrier to be the responsibility of the patient.

**EXPECTATIONS:** Insurance carriers will only cover the portions of surgical procedures that meet their established criteria for medical necessity. They will not cover any procedure that is performed for the enhancement of your appearance. You may discuss these types of appearance enhancements with your surgeon at the time of your consultation as they often can be performed at the same time as your insurance related procedure at a cost savings.

**GUARANTEES OF OUTCOME:** **There is no such thing as permanent or perfect surgery.** Harbor Plastic Surgery Center Surgeons cannot give or provide any guarantee to surgical outcome. Complications and Risks are outlined on our patient consent form and should be read carefully. If you should have any questions, please do not hesitate to discuss with your surgeon or their clinical staff.

**PATIENT RIGHTS AND RESPONSIBILITIES:** WASHINGTON STATE LAW GUARANTEES THAT YOU HAVE THE RIGHT AND OBLIGATION, AS A PATIENT, TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED SURGICAL, MEDICAL, OR DIAGNOSTIC PROCEDURE. WITH THIS INFORMATION YOU MAY MAKE THE INFORMED DECISION WHETHER OR NOT TO UNDERGO THE PROCEDURE AFTER KNOWING THE RISKS AND HAZARDS INVOLVED. THIS DISCLOSURE IS NOT MEANT TO SCARE OR ALARM YOU; IT IS SIMPLY AN EFFORT TO MAKE YOU BETTER INFORMED SO YOU MAY GIVE OR WITHHOLD YOUR CONSENT TO THE PROCEDURE

I have read and understand Harbor Plastic Surgery Center financial and insurance policies.

\_\_\_\_\_ Date: \_\_\_\_\_

Patient/Legal Guardian's Name



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

The Federal government mandates that you be informed

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or 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
- ◆ A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand I can be provided with a *Notice of Information Practices* that details a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restriction as how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing to Harbor Plastic Surgery Center located at: 11511 Canterwood Blvd NW, Suite 310, Gig Harbor, WA 98332 except to the extent that the organization has already taken action in reliance on the consent.

Please read the following information and then indicate your agreement with these statements by circling (yes / no) for each statement.

### Please circle

1. yes / no I understand that I will be informed should my medical case be included in any investigational, research, or educational studies.
2. yes / no I have received a copy of my surgeon's medical credentials.
3. yes / no I consent to permit a sample of my blood or body fluid(s) to be tested should any person (surgeon, nursing staff or other personnel) at Harbor Plastic Surgery Center be accidentally contaminated by either or both substances.
4. yes / no Are there other restrictions that you wish to have? If yes, please explain.

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I fully understand and **accept/decline** the terms of this consent.

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Patient/Guardian Signature

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Date

---

Witness Signature Date

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Date

## PATIENT'S RIGHTS & RESPONSIBILITIES

**As our patient we would like to make you aware of your rights and responsibilities. You may exercise your rights without being subject to discrimination or reprisal.**

**Personal Privacy:** Your personal privacy and safety are very important. It is your right by virtue of your physical surrounding and respect of dignity by all healthcare workers and business office employees that your privacy and safety be maintained. It is the patient's responsibility to indicate to our Facility's Management Team if at any time you feel your privacy or safety is being violated.

**Receive care in a safe setting:** By virtue of trained, professional healthcare workers and adherence to State, Local and Federal safety standards, Harbor Plastic Surgery Center strives to maintain the highest standards. It is the patient's responsibility to indicate to our facility's management if at any time you feel your safety is being violated.

**Be free from all forms of abuse or harassment:** As our patient it is your responsibility to file a grievance with our facility's management and to be assured our ASC will respond and take your grievances seriously.

**Information Disclosure:** You have the right to accurate and easily understood information about your health plan, healthcare professionals and your health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, help will be provided so you can make informed health care decisions. If you are in need of a translator; A translator will be provided to you upon request.

**Choice of Providers:** You have the right to choose health care providers. The successful outcome of any patient/doctor relationship requires the patient to be comfortable with their physician and his staff. Therefore, if you wish not to see any physician at Harbor Plastic Surgery Center, please notify our staff immediately. Seeing your physician of choice may not be possible in an emergent situation.

**Access to Emergency Services:** If you feel your emergent condition is life threatening please call 911 before contacting our office. If you have severe pain, an injury or sudden illness that makes you believe that your health is in serious danger, you have the right to be screened and stabilized using emergency services. Harbor Plastic Surgery Center has a physician on call 24 hours per day/Seven days per week. In case of emergency please contact us at (253) 509-4438.

**Participation in Decisions:** You have the right to know your treatment options and take part in decisions about your care. Parents, guardians, family members or others that you select can represent you if you cannot make your own decisions.

**Respect and Non-Discrimination:** You have a right to considerate, respectful care from your doctors and his health care staff. All medical decisions will be based on current medical standards and knowledge.

**Confidentiality of Health Information:** You have the right to talk privately with your health care provider and to have your health care information protected. You also have the right to read and receive a copy of your own medical record. You have the right to ask the doctor to change his medical record if it is not correct, relevant or complete.

**Health Insurance Problems:** If you have concerns about your insurance, it is sometimes helpful to start with customer service at your insurance company. Harbor Plastic Surgery Center will provide any required assistance deemed necessary by your insurance carrier in order to process your claims correctly.

**Billing and Claim Concerns:** Harbor Plastic Surgery Center utilizes a separate outside facility to handle all of their claim submission. However, any billing related questions should be directed to the Harbor Plastic Surgery Center.

**Advance Directives:** It is the policy of Harbor Plastic Surgery Center that in the event a patient goes into cardiac or respiratory distress or any other medical emergency, all emergency care will be provided, including the calling of paramedics and transfer to a local hospital when indicated. Harbor Plastic Surgery Center policy is to make every effort to resuscitate all patients. If a patient



wishes are not to be resuscitated (DNR) the patient must bring a copy of his/her POLST (Physicians Orders of Life Sustaining Treatment) to have on our records. This POLST form must be completed by your primary care physician and cannot be completed by Harbor Plastic Surgery Center Physician.

**Ownership:** Harbor Plastic Surgery Center is a privately owned Corporation by Justin H. Piasecki, MD.

**Complaints and Appeals:** You have the right to a fair, fast and objective review of any complaint you have against your physician, their staff or the facility. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of the health care facilities.

If you have complaints or concerns you have the right to file them with the following:

**Harbor Plastic Surgery Center**

Jill Piasecki, Administrator

11511 Canterwood Blvd NW, Suite 310

Gig Harbor, WA 98332

Email: [jill@drpiasecki.com](mailto:jill@drpiasecki.com)

Medicare Ombudsman

1-800-Medicare (1-800-633-4227)

<http://www.medicare.gov/Ombudsman/resources.asp>

**Washington State Department of Health**

[Health Systems Quality Assurance](#)

Washington State Department of Health

310 Israel Road SE

Tumwater, Washington 98501

PO BOX 47850

Olympia, Washington 98504-7850

(360) 236-4600

**Patient Responsibilities – As a patient it is your responsibility to:**

**Medical History:** You are required to provide a complete and accurate history to the best of your ability. This includes, but is not limited to all medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.

**Follow Treatment Plan:** Your prescribed treatment plan was designed for the best outcomes. If you have any questions or concerns with the treatment plan, you have 24X7 access to your physician. It is your responsibility to contact him if you are confused or do not agree with the plan. Otherwise, we expect that you are following your treatment plan.

**Transportation:** Depending on the treatment performed, you may be required to have a responsible adult to transport you home and remain with you for 24 hours following your procedure. This will be discussed with your doctor.

**Advance Directives:** It is your responsibility to inform us of your Advance Directive, Living Will or any medical power of attorney.

**Respectful Behavior:** We expect that our patients will treat our physicians and staff in a courteous, professional and respectful manner.

**Termination** We believe that you have an important role in your care. Failure to comply with the patient responsibilities may result in your termination as a patient. If this happens, we will refer you to another provider to continue your care.



**Justin H. Piasecki, M.D.**  
**DBA: HARBOR PLASTIC SURGERY CENTER**  
**11511 Canterwood BLVD NW, SUITE 310**  
**GIG HARBOR, WA 98332**  
**(253) 858-5040**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
 AGE: \_\_\_\_\_

I HAVE RECEIVED INFORMATION FROM MY SURGEON JUSTIN H. PIASECKI, M.D..

**I understand that the information received contains the following:**

- My Patient Rights and Responsibilities (including Grievance Process, Advance Directives and Physician Ownership)
- A Surgical Preparation Time Line
- Post Operative Instructions
- Financial and Insurance Information
- Medications to Avoid List
- Copy of Consent Form (that I will be signing the day of surgery)

**I understand that it is my right to have this information translated into my primary language for my better understanding.**

I will not require any assistance for translation regarding my medical care. \_\_\_\_\_ Patient initial

I will be able to provide a responsible adult as my own translator. \_\_\_\_\_ Patient initial

I will need Harbor Plastic Surgery Center to provide me with a translator  
 in the following language/dialect \_\_\_\_\_ Patient initial

**I understand that I will have a pre operative conference with my surgeon’s clinical staff to review the above information. I understand that it is my responsibility to have reviewed this information prior to that appointed conference.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness to Patient Signature Only: \_\_\_\_\_ Date: \_\_\_\_\_