Dr. Mary Ella Carter, MD, FACS

Sibley Medical Building
5215 Loughboro Road, NW
Suite 430
Washington, DC 20016
(202) 363-6844

Thank you for choosing the practice of Dr. Mary Ella Carter for your plastic surgery care. We are truly looking forward to serving you

If you are unable to keep your confirmed appointment, please call (202) 363-6844 to reschedule your visit to suit your needs. Recognizing how valuable your time is, we offer these helpful suggestions to ensure that your services will not be delayed unnecessarily.

Prior to your appointment please complete the following five tasks**:**

1. Read the Notice of our *Financial Responsibility Practice;*
2. Complete and sign all the Dr. Mary Ella Carter, MD, FACS registration forms;
3. Obtain any referrals required by your insurance company;
4. Acquire copies of all diagnostic studies, such as x-ray and MRI films and any reports and test results that are related to your injury or condition;

On the day of your appointment we ask that our new patients please**:**

arrive 15 minutes prior to their confirmed appointment so that their registration will be completed in time to see the doctor on schedule

bring with you the following five items:

1. the enclosed forms completed and signed;
2. all current insurance cards and Medicare cards;
3. any referrals required by your insurance company so as to not be held responsible for the full cost of your visit at the time of your appointment
4. any diagnostic studies such as films and reports related to your injury or condition;
5. means for satisfying the co-payment required by your insurance company

Once again, thank you for entrusting your plastic surgery care to the Dr. Mary Ella Carter, MD FACS. . If you have any questions, please do not hesitate to contact us at (202) 363-6844.

Patient Registration
Mary Ella Carter, MD, FACS

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

Patient Signature ***Date***

Patient Information			
Patient Name: (Last)		(First)	(MI)
Social Security #	☐Female ☐Male	Date of Birth Age:	Marital Status M W D S
Street Address		Home Phone	
City		Work Phone	
State ZIP		Cell Phone	
Bill to Name		Fax	
Billing Address		E-mail	
City		Emergency Contact Name	
State ZIP		Emergency Contact Phone	
Employment Information		Employer Name	
Occupation		Employer Phone	

Referring and Primary Care Physician Information				
Referring Doctor Name			Primary Care Doctor Name	
Street Address			Street Address	
City			City	
State ZIP			State ZIP	
Phone			Phone	
Fax			Fax	
Pharmacy	Name	Phone		Fax
Primary Insurance			***Secondary Insurance***	
Company			Company	
Group #			Group #	
ID #			ID #	
Policy Holder Name date of birth			Policy Holder Name date of birth	

Mary Ella Carter, MD, FACS

Health History
New Patient

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

_______________________________________ ____

Patient's Name (Print: First Middle Last) ***Patient's Signature*** ***Date***

I have reviewed and discussed this form with this patient. ____

Physician's Signature ***Date***

Date of Birth		**Referring Physician**	

Reason for your visit today
Biopsy Report Available: ☐ **yes** ☐ **no**

Medications: list ALL that you are currently taking	**Allergies: list ALL medications and foods allergies**
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10	**Allergy to latex** ☐ **yes** ☐ **no**
☐ **I take no medications currently.**	☐ **I have no known allergies.**

List **ALL** prior **operations or surgeries** you have had (included dates if known)
☐ **I have not had any surgery in the past.**

List **ALL** your **Diagnosed Medical Problems** *(not just those related to your current office visit)*
☐ **I have no known medical problems.**

Patient Name__________________________________ Date_______________

Please answer the following questions	✓ *yes*	✓ *no*
Do you smoke cigarettes?		
If so, how many packs per day?		
How many years have you been smoking?		
Do you smoke a pipe or cigars?		
Do you dip snuff or chew tobacco?		
Do you drink alcohol?		
How often and how much alcohol do you drink?		
Do you use any street drugs?		
If so, which drugs do you use?		

REVIEW OF SYSTEMS (ROS) Please ✓ symptoms you currently have or have had in the past year

	General		***Eye, Ear, Nose, Throat***		***Musculoskeletal***		***Psychiatric***
	Fevers or Chills		Difficulty swallowing		Joint pains		Anxiety
	Dizziness		Hearing loss		Muscle aches		Depression
	Fainting spells		Hoarseness		Ankylosing spondylitis		Psychiatric hospitalization
	Fatigue		Nose bleeds		Weak bones		Panic attacks
	Frequent headaches		Ringing in ears		Rheumatoid arthritis		Suicidal thoughts
	Insomnia		Sinus problems		Osteoarthritis		Psychiatric drugs
	Sweats		Vision - blurred		Bone cancer		Memory loss
	Weight changes		Poor vision		Bone infections		Other:
	Other:		Other:		Other:		***MEN only***
	Cardiovascular		***Gastrointestinal***		***Genito-Urinary***		Breast lumps
	Ankle swelling		Poor appetite		Bladder control		Enlarged prostate
	Chest pains		Bowel changes		Blood in urine		Erectile dysfunction
	Enlarged heart		Constipation		Frequent urination		Penis discharge
	Heart attack		Diarrhea		Kidney stones		Prostate cancer
	Heart murmur		Excessive thirst		Painful urination		Other:
	Heart palpitations		Heartburn		Urgent urination		***WOMEN only***
	High blood pressure		Nausea		Weak stream		Abnormal Pap Smear
	Shortness of breath		Rectal bleeding		Other:		Breast Lumps
	Irregular heart beat		Stomach pain		***Neurological***		Vaginal discharge
	Prolonged bleeding		Ulcers		Loss of fine motor control		Severe menstrual pain
	History of blood clots		Vomiting		Weakness		Hot flashes
	Other:		Other:		Paralysis		Other:
	Endocrine		***Skin***		Poor balance	Date of last period:	
	Blood sugar problem		Bruise easily		Seizures	Age periods began:	
	Use of steroids		Foot ulcers		Speech difficulties	Age of menopause:	
	Over Active Thyroid		Rashes		Tremors	Are you pregnant?	
	Under Active Thyroid		Sores that won’t heal		Muscle wasting	# of pregnancies:	
	Other:				Other:	# of live births:	

Acknowledgment of Financial Responsibility Practices
Acknowledgment of Notice of Privacy Practices
Mary Ella Carter, MD, FACS

By my signature below, I acknowledge:

- my receipt and acceptance of the *Notice of Financial Responsibility Practices of Dr. Mary Ella Carter* dated June 15, 2011.

And, when necessary in processing insurance claims for medical or surgical treatment or services rendered to me, I expressly authorize:

- the release of any medical information about me by any holder of said information to any insurance carrier, who may provide financial assistance for this treatment or service;
- the release to the Centers for Medicare and Medicaid and/or to the Health Care Financing Administration and its agent(s) of any medical information necessary to determine benefits;
- the payment by my insurance carrier(s) of insurance and/or Medicare benefits directly to Dr. Mary Ella Carter, MD, FACS

________________________________ ____

Patient Name (Print: First, Middle, Last) *Patient Signature* *Date*

By my signature below, I acknowledge:

- access to the notices regarding company relationships, ancillary services and/or physician relationships;
- my receipt and acceptance of the Mary Ella Carter, MD, FACS *Notice of Privacy Practices* dated June 10, 2011.

________________________________ ________________________________

Patient Name (Print: First, Middle, Last) *Patient Signature*

________________________________ ________________________________

Personal Representative Name (Print first, MI, Last) *Personal Representative Signature*

________________________________ ________________________________

Representative's Relationship to Patient *Date*

OFFICE USE ONLY

_______________________________or ____ having the following relationship to the
(Name of Patient) (Personal Representative of Patient)

patient_____________________________, was offered a copy of the Mary Ella Carter, MD, FACS the Notice of Financial Responsibility Practices

(and a copy of the Mary Ella Carter, MD, FACS Notice of Privacy Practices
.

	Accepted copy	Signed acknowledgment	Did not accept copy	Did not sign acknowledgment
Financial				
Privacy				

____ ______________________________

Staff Member Signature *Date*

Notice of Privacy Practices
Mary Ella Carter, MD, FACS

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Our Commitment to you

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and services you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our practice, whether made by practice staff or your personal doctor. If we provide care for you while you are admitted to a hospital, that hospital may have different policies or notices regarding their use and disclosure of your medical information created while you are a patient in their facility. Our employees and agents and the other health care professionals providing services to you in our office are subject to this notice.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires us to

- Make sure that medical information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

WE USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

- For Treatment. We provide medical information about you to doctors, nurses, technicians, medical students or other office or hospital personnel who are involved in your care. We also may disclose medical information about you to people outside our office or the hospital who may be involved in your medical care such as family members, other individuals or clergy that are part of your care unless you specifically object in writing to our disclosures to these family members, individuals or clergy
- For Payment. We may discuss your medical information with your health insurer to verify your eligibility for benefits, obtain prior authorization and to bill and receive payment for the treatment and services you receive from us.
- For Health Care Operations. We may use and disclose medical information about you for various practice functions such as reviewing the quality of care delivered, education and for planning.
- Appointment Reminders and Follow up. We may use and disclose medical information to contact you as a reminder that you have an appointment with us. If we try to contact you by phone and you are not available, we may leave a message with a family member or on your answering machine.
- Business Associates. We may provide your medical information to outside parties, such as a billing company, so that they can perform certain functions or services on our behalf. Each Business Associate must sign a contract with us before we send them any information. That contract requires them to protect the confidentiality of your medical information.
- Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law.
- To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or that of another person or the public.
- Organ and Tissue Donation. If you are an organ donor or potential recipient, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donor bank, as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.
- Public Health Risks. We may disclose medical information about you for public health activities. These activities may include; the prevention or control of disease, report births and deaths, report child abuse or neglect, to notify people of recalls and to report reactions to medications.
- Health Oversight Activities. We may disclose medical information to health oversight agencies for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Judicial Proceedings.** We may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else, after reasonable efforts to notify you or to obtain a protective order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official, to identify or locate a suspect, witness or missing person, or victims of crime (with your consent in some circumstances), to report deaths from criminal conduct, crimes on the premises or, in emergencies, to report a crime.
- **Coroners, Medical Examiners, and Funeral Directors** We may release medical information to a coroner, medical examiner or funeral director to identify a deceased person, determine cause of death, or as reasonably necessary to carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOU HAVE THE FOLLOWING RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer, Dr. Mary Ella Carter. If you request a copy of the information we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request in writing that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. We will comply with the outcome of the review.

- **Right to Amend** If you feel that medical information we have about you in incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the practice. You should contact our Privacy Officer (301) 356-1612 to discuss this process.
- **Right to Accounting of Disclosures** You have the right to request an *accounting of disclosures.* This is a list of disclosures we made of medical information about you. You should contact our Privacy Officer (202) 363-6844 to discuss this process.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request we limit the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You must submit your request in writing to the Privacy Officer, Dr. Mary Ella Carter.
- **Right to Request confidential communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You must submit your request in writing to the Privacy Officer, Dr. Mary Ella Carter.
- **Right to a Paper Copy of this Notice.** You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, ask for it at the front desk.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services (the “Secretary”). To file a complaint with the Practice or for information on how to complain to the Secretary contact our Privacy Officer (202) 363-6844. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Notice of Financial Responsibility Practices
Mary Ella Carter, MD, FACS

To meet the needs of our patients, Dr. Mary Ella Carter participates in various insurance programs. Each insurance company has its own specific guidelines regarding the level of care and patient financial responsibility. While we will work with you to provide your care within the guidelines of your plan, our main concern is providing you with quality and efficient health care. We expect our patients to understand and acknowledge their financial responsibilities.

To address your responsibilities as a patient, please carefully review the following items:

- Payment for all services rendered is your financial responsibility.
- If during registration you provide to us your complete health insurance information, we will submit our charges to your insurance carrier for payment. You are responsible for all charges if you do not provide complete insurance information.
- If you have full insurance coverage and/or our practice is one of your network providers, you are responsible for paying your annual deductibles, co-payments, co-insurance and all charges for non-covered services and products at the time our services are rendered.
- If your insurance plan considers our practice to be an out-of-network provider, you are responsible for all charges.
- If Medicare is your only insurance carrier, you are fully responsible for the 20% co-insurance due after the Medicare payment, as per Medicare guidelines.
- If after services have been rendered, the health plan, medical group or other insurance carrier determines your charges to be ineligible Dr. Mary Ella Carter will bill you directly, and you are responsible for all charges.
- Dr. Ella Carter will not accept responsibility for collecting payment of your insurance claim or for negotiating a settlement on a disputed claim.
- All dishonored checks are subject to a $15 charge, for which we will bill you directly.
- All patients are requested to sign an acknowledgment of their financial responsibility. In the event the patient chooses to not sign this acknowledgment, Dr. Mary Ella Carter reserves the right to withhold treatment.

If at anytime you have questions or concerns about financial matters relevant to our services, please call the office of Dr. Mary Ella Carter at (202) 363-6844.