Mary Ann Piskun, MD, PLLC
500 Quail Creek, Suite B
Amarillo, TX 79124

Financial Policies

Cosmetic Surgery - If you are seeking cosmetic services, the initial cosmetic consult is $70.00 and will be collected when you check in for your appointment. Once you have discussed the possible procedure or surgery with Dr. Piskun, our office staff will provide you with a quote that will include all professional fees by Dr. Piskun, surgical and anesthesia charges at the Surgery Center on Soncy or facility of your choice, preoperative lab work required, cosmetic insurance policy coverage, and any other garments or supplies required, based on the procedures you are considering. When you are ready to schedule your procedure, a $300 scheduling deposit is required at that time and this will be applied towards your procedure costs. The balance of the fees is due at least one week prior to the scheduled surgery date.

If you are interested in other cosmetic services such as Botox, Radiesse, Asclera, or Juvéderm, we are happy to provide cost estimates prior to your appointment. Payment is required at the time of service for all of these treatments. When you schedule a Botox appointment, it is extremely important that you keep your appointment. Botox requires premixing and is extremely expensive if we have to waste the product when people do not show up. Because of this, we have implemented a $65.00 fee for patients that do not show up for their appointment and do not notify us at least 4 hours in advance.

Accepted forms of payment - We accept cash, checks, VISA, MasterCard, Discover or Cashier's Checks.

Insurance related care - As a service to our patients, our office is happy to file claims for your medical care directly to your insurance company. Please supply our office with all the information necessary to submit your claim. We will need copies of the front and back of your insurance card, and also any secondary or supplemental insurance coverage you have. If you have Medicaid coverage, current verification must be presented each month when seen in the office. If you do not have proof of Medicaid coverage when you arrive for your appointment, we will kindly reschedule your appointment to a later date.

In a Plastic Surgery practice, there are frequently procedures that may or may not be covered by your insurance plan. Insurance plans do not cover cosmetic surgeries and we do not submit those to any insurance plans. However, cosmetic surgeries related to breast cancer surgery and reconstruction, are typically covered services. Our office staff will work with you and your insurance in those situations. If you have any questions regarding the procedure you are considering, please feel free to contact our billing staff.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office or prior to surgery if we know your insurance plan does not cover that procedure.

Referral Requirements – If you have an HMO plan or Medicaid PCCM, you must have a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we will need to reschedule your appointment, or you may elect to pay in full for all services rendered prior to being seen.

Co-payments - We require your co-payment at the time of service. The copayment listed for a Specialist physician will apply.

Deductible - Our office will contact you to obtain your insurance information prior to your appointment, if we did not obtain all the information at the time the appointment was made. This gives us the opportunity to contact your insurance in advance to verify coverage, copays, deductibles and amounts applied to your deductible, so we can make your check-in process go as quickly and smoothly as possible on the day of your appointment. You will be required to pay copays and the amount of your charges that will apply towards your unmet deductible, at the time of service.

Payment Plans - If you are uninsured or need a longer time to pay your balance after insurance, you must visit with the Billing staff member regarding payment arrangements. This does not apply to cosmetic services or surgeries. We expect payment of 50% of the outstanding balance and will work with you to set up a 3-6 month payment plan to finalize your balance.

Dr. Piskun is a provider in the following insurance plans and networks:
Medicare – Traditional Medicare some Medicare Advantage plans
Medicaid
Blue Cross Blue Shield
United Healthcare
BSA Network
Alliance Network

It is the patient's responsibility to know and understand his/her insurance policy and to determine if Dr. Piskun is considered "in network" under your plan. If you choose to seek medical care with Dr. Piskun as an "out-of-network" provider, know that most plans significantly reduce the amount of payment for medical care and you will be responsible for a higher percentage of the medical bill. **It is your responsibility to know your plan and coverage.**

If you do not have health insurance and your visit is not for cosmetic services, you are responsible for payment at the time of service. Care Credit is a financing program available to all patients and information can be found at www.carecredit.com or brochures are available at our office.

If you are unable to keep your appointment, please notify our office at 806-358-8731. We have an answering service that accepts messages when the office is closed.

Mary Ann Piskun, MD

500 Quail Creek, Suite B Amarillo, Texas 79119
(806)358-8731 FAX (806)358-8837

Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document, if desired.

Authorization for Release of Information

I give my authorization for my personal health information to be shared with family member(s) and other designated person(s) listed below if requested. This authorization may be revoked or limited in writing by me and will be documented in my medical record.

Name	Relation to Patient	Phone #
Name	Relation to Patient	Phone #
Name	Relation to Patient	Phone #

OR – NONE

_____ _____
Signature of Patient Date

_____
Name of Personal Representative

_____
Description of Representative's Authority

Mary Ann Piskun, MD

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Patient Financial Responsibility

I agree to be responsible for payment of my medical care or the medical care for the below mentioned patient. I have read, understand and agree to these financial policies. I understand that non-covered and out of network services, as well as applicable copays and deductibles are my responsibility. I authorize my insurance benefits be paid directly to Dr. Mary Ann Piskun. I authorize Dr. Mary Ann Piskun's practice to release pertinent medical information to my insurance company as needed to facilitate payment of the claims.

Patient name (Printed): _____

Signed: _____
Patient or guardian

Guardian name (Printed): _____

Date _____

Mary Ann Piskun, MD, PLLC

Date: _____ Name: _____

Reason for seeing the Dr. today_____

_____

SOCIAL HISTORY

Do you smoke? _____ Packs per day_____
Do you drink coffee_____ Cups/day_____
Do you drink alcoholic beverages_____?
Ounces per day_____

DO YOU HAVE A FAMILY HISTORY OF:

___ Breast Cancer
____ Diabetes
____ Kidney Disease
____ Heart Disease
____ Other Cancer
If yes, please explain:

____ _____

_____

MEDICAL HISTORY

Age	Height	Weight

Do you have an implanted heart device such as an ICD or pacemaker? _____

Have you ever consulted a professional for an emotional problem? _____If yes, please explain____

_____

Have you had any previous surgery? _____ Please list:

YEAR SURGEON

_____ _____ _____
_____ _____ _____
_____ _____ _____

WOMEN ONLY

Are you pregnant? _____
When was your last menstrual period? _____
Number of children you have_____
Do you plan anymore children in the near future? _____
Did you breast feed your children? _____
Did your breasts enlarge with pregnancy? _____
What bra size are you now? _____
How large would you like to be? _____
Are your breasts equal in size? _____
Do you have neck/shoulder pain? _____
Do you have back problems? _____
Do you have skin irritation beneath your breast? _____
Do you have scoliosis/curvature of the spine? _____
Do your breasts sag? _____
Do you have fibrocystic disease? _____
Have you ever had a lump in your breast? _____
Have you ever had a breast biopsy/breast surgery? _____
Do you have a family history of breast cancer on your Mother's side? _____
Have you had a mammogram recently? _____
If so, when? _____

	YES	NO
Allergies or hay fever	____	____
Chest problems	____	____
Chronic sinus problems	____	____
Chronic bronchitis	____	____
Asthma	____	____
Epilepsy or seizures	____	____
Diabetes	____	____
Thyroid disease	____	____
Blood clotting problems	____	____
Are you taking a blood thinner	____	____
Do you bruise easily	____	____
Anemic	____	____
Have a blood disease	____	____
Heart problems	____	____
High blood pressure	____	____
Low blood pressure	____	____
Kidney problems	____	____
Liver problems	____	____
Have you had, or do you have hepatitis or jaundice	____	____
Have muscle weakness	____	____
Arthritis	____	____
Do you take steroids	____	____
Do you wear glasses/contacts	____	____
Do you have false teeth or caps	____	____

500 Quail Creek, Suite B Amarillo, TX 79124
806-358-8731

Patient Name_____ Date of Birth_____ SS#_____
(Last name, First name, MI)

Address_____City _____ ST_____ Zip_____

Sex M F Marital Status M S D W Race_____ Driver's License #_____ Home Phone #_____

Employed by_____ Work Phone _____ Cell Phone _____

Employer address _____

Spouse's Name_____ DOB_____ SS#_____ Cell Phone _____

Employed by_____ Work Phone _____

Responsible Party if Patient is a Minor _____ SS# _____ Relationship _____ Phone _____

Address_____ City _____ ST_____ Zip_____

Employed by_____ Work Phone _____

Contact in case of emergency _____ Phone _____

Referring Physician's Name _____ Address _____

INSURANCE INFORMATION – PLEASE COMPLETE ALL APPLICABLE INFORMATION
A current copy of your insurance card is required for each visit. You are responsible for paying the co-pay if applicable at each office visit. Please keep us informed of any changes in your address, phone number or insurance provider.

Primary Insurance Co_____ ID/Group # _____

Address _____ Phone # _____

Policy Holder Name _____SSN_____DOB_____ Co-Pay _____

Secondary Insurance Co_____ ID/Group # _____

Address _____ Phone # _____

Policy Holder Name _____SSN_____ Co-Pay _____

Primary Care Physician _____

I hereby authorize physician and employees to render routine medical care. The duration of this consent is indefinite and continues until revoked in writing.

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Mary Ann Piskun, MD for any service furnished me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read the information provided and have completed the above answers. I certify that information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

_____ _____
Signature Date

_____ _____
Parent (if minor) or Guardian Date

Mary Ann Piskun, MD

500 Quail Creek, Suite B Amarillo, Texas 79124
(806)358-8731 FAX (806)358-8837

Patient Name _____ Date_____

Please print legibly each medication as well as the dosage you are currently taking. This should include all medications whether prescribed or over the counter.

MEDICATION	**DOSAGE**	**PRESCRIBED BY**

If more room is needed, please attach additional sheet.

ALLERGIES – Please list any medications you are allergic to:

_____ _____ _____

_____ _____ _____

PHARMACY –

Mary Ann Piskun, MD

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(806)358-8731 FAX (806)358-8837

Photography Consent and Release

I understand and consent to having photographs taken and recorded to document my care. I understand that Mary Ann Piskun, MD PLLC will retain the ownership rights to these photographs but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. I understand that images may need to be transmitted electronically by secure email or text, only as it relates to continuity of care among my healthcare team members or to another physician outside the practice that is involved in your healthcare treatment. While we have implemented the use of secure methods of transmitting photographs and protected healthcare information within our practice and team members, we cannot guarantee the security of that information when sent to outside physicians involved in your care, or received directly from patients through electronic means such as emails or text messages.

Date_____

Patient Signature_____

Printed Name_____

Witness Signature_____

Revised 10/5/2013

MARY ANN PISKUN, MD PLLC
NOTICE OF PRIVACY PRACTICES

Effective Date: February 2013

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

If you have any questions about this Notice, please contact: Lu Ann Weldon at 806-358-8731

The office of Mary Ann Piskun, MD, PLLC understands that medical information about you and your health is personal and are committed to protecting this information. When you receive care from Mary Ann Piskun, MD, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record.

This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

We shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Mary Ann Piskun, MD will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses, and disclosures are necessary to run our medical practice in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, we may provide a written or telephone reminder that your next appointment with Mary Ann Piskun, MD is coming up.
- **Photography/Video Taping or Other Imaging.** We may photograph, videotape, digital or other images to record and document your care. We will retain the ownership rights to the photographs, videotapes, digital, or other images, but you are allowed access to view them or obtain copies. These images will be stored in a secure manner that will protect your privacy and that they will be kept for the time period required by law or outlined in Mary Ann Piskun, MD, PLLC policy. Images that identify you will be released and or used outside the practice only upon written authorization from you or your legal representative.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **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. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:
  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order or subpoena; or
  - If Mary Ann Piskun, MD determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If your are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained 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. Usually, this includes medical and billing records.
  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Mary Ann Piskun, MD. If you request a copy of the information, Mary Ann Piskun, MD may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.
  Mary Ann Piskun, MD may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Mary Ann Piskun, MD will review your request and denial. The person conducting the review will not be the person who denied your request. Mary Ann Piskun, MD will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask Mary Ann Piskun, MD to amend the information. You have the right to request an amendment for as long as the information is kept by Mary Ann Piskun, MD.
  To request an amendment, your request must be made in writing and submitted to Mary Ann Piskun, MD. In addition, you must provide a reason that supports your request.
  Mary Ann Piskun, MD may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, Mary Ann Piskun, MD may deny your request if you ask us to amend information that:
  - Was not created by Mary Ann Piskun, MD unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by Mary Ann Piskun, MD;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.
  To request this list you must submit your request in writing to Mary Ann Piskun, MD. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Mary Ann Piskun, MD will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information Mary Ann Piskun, MD uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information Mary Ann Piskun, MD discloses about you to someone who is involved in your care or the payment for your care.
  Mary Ann Piskun, MD is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which Mary Ann Piskun, MD has been paid out of pocket in full. Should Mary Ann Piskun, MD agree to your request, Mary Ann Piskun, MD will comply with your request unless the information is needed to provide you emergency treatment.
  To request restrictions, you must make your request in writing to. Mary Ann Piskun, MD. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Mary Ann Piskun, MD's use and/or disclosure; and (3) to whom you want the limits to apply.
- **Right to Request Confidential Communications.** You have the right to request that Mary Ann Piskun, MD communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that Mary Ann Piskun, MD contact you only at work or by mail.
  To request that Mary Ann Piskun, MD communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. Mary Ann Piskun, MD will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with Mary Ann Piskun, MD or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with Mary Ann Piskun, MD, contact the Privacy Officer at *(806-358-8731)*. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

ACKNOWLEDGMENT

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that Mary Ann Piskun, MD provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient