JENNIFER MURDOCK, MD
OCULOFACIAL PLASTIC SURGERY

Please keep this page for your records and information.

Welcome to Jennifer Murdock, MD. We're excited that you have selected us to provide you with the highest quality medical and surgical care. We've outlined the key items that are required before and during your office visit.

We are here for you at JMMD, please feel free to contact us and follow us through any of the following:

(305)315-5577

info@jennifermurdockmd.com

601 N Federal Hwy, Suite 411
Hallandale Beach, FL 33009

12750 NW 17th St, Suite 226
Miami, FL 33162

For communication regarding private and medical information, please utilize our:

Patient Portal at www.jennifermurdockmd.com

Request a secure link to use the HIPAA secure app, Spruce, on your phone

Prior to Your Appointment:

1. Please review and complete the new patient forms.
2. Please contact your insurance company to verify your medical coverage. You may be responsible for additional fees and copayments.
3. If you are seeing Dr. Murdock for a Cosmetic Consultation or Self-Pay visit, a fee will be collected PRIOR to your appointment to hold the time slot. Please review the financial policy for complete information about payments.
4. If your primary care Doctor is listed on your insurance card, you may be required to have a referral. Please contact your primary care Doctor to confirm whether or not a referral is required.

Day of Your Appointment:

1. Medications – please either bring a current list of all medications you are taking, or provide your pharmacy information and permission to acquire this information electronically (see on forms below).
2. Insurance Cards – please bring all current insurance cards with you to the appointment.
3. Photo ID – We are required to obtain a copy of your photo ID. This is to protect you from someone else using your medical insurance (a type of identity theft).

Welcome! Thank you for choosing Jennifer Murdock, MD for your reconstructive and cosmetic surgery needs. Please complete the following information and either email them to info@jennifermurdockmd.com or use our HIPAA secure patient portal at www.jennifermurdockmd.com.

Patient Information

Full Name: _____ _____ _____
Last *First* *M.I*

DOB: _____ Email Address: _____
MM/DD/YYYY

Address 1: _____
Street Address *Apt #/Unit*

Address 2: _____ _____ _____
City *State* *Zip Code*

Cell Phone: _____ Home Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about Jennifer Murdock, MD? (check all that apply)

☐ Referring Doctor ☐ Friends/Family ☐ TV/Radio ☐ Internet ☐ Mailing/Newspaper ☐ Event/Exhibit

☐ Insurance ☐ Other:

- By providing my contact information above, I authorize my health care provider to employ automated outreach and messaging systems to notify me regarding scheduled appointments, scheduling of appointments, and/or balances due. ……..(initials)
- Preferred contact: Email / Home / Cell / Other (circle one)
- JMMD is committed to providing all of our patients with exceptional care. When a patient cancels an appointment without prior notice, it may prevent another patient from being seen. Kindly provide 24 hour notice to cancel or change a scheduled appointment. We reserve the right to charge a $50 fee for missed appointments when prior notice has not been given. …….. (initials)

Insurance Information

At JMMD, we do our best to assist with insurance verification and eligibility in order to best serve our patients; however, this information is often complex and may require further assistance from you. For further questions, please contact our office at 305-315-5577 or email your questions to info@jennifermurdockmd.com.

Primary Medical Insurance: _____ ID & Group #: _____

Subscriber Name and DOB: _____ Relationship: _____

Secondary Medical Insurance: _____ ID & Group #: _____

Subscriber Name and DOB: _____ Relationship: _____

- Office visits may be categorized as "medical" and/or "cosmetic" depending on your needs or findings of your exam. Cosmetic consultations are typically associated with procedures not considered "medically necessary" or not covered by insurance, while medical exams are associated with diagnoses such as tearing, droopy eyelids obstructing vision, trauma, thyroid eye disease, etc. …….. (initials)
- JMMD contracts with many major insurance plans; however, I acknowledge that it is my responsibility to confirm specific health plan coverage and benefit levels. I understand that I am financially responsible and agree to pay any charges for care rendered to me not covered by my insurance plan. I agree that for services rendered to me by Jennifer Murdock MD, PLLC, I will pay my account at the time of service or upon insurance claim processing. …….. (initials)
- If payment plan consideration is necessary, I understand that it is my responsibility to call and make financial agreements satisfactory to JMMD for payment. …….. (initials)
- Any benefits under any policy of insurance or other party liable to the patient, is hereby assigned to Jennifer Murdock MD, PLLC. If copayments and/or deductibles are assigned by my insurance company or health plan, I agree to pay them to JMMD. …….. (initials)
- If you do not have insurance, payment is required at the time of service and you will be seen as a Private Pay patient. …….. (initials)
- Please be aware that when we call to verify your benefits, your healthcare insurance company discloses to us that verification of benefits is not a guarantee for payment. Payment will be finalized according to your plan's benefits when your healthcare insurance company receives and processes the claim. …….. (initials)

Patient Agreement

- **Consent for Treatment:** I authorize Jennifer Murdock, MD to assess and treat me, complete tests and administer medications considered necessary or advisable. I understand that my healthcare provider is available to explain the purpose of any procedure and that I have the right to refuse, even if against medical advice.
- **Release of Medical Information:** If I would like a copy of my health information released to me or any individual(s), I will request and submit an Authorization for Release of Medical Information. A release may be revoked by me in writing at any time. I understand that a copy of my records is subject to fee for labor/supplies/postage.
- **Notice of Privacy Practices**: I acknowledge that I have been made aware of JMMD's privacy practice. I understand a copy of the Notice of Privacy Practices is available at my request.
-

Patient or Authorized Signatory: _____ Date: _____

Billing Agreement

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Jennifer Murdock MD, PLLC. I am responsible for any applicable deductible, copayment, or fee prior to the provision of services. JMMD will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. JMMD may file a claim for payment with my insurance company as a courtesy to me. If the primary insurance company fails to pay JMMD in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to JMMD. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

Patient or Authorized Signatory: _____ **Date:** _____

Media Agreement

Dr. Murdock values education and endeavors to teach through lectures, publications, teaching conferences, and media. By signing here, you provide permission for Dr. Murdock to use de-identified testing or unidentifiable photographs in any medium for educational or promotional purposes.

Patient or Authorized Signatory: _____ **Date:** _____

Photography Authorization, Release, and Discharge

I consent to the taking of photographs, audio/video and other images ("imaging records") by Dr. Jennifer Murdock, or her designee, of me or of my likeness or parts of my body in connection with plastic surgery procedures and consultations.

I understand that such imaging records may be published in print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, scientific presentations, teaching courses, and internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods, results, issues, trends, and similar matters.

I will not be identified by name in any publication. I understand that in some circumstances the photographs may portray features which shall make my identity recognizable. Further, I recognize that in some instances the photographs or audio/video files may be transformed into a non-photo likeness of me.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive.

I hereby warrant that I am over eighteen years of age, and competent to contract in my own name.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization, Release and Discharge and fully understand its terms.

Patient Signature: _____ **Date:** _____

Printed Name:_____ **DOB:** _____

If the patient is a minor:

I have read the above Authorization, Release, and Discharge. I am the parent, guardian or conservator of (patient name) _____(DOB)_____, a minor. I am authorized to sign this consent on his/her behalf and I voluntarily grant this consent as a contribution in the interest of public education.

Signature of Parent/Guardian: _____ **Date:** _____

Printed Name of Parent/Guardian: _____

Medical History Questionnaire

If you provide your Primary Care Physicians name and sign the attached Authorization to Release and Receive Medical Information, we will attempt to gather the following information from their office and you may skip this section. Please provide any updated information or relevant changes. Please note that if we are unable to collect your medical history and medications from your primary care physician, we will review this information during your appointment.

- **Release of Protected Health Information:** I hereby authorize JMMD to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from third party health care providers, laboratories, radiology facilities or other institutions and providers. I also understand that I have the right to revoke this authorization at any time by sending a written notification to JMMD. …….. *(initials)*

Referring Doctor:		**Primary Care Doctor:**	

List any medical problems that other doctors have diagnosed:

☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Autoimmune Disease

Other:

Surgeries, including prior Cosmetic Surgeries

Year:	Procedure:	Location:

Pharmacy Information	
Pharmacy Name:	Address/Phone:

- JMMD has my permission to obtain a list of my prescriptions directly from my pharmacy. …….. *(initials)*

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

You may also provide a copy of your medications with this form.

Name the Drug	Strength	Frequency Taken

Allergies to medications:	
Name the Drug:	Reaction You Had:

HEALTH HABITS AND PERSONAL SAFETY

Vaccines	Yearly Flu			☐ Yes	☐ No
	Shingles			☐ Yes	☐ No
	Pneumococcal			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			

FAMILY HEALTH HISTORY

Does anyone related to you have/had any of the following:						
Heart Disease or Heart Attack:	☐	Yes	☐	No	**Relationship:**	
Diabetes Mellitus:	☐	Yes	☐	No	**Relationship:**	
Graves' Disease or Thyroid Eye Disease:	☐	Yes	☐	No	**Relationship:**	
Lupus or other autoimmune disorders:	☐	Yes	☐	No	**Relationship:**	
Neurologic disorders (muscle weakness):	☐	Yes	☐	No	**Relationship:**	

WOMEN ONLY

Are you pregnant or breastfeeding?	☐ Yes	☐ No

OTHER PROBLEMS

Please tell us if you currently have any medical or health symptoms that are being evaluated or are presently causing you discomfort.

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OCULOFACIAL PLASTIC SURGERY

Acknowledgement of Receipt of Privacy Policy

By signing this form, you are agreeing that you have been given a copy of the Jennifer Murdock MD, PLLC Privacy Policy, which describes how we use and disclose your health information. By signing below you acknowledge that you have read, understand, and agree with the Privacy Policy. You have the right to sign this Acknowledgement. In the case that we do not receive a signed Acknowledgement, we must document our good faith effort to obtain your signed acknowledgement and reason why it was not obtained.

Receipt of Privacy Policy received by:

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

RELATIONSHIP TO PATIENT: _____

Jennifer Murdock, MD, PLLC
601 N Federal Highway, Suite 411 • Hallandale Beach, FL 33009
12750 NW 17th St, Suite 226 • Miami, FL 33182
Phone: 305-315-5577 | Fax: 832-324-6986 | jennifermurdockmd.com

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OCULOFACIAL PLASTIC SURGERY

PATIENT PHOTOGRAPHIC AUTHORIZATION, RELEASE, AND DISCHARGE

I consent to the taking of photographs, audio/video and other images ("imaging records") by Dr. Jennifer Murdock, or her designee, of me or of my likeness or parts of my body in connection with plastic surgery procedures and consultations.

I understand that such imaging records may be published in print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, scientific presentations, teaching courses, and internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods, results, issues, trends, and similar matters.

I will not be identified by name in any publication. I understand that in some circumstances the photographs may portray features which shall make my identity recognizable. Further, I recognize that in some instances the photographs or audio/video files may be transformed into a non-photo likeness of me.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive.

I hereby warrant that I am over eighteen years of age, and competent to contract in my own name.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization, Release and Discharge and fully understand its terms.

Signature _____ *Date* _____
Name _____ *DOB* _____

I have read the above Authorization, Release, and Discharge. I am the parent, guardian or conservator of _____(DOB)_____, a minor. I am authorized to sign this consent on his/her behalf and I voluntarily grant this consent as a contribution in the interest of public education.

Parent/Guardian _____ *Date* _____
Name of Parent/Guardian _____

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