Specialists IN PLASTIC SURGERY, PA

(Please Print Legibly & Fill In ALL Fields)

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET AND APT # CITY STATE ZIP CODE

LAST 4 OF SOC. SEC. #: _____

DATE OF BIRTH:_____/_____/_____

AGE: _____

Status: ☐ Single ☐ Married ☐ Other

***Please mark your preferred method(s) of contact:**

☐ **HOME PHONE:** _____

☐ **WORK PHONE:** _____

☐ **CELL PHONE:** _____

☐ **EMAIL:** _____

Occupation:_____ **Employer:**_____

EMERGENCY CONTACT - NAME: _____

RELATIONSHIP: _____ **HOME / CELL PHONE NUMBER:**_____

PRIMARY INSURANCE COMPANY: _____ **INSURANCE ID #:**_____

GROUP #: _____

SUBSCRIBER'S NAME: (IF OTHER THAN PATIENT) _____

SUBSCRIBER'S DATE OF BIRTH: _____ / _____ / _____ LAST 4 OF SOC SEC #: _____

IF SECONDARY INSURANCE, LIST COMPANY: (ID# / GROUP #) _____

REFERRED BY: _____

PRIMARY MEDICAL DOCTOR: _____

GUARANTOR INFORMATION (Please complete if patient is a minor.)

NAME: _____ **RELATIONSHIP TO PATIENT:**_____
LAST FIRST MIDDLE

ADDRESS: _____ **HOME PHONE:**_____
STREET AND APT # CITY STATE ZIP CODE

DATE OF BIRTH: _____/_____/_____ LAST 4 OF SOC SEC #:_____ **EMPLOYED BY:**_____

I authorize Dr. _____ to bill my insurance company and authorize all of my insurance benefits to be paid directly to Dr._____. Regardless of whether I have insurance coverage or am a self-pay patient, I understand that I am responsible for all bills, co-pays, deductibles and non-covered services being paid in a timely manner. I authorize all pertinent information to be released to my referring physicians, primary care physicians and my insurance carriers. I understand payment is due at the time services are rendered. I understand that the parent or guardian requesting treatment for a minor is responsible for all fees for services rendered.

Signature _____ **Date** _____

IMPORTANT:
Please fill out this form completely and sign.

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PATIENT NAME: _____
DOB: _____

HEIGHT: _____

WEIGHT: _____

Pharmacy Name:_____ **Address / Ph #:** _____

LIST ALLERGIES: (INCLUDE FOOD / LATEX) ***OR*** **NO KNOWN DRUG ALLERGIES**: ☐

LIST ALL MEDICATIONS: *(INCLUDE OVER-THE-COUNTER, VITAMINS/ HERBS / HOMEOPATHIC)*

NAME:	DOSE:	NAME:	DOSE:

MEDICAL HISTORY – CHECK THE APPROPRIATE BOX YES OR NO

Asthma or Shortness of breath	☐YES☐NO	Diabetes	☐YES☐NO	Kidney Disease	☐YES☐NO
Anxiety	☐YES☐NO	Fainting	☐YES☐NO	Motion Sickness	☐YES☐NO
Breast Cancer	☐YES☐NO	GERD / Reflux	☐YES☐NO	Psychiatric Disorder **TYPE:** _____	☐YES☐NO
Genetic Mutation **TYPE:** _____	☐YES☐NO	Heart Attack **WHEN**: _____	☐YES☐NO	Seizures **TYPE:** _____	☐YES☐NO
Cancer (Other) **TYPE:** _____	☐YES☐NO	Heart Disease	☐YES☐NO	Sleep Apnea: If yes, do you use - CPAP or BiPAP (**circle**)	☐YES☐NO
Chronic Headache	☐YES☐NO	Hepatitis / Liver Disorder	☐YES☐NO	Stroke	☐YES☐NO
Clotting Disorder	☐YES☐NO	High Blood Pressure	☐YES☐NO	Thyroid Disorder	☐YES☐NO
COPD	☐YES☐NO	HIV / AIDS (**circle**)	☐YES☐NO	Other Medical Issues: _____ _____	☐YES☐NO
Depression	☐YES☐NO	Keloid Scars	☐YES☐NO		

NAME & DOB: _____

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PLEASE LIST ALL OPERATIONS THAT YOU HAVE HAD:

SURGERY	YEAR	SURGEON	ANESTHESIA COMPLICATIONS?
			☐YES ☐NO
			☐YES ☐NO
			☐YES ☐NO
			☐YES ☐NO
			☐YES ☐NO
			☐YES ☐NO
			☐YES ☐NO

Have you been hospitalized for any other reason? ☐**YES** ☐**NO**
If yes, please explain.

_____

FAMILY HISTORY:
List any **family** history of significant illness (example: heart disease, diabetes, melanoma, malignant hyperthermia, breast cancer)

_____

SOCIAL HISTORY:

TOBACCO: ☐**YES** ☐**NO** PACKS PER DAY: _____ QUIT DATE: _____

E-CIGS / VAPING / CHEW: ☐**YES** ☐**NO**

ALCOHOL: ☐**YES** ☐**NO** Amount / week: _____

RECREATIONAL DRUGS: ☐**YES** ☐**NO** Name: _____

Do you have any children? ☐**YES** ☐**NO** If so, how many? _____

***PLEASE READ STATEMENT BELOW & INITIAL-**

"I CONSENT TO PHOTOGRAPHS BEING TAKEN AT TODAY'S VISIT FOR MY MEDICAL CHART & RECORDS PURPOSES ONLY. THESE PHOTOGRAPHS WILL NOT BE SHARED IN ANY WAY WITHOUT MY EXPRESS WRITTEN APPROVAL."

Initials: _____

SIGNATURE_____ **DATE**_____

Specialists IN PLASTIC SURGERY, PA

Acknowledgment of Receipt of Notice

By signing this form, you are granting consent to Specialists in Plastic Surgery, P.A. to use and disclose your protected health information (PHI) for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practice is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Official.

My signature below constitutes my acknowledgment that I have been provided with a copy of the Notice of Privacy Practices.

_____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:

_____

Consent to Leave Voicemail Messages Containing Medical Information

Specialists in Plastic Surgery, P.A. may contact me by telephone at any number contained in my record, including wireless telephone numbers, for the purposes of communicating with me about my health care, servicing my account and collecting amounts due.

I give permission to leave voicemail messages/send emails regarding:

□ My appointments-scheduling/reminders □ My Test Results □ My Discharge □My Health
□ My bills □ Only these things:_____

Limited Release of Information to Family/Friends

I give my permission to Specialists in Plastic Surgery, PA to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care. I understand that I am not required to complete this form in order to obtain health care.

Name: _____ Phone Number:_____

Relationship: _____Talk to this person about (check each box that applies):

□ My appointments-scheduling/reminders □ My test results □ My Discharge □My Health
□ My bills □ Only these things:_____

Specialists IN PLASTIC SURGERY, PA

Financial & Clinic Policies

Patient Name: _____ **DOB: _____**

Payment is due in full at the time of service for all office visits, ancillary services and products. We accept cash, checks, cashier's checks, and money orders, Visa, MasterCard, AMEX, and Discover for your convenience. There is a $25 charge for returned checks.

Financing Options: As a service to our patients, we offer financing through Alphaeon, CareCredit and MLend.

Insurance: Specialists in Plastic Surgery, PA is in network with Ambetter, BCBS, Blue Medicare, Blue Value, Cigna, Coventry, Humana, Humana Medicare, Medcost Preferred, Medicare, UHC, UMR.

Quotes: Fee quotes are valid for 12 months from date of signature.

Cancellation/Rescheduling of your Consultation Appointment: Specialists in Plastic Surgery, PA requires 24 hour business day notice to cancel or reschedule your consultation appointment.

Cancellation/Rescheduling of your Cosmetic Surgery: Specialists in Plastic Surgery, PA requires 14 days to cancel or reschedule your surgery. A cancellation fee of 10% will be applied for cancellations within 14 days. Exceptions may be made for documented emergency or medical issue.

Surgical Payments: The payment for all surgical procedures will be collected two weeks prior to the surgery date. A deposit of $500 is required at the time of scheduling your surgery. If payment in full is not collected, the surgery will be canceled and the patient will be responsible for the associated financial penalties for surgery cancellation. I understand that CRNA payments must be made in the form of cash or check.

FMLA/Short-Term Disability/Medical Records: There is a $10 charge for processing paperwork and medical records. This must be paid before processing begins.

Lab Fees/Prescriptions: All prescriptions, lab/EKG and other diagnostic testing ordered are the responsibility of the patient.

I acknowledge that I am financially responsible for all charges. By signing this form, I fully understand and agree to the terms and conditions of the Financial Policy of Specialists in Plastic Surgery, PA.

Patient Signature:_____ **Date:_____**