ASSOCIATES IN
Plastic Surgery
Est.1978

ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS? (Check Box/s Below)

	YES	NO		YES	NO		YES	NO
Aspirin, Bufferin, Anacin	☐	☐	Sleeping pills	☐	☐	Shots	☐	☐
Blood pressure pills	☐	☐	Thyroid medicine	☐	☐	Water pills	☐	☐
Cortisone	☐	☐	Headache pills	☐	☐	Antibiotics	☐	☐
Digitalis	☐	☐	Medicine for Arthritis	☐	☐	Barbiturates	☐	☐
Hormones	☐	☐	Tranquilizers	☐	☐	Birth control pills	☐	☐
Insulin or diabetic pills	☐	☐	Weight reducing pills	☐	☐	Phenobarbital	☐	☐
Iron or poor blood meds	☐	☐	Blood thinning pills	☐	☐			
Laxatives	☐	☐	Dilantin	☐	☐			

Have you ever taken or are you presently taking diet pills? YES ☐ NO ☐ When? _____

Other drugs not listed: Name _____ Dosage _____

Write in the names and dates of any operations which you have had: _____

_____

Name any drugs or foods to which you are allergic: _____

_____

Serious injuries or accidents: _____

_____

	YES	NO
Do you have eye problems?	☐	☐
("dry eye syndrome", glaucoma, detached retina, allergic reactions, etc.)		
Do you wear glasses or contact lenses?	☐	☐
Have you ever had a blood transfusion?	☐	☐
Do you frequently have bleeding gums?	☐	☐
Have you ever bled excessively from a tooth extraction?	☐	☐
Do you bleed excessively from a laceration?	☐	☐
Do you have nose bleeds?	☐	☐
How often? _____		
Do you take aspirin regularly?	☐	☐
How often? _____		
(Yes, stop taking aspirin until two weeks after your surgery)	☐	☐

WOMEN ONLY

	YES	NO
Are you still having regular monthly menstrual periods?	☐	☐
Are you now on or have you ever taken the birth control pill? When? _____	☐	☐
Have you ever had bleeding between your periods? When? _____	☐	☐
Do you have very heavy bleeding with your periods? When? _____	☐	☐

Date of last Pap Smear Test _____

Any complications of pregnancy? _____

Date of last menstrual period _____ Could you be pregnant now? _____

Do you have any family history of breast cancer? _____

Date of last mammogram _____

NOTE: We recommend regular breast and pelvic exams by your regular physician for all adults.

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ASSOCIATES IN PLASTIC SURGERY / CUMBERLAND SURGERY CENTER
PAYMENT POLICY FOR SERVICES NOT COVERED BY INSURANCE OR MANAGED CARE PLANS

We ask you to note that the patient/guarantor is responsible for payment for all services provided by our physicians or staff which are not covered by your insurance.

In the event your specific insurance or managed care plan denies payment for any of the following reasons for any service you have authorized or requested, the balance of our charges will be due from the patient/guarantor:

1. Procedures are cosmetic in nature.
2. Procedures are deemed medically unnecessary.
3. Required referrals, pre-approvals, or pre-certifications were not obtained or provided.
4. Benefits are not due under the plan of coverage of the participant or beneficiary.
5. Our surgeons or Cumberland surgical facility are not covered providers for your insurance plan.

We reserve the right to ask for payment in advance for any such "non-covered services", or to ask for payment in full at a later date should the "non-covered services" be determined after services have been provided.

I acknowledge that I have received written notice that I am fully responsible for non-covered services, and I agree to be responsible for full payment.

Signature: _____ Date: _____

FOR SCHEDULED SURGERIES (to be completed by surgery counselor)
We believe that your insurance company or managed care plan could deny payment for the service(s) listed below for the reasons we have noted.

_____

_____

REASON(S):

_____ Required referrals, pre-approvals, or pre-certifications were not obtained or provided.

_____ Procedure frequently deemed cosmetic.

_____ Medical necessity may be questioned.

_____ Procedure contractually excluded.

_____ Cumberland is not a covered provider for your insurance company.

_____ Other: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

ASSOCIATES IN Plastic Surgery Est.1978

8425 CUMBERLAND PLACE
BATON ROUGE, LA 70806

POS Reorder # 9410713 POS BATON ROUGE (800) 331-4976

☐ GARY W. COX, M.D.
☐ JOHN A. DEAN, M.D.
☐ ANDREW C. FREEL, M.D.

OUR OFFICE POLICY REQUIRES PAYMENT FOR OFFICE VISITS AT THE TIME OF SERVICE.

PLEASE CHECK PAYMENT METHOD FOR TODAY'S VISIT: CASH ☐ , CHECK ☐ , VISA ☐ , MASTERCARD ☐ , DISCOVER ☐ , AMERICAN EXPRESS ☐ , OTHER _____

PLEASE PRINT CLEARLY DATE _____

PATIENT INFORMATION

PATIENT'S FULL NAME _____ DATE OF BIRTH _____ AGE _____ SEX _____

PT. ADDRESS _____ CITY _____

STATE _____ ZIP _____ HOME PHONE NO. _____ WORK PHONE # _____

EMAIL ADDRESS: _____ CELL PHONE # _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced SOCIAL SECURITY NO. _____ DRIVER LICENSE NO. _____

EMPLOYED BY _____ ADDRESS _____

Who referred you to us? Physician _____ Friend/Relative _____ ☐ Yellow Pages ☐ Web ☐ Newspaper ☐ Magazine

NAME OF PERSON NOT LIVING WITH YOU TO BE NOTIFIED IN AN EMERGENCY _____

PHONE # _____

NAME OF SPOUSE (OR PARENT IF SINGLE) _____ SOCIAL SECURITY NO. _____

SPOUSE OR PARENT'S EMPLOYER _____ OCCUPATION _____

BILLING INFORMATION

WHO IS RESPONSIBLE FOR PAYMENT? _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ EMPLOYER ☐ OTHER

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ OCCUPATION _____

SOCIAL SECURITY NO. _____ DRIVERS LICENSE NO. _____

HOME PHONE # _____ EMPLOYER PHONE # _____

MEDICAL INSURANCE INFORMATION

DOES THE PATIENT HAVE MEDICAL INSURANCE? YES _____ NO _____

IS THIS VISIT DUE TO AN ACCIDENT? YES _____ NO _____ IF YES, AUTO? _____ OTHER? _____

DATE OF ACCIDENT _____

NAME OF **PRIMARY INSURANCE COMPANY** _____

MAIL CLAIM TO: _____ CITY _____ STATE _____

ZIP _____ INSURANCE CO. PHONE # _____

POLICY HOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____

POLICY / ID CERTIFICATE # _____ GROUP / PAYOR # _____

POLICY HOLDER'S DATE OF BIRTH _____ POLICY HOLDER'S SOCIAL SECURITY # _____

NAME OF SECONDARY INSURANCE COMPANY _____

MAIL CLAIM TO: _____ CITY _____ STATE _____

ZIP _____ INSURANCE COMPANY PHONE # _____

INSURED NAME _____ RELATIONSHIP TO PATIENT _____

POLICY / ID CERTIFICATE # _____ GROUP / PAYOR # _____

SECONDARY HOLDER'S DATE OF BIRTH _____ SECONDARY HOLDER'S SOCIAL SECURITY # _____

WORKERS' COMP.

IS THIS VISIT DUE TO A JOB RELATED INJURY? YES _____ NO _____ DATE INJURED _____

* PLEASE FILL OUT WORKERS' COMP. FORM *

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay for all charges for such treatment. **WE REQUIRE THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.**

I agree that this office will prepare and file any insurance claim which I have in connection with treatment received, and I agree, as evidenced by my signature, to assignpayment of any applicable benefits payable to my insurance company to this office. A copy of this agreement will be considered as valid as an original. I also authorize the release of all information necessary to secure payment of my claim.

I understand the practice is not responsible for collecting payment from my insurance company. If the company delays or withholds payment of my claim, I will be responsible for direct payment. I am also responsible for any and all amounts which insurance does not pay, including any deductible amounts, coinsurance or charges not covered. I understand and agree that a service charge in the amount of 1.5% (one and one half percent) or 18% per annum will be assessed on the unpaid balance after 90 days from the date of service. If it becomes necessary to refer this account to an attorney or collection agency for collection, I am responsible to pay all reasonable collection agency and/or attorney fees and court costs.

I agree to be photographed before and after any surgical procedure and understand these photographs will remain the property of my treating physician.

SIGNATURE _____
Patient, Parent, or Legal Guardian

DATE _____

SIGNATURE _____
Other Account Guarantor

ASSOCIATES IN Plastic Surgery Est.1978

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Associates in Plastic Surgery, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices for Associates in Plastic Surgery.

Name and relationship of the person you wish to allow access – for example, your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:

Name of Person or Entity	**Relationship**

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Associates in Plastic Surgery and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at Associates in Plastic Surgery. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

_____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____ _____

Description of Personal Representative's Authority | Date

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Associates in Plastic Surgery.

Signed: _____ Date: _____ Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship and describe authority to act:

☐ parent or guardian of minor patient ☐ beneficiary or personal representative of deceased patient
☐ guardian or conservator of an incompetent patient

Name of Patient: _____

For Office Use Only

Signed form received by: _____ Acknowledgement refused: _____

Good Faith Efforts to obtain Acknowledgement: _____

Reasons acknowledgement was not obtained: _____

ASSOCIATES IN
Plastic Surgery
Est.1978

Gary W. Cox, M.D., F.A.C.S.*
John A. Dean, M.D., F.A.C.S.* | Andrew C. Freel, M.D., F.A.C.S.*

* Physicians Certified by the American Board of Plastic Surgery

Confidential Record

Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in decisions regarding your care.

Name: _____ _____ _____
Last First Middle

Age _____ Ht. _____ Wt. _____ Sex _____ Marital Status: ☐ S ☐ M ☐ W ☐ Divorced or Separated

Date of Last Physical Examination _____ Physician's Name _____

Family or Referring Physician _____ Address & Phone No. _____

DO YOU HAVE OR HAVE YOU HAD: (Check Box/s Below)

	YES	NO		YES	NO		YES	NO
Stroke	☐	☐	Hay Fever	☐	☐	Keloids / Thick Scars	☐	☐
Cancer	☐	☐	Colitis	☐	☐	Rheumatic Heart	☐	☐
Tuberculosis	☐	☐	Goiter	☐	☐	Bleeding Tendency	☐	☐
Leukemia	☐	☐	Mitral Valve Prolapse	☐	☐	High Blood Pressure	☐	☐
Bronchitis	☐	☐	Sleep Apnea with or			Congenital Heart Disease	☐	☐
Epilepsy	☐	☐	without CPAP machine	☐	☐	Nervous Breakdown	☐	☐
Pneumonia	☐	☐	Bladder Infection	☐	☐	Dizziness / Fainting	☐	☐
Diabetes	☐	☐	Asthma	☐	☐	AIDS	☐	☐
Arthritis	☐	☐	Heart Attack	☐	☐	Sickle Cell Disease	☐	☐
Depression	☐	☐	Stomach Ulcers	☐	☐	Latex Allergies	☐	☐
Hepatitis / Jaundice	☐	☐	Kidney Disease	☐	☐	Deep Venous Thrombosis	☐	☐
Migrane	☐	☐	Tonsilitis	☐	☐			

What procedure are you interested in? _____

	YES	NO	
Do you wear dentures?	☐	☐	
Do you smoke?	☐	☐	How much? _____ How many years? _____
Do you drink alcohol or beer regularly?	☐	☐	How much? _____
Date of Last Chest X-ray _____			Date of Last EKG _____