POS-I-FORMS

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

ASSOCIATES IN PLASTIC SURGERY
8425 CUMBERLAND PLACE
BATON ROUGE, LA 70806

☐ GARY W. COX, M.D.
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☐ JENNA M. BOURGEOIS, 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 # ___ 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 ___ ☐ RealSelf ☐ 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/I.D. 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 CO. PHONE # ___

INSURED'S NAME ___ RELATIONSHIP TO PATIENT ___

POLICY/I.D. 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 assign payment 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 1½% (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

Confidential Health Questionnaire

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 will be used by your doctor in decisions regarding your care.

Name: _____ _____ _____
Last First Middle

Age _____ Ht. _____ Wt. _____ Sex Male ☐ Female ☐

Phone Number _____ Email _____

Any restrictions in contacting you? Calls YES ☐ NO ☐ Text YES ☐ NO ☐ Email YES ☐ NO ☐

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Occupation: _____

Primary Care Physician _____ Phone Number _____

Referring Physician _____ Phone Number _____

REASON FOR OFFICE VISIT TODAY: _____

DO YOU HAVE OR HAVE YOU HAD: (check box/s below)

	YES	NO		YES	NO		YES	NO
Stroke	☐	☐	Pneumonia	☐	☐	Sickle Cell	☐	☐
Heart Attack	☐	☐	Asthma	☐	☐	HIV or AIDS	☐	☐
Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐	Keloids/Thick Scars	☐	☐
High Blood Pressure	☐	☐	Bronchitis	☐	☐	Arthritis	☐	☐
Congenital Heart Disease	☐	☐	Depression	☐	☐	Stomach Ulcers	☐	☐
Cancer	☐	☐	Anxiety	☐	☐	Colitis	☐	☐
Leukemia	☐	☐	Mental Illness	☐	☐	Skin Sensitivity	☐	☐
Hepatitis/Jaundice	☐	☐	DVT	☐	☐	Latex Allergies	☐	☐
Sleep Apnea	☐	☐	Migraines	☐	☐	Tape Allergies	☐	☐
Use CPAP Machine	☐	☐	Epilepsy	☐	☐			

Please list any medications you are currently taking: (including dietary supplements, over the counter medications, and herbal medicine) _____

_____

_____

_____

Do you use Aspirin, Advil, or Motrin regularly? YES ☐ NO ☐

Please list any food or medications that you are allergic to and what is your reaction:

_____

_____

Have you been on cortisone or steroid treatments? YES ☐ NO ☐ When: _____

Please list previous operations that you have had: (procedure, surgeon, and year)

_____

_____

_____

_____

Have you ever had a weight loss surgery/procedure? YES ☐ NO ☐ When: _____

Are you a smoker? YES ☐ NO ☐ History of smoking: YES ☐ NO ☐ When did you quit? _____
How many packs a day were you smoking? _____ For low long? _____

Have you or any family members ever had:
Difficulty with anesthesia? YES ☐ NO ☐ _____
History of abnormal or excessive bleeding? YES ☐ NO ☐ _____
History of abnormal blood clotting (DVT or PE)? YES ☐ NO ☐ _____

Do you have any family history of any cancers or serious illnesses? _____

_____

WOMEN ONLY
Date of last menstrual cycle _____ Could you be pregnant now? _____

How many times have you been pregnant? _____ How many live births did you have? _____

C-section YES ☐ NO ☐ _____ Vaginal delivery YES ☐ NO ☐ _____

Date of last mammogram _____ Where? _____
Result of mammogram _____

Do you have a family history of Breast Cancer? YES ☐ NO ☐ Relationship: _____

_____

****WE RECOMMEND REGULAR PELVIC AND BREAST EXAMS WITH YOUR REGULAR PHYSICIAN****

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 / 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: _____