

**ASSOCIATES IN PLASTIC SURGERY**

 8425 CUMBERLAND PLACE  
 BATON ROUGE, LA 70806

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- GARY W. COX, M.D.
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- JOHN A. DEAN, M.D.
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- ANDREW C. FREEL, 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 \_\_\_\_\_

<b>PATIENT INFORMATION</b>	PATIENT'S FULL NAME _____ DATE OF BIRTH _____ AGE _____ SEX _____ PT. ADDRESS _____ CITY _____ STATE _____ ZIP _____ HOME PHONE # _____ WORK PHONE # _____ EMAIL ADDRESS: _____ CELL PHONE # _____ MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced SOCIAL SECURITY NO. _____ DRIVER LICENSE NO. _____ EMPLOYED BY _____ ADDRESS _____ Who referred you to us? Physician _____ Friend/Relative _____ <input type="checkbox"/> RealSelf <input type="checkbox"/> Web <input type="checkbox"/> Newspaper <input type="checkbox"/> 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 _____
<b>BILLING INFORMATION</b>	WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> EMPLOYER <input type="checkbox"/> OTHER ADDRESS _____ CITY _____ STATE _____ ZIP _____ EMPLOYED BY _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ OCCUPATION _____ SOCIAL SECURITY NO. _____ DRIVERS LICENSE NO. _____ HOME PHONE # _____ EMPLOYER PHONE # _____
<b>MEDICAL INSURANCE INFORMATION</b>	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 <b>PRIMARY INSURANCE COMPANY</b> _____ 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 <b>SECONDARY INSURANCE COMPANY</b> _____ 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 # _____
<b>WORKERS' COMP.</b>	IS THIS VISIT DUE TO A JOB RELATED INJURY? YES _____ NO _____ DATE INJURED _____ * PLEASE FILL OUT WORKERS' COMP. FORM *
<b>FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT</b>	
I authorize treatment of the person named above and agree to pay for all charges for such treatment. <b>WE REQUIRE THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.</b> 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.	

DATE \_\_\_\_\_

 SIGNATURE \_\_\_\_\_  
 Patient, Parent, or Legal Guardian

 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 \_\_\_\_\_

What procedures are you interested in? \_\_\_\_\_

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

	YES	NO		YES	NO		YES	NO
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Keloids/Thick	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Scars Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin Resistance	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Skin Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	DVT	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Tape Allergies	<input type="checkbox"/>	<input type="checkbox"/>
CPAP Machine	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>

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\*\***



**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.

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**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: \_\_\_\_\_