ASSOCIATES IN
Plastic Surgery
Est.1978

Patient Name_____

Date of Birth_____ Gender ▫ M ▫ F Social Security Number_____-_____-_____

Address_____

City_____State_____Zip_____

Email_____

Home#_____Work#_____Cell#_____

Employed by_____Occupation _____

Emergency Contact_____Phone#_____

Responsible party if patient is a minor_____ ▫Parent ▫Guardian

Name of Primary Insurance Company_____

Policy Holder's Name _____Relationship to patient _____

Name of Secondary Insurance Company _____

Policy Holder's Name_____Relationship to patient _____

## 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 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 my surgical procedure and understand these photographs will remain the property of my treating physician.

DATE_____SIGNATURE_____

Patient, Parent, or Legal Guardian

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## 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: _____

Age: _____Height: _____Weight: _____

Occupation: _____Employed by: _____

Primary Care Physician: _____Phone Number: _____

Referring Physician: _____Phone Number: _____

How did you hear about us? _____

What procedures are you interested in? _____

_____

### 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** | ☐ | ☐ |
| **Diabetes** | ☐ | ☐ | **Depression** | ☐ | ☐ | **Stomach Ulcers** | ☐ | ☐ |
| **Insulin Resistance** | ☐ | ☐ | **Anxiety** | ☐ | ☐ | **Colitis** | ☐ | ☐ |
| **Congenital Heart Disease** | ☐ | ☐ | **Mental Illness** | ☐ | ☐ | **Skin Sensitivity** | ☐ | ☐ |
| **Cancer** | ☐ | ☐ | **DVT** | ☐ | ☐ | **Latex Allergies** | ☐ | ☐ |
| **Leukemia** | ☐ | ☐ | **Migraines** | ☐ | ☐ | **Tape Allergies** | ☐ | ☐ |
| **Hepatitis/Jaundice** | ☐ | ☐ | **Sleep Apnea** | ☐ | ☐ | **CPAP Machine** | ☐ | ☐ |
| **Epilepsy** | ☐ | ☐ | | | | | | |

Please list current medications: (including dietary/herbal supplements and over the counter medications)

_____

_____

Do you use Aspirin, Advil or Motrin regularly? ☐no ☐yes _____

Please list any medications and/or foods that you are allergic to and your reaction:

_____

_____

Please list previous operations: (including procedure, surgeon and year)

_____

_____

Are you under contract with a pain management doctor? ☐no ☐yes _____

Have you had weight loss surgery/procedure? ☐no ☐yes If yes, when? _____

Are you a smoker? ☐no ☐yes Ex-smoker? ☐no ☐yes If yes, when did you quit? _____

Have **you** or any **family members** ever had: (if you select yes below, please explain)

- Difficulty with anesthesia? ☐no ☐yes _____
- Abnormal or excessive bleeding? ☐no ☐yes _____
- Abnormal blood clotting? (DVT or PE) ☐no ☐yes _____
- Cancers or serious illnesses? ☐no ☐yes _____

**Women Only**

Date of last menstrual cycle: _____ Are you pregnant? ☐yes ☐no

Number of: pregnancies _____ live births _____ C-sections _____ vaginal deliveries _____

Date of last mammogram: _____ Facility of last mammogram: _____

Result of mammogram: ☐normal ☐abnormal _____

Do you have family history of breast cancer? ☐no ☐yes If yes, please provide relationship:

_____

**We recommend regular pelvic and breast exams with your regular physician**

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# 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: _____

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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: _____