Affiliates in Plastic Surgery

PATIENT REGISTRATION FORM

Patient's Full Name: _____

Preferred Phone Number (home ☐ cell ☐ work☐): _____

E-mail Address: _____

Preferred method of communication: ☐ Email ☐ Telephone

Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Social Security # (optional): _____

Emergency Contact: _____ Relationship to Patient: _____

Phone Number: _____

Reason for consultation? _____

Who referred you to our practice? _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Patient is Subscriber/ Policy Holder: ☐ Y | N ☐ Patient is Subscriber/Policy Holder: ☐ Y | N ☐

INSURED INFORMATION (if other than patient) – We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Date of Birth: _____

HIPAA ACKNOWLEDGEMENT

I understand a copy of the HIPAA privacy practice is available to me upon request.

Name(s): _____ Relationship to Patient: _____

Signature: _____ Date: _____

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MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

Gender: _____ Height: _____ ft. _____ in. Weight: _____ lbs.

Primary Care Physician: _____ Other Physician(s):_____

Please list any **medical problems** you have had:

_____

Please list any **SURGERIES** you have had:

_____

Medications (prescription and over the counter), vitamins and herbal supplements:

_____

Do you take aspirin or blood thinning medication? ☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes ☐ No If yes, how much? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, how much? _____

Have you used any recreational drugs in the last few months? ☐ Yes ☐ No

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No If yes, please list: _____

Please check the boxes below if you have ever had any of the following:

☐ Asthma	☐ Thyroid problems	☐ Jaundice
☐ Heart disease	☐ Stroke	☐ Shortness of breath
☐ Cancer	☐ Glaucoma	☐ Severe headaches
☐ Liver problems	☐ Hernia	☐ Urinary difficulty
☐ Bleeding problems	☐ Seizures	☐ Swelling of legs
☐ Blood clots	☐ Diabetes	☐ Other: _____

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AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

_____ Initials. CONSENT FOR TREATMENT: By this document, I do hereby request and authorize AIPS (Affiliates in Plastic Surgery), its medical practices and providers to perform evaluation, treatment services and procedures as necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

_____ Initials. CONSENT TO THE USE OF TELEMEDICINE: I consent to the use of telemedicine, including various video and audio transmission, for interaction with my physician. I understand that there are risks that include security failure and breach of privacy and of personal medical information, in addition to poor transmission quality and the resulting limitation of evaluation and judgment. I also agree to disclose the geographic state in which I am present during a telemedicine visit.

_____ Initials. INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to AIPS for service(s) furnished to me. I authorize AIPS to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to AIPS. I hereby authorize that photocopies of this form to be valid as the original. I authorize AIPS and/or its legitimate agents to act on my behalf in requesting and filing an appeal regarding the rejection/denial medical services rendered. I acknowledge I am responsible for all charges for services provided which are not covered by my health insurance carrier or for which I am responsible for payment under my health insurance plan including (but not limited to) co-pays, co-insurances and deductibles. I also understand and acknowledge that in the case of out of network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge(s), and in the event my insurance plan does not reimburse these services provided to me, I will be responsible for any remaining balance.

_____ Initials. REQUIRED REFERRAL: Some insurance companies require a referral or authorization for office visits. If required, it is the responsibility of the patient to obtain and provide the referral to our office. Patient or legal guardian will be subject to a fee of $100 if an appropriately dated referral is not provided to our office within 15 days of service.

_____ Initials. PHOTOGRAPHIC CONSENT: I consent to the taking of photographs or video of me or parts of my body in connection with the plastic surgery procedure(s) intended or performed. I understand that such photographs, videos or case histories may be published in print, visual or electronic media for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that in some circumstances these may portray features that shall make my identity recognizable. I understand that I have the right to revoke this authorization in writing at any time and that refusal to sign will have no effect on my medical treatment. I release and discharge Affiliates in Plastic Surgery, LLC. from all rights that I may have in the photographs, video, or case histories and from any claim that I may have relating to such use in publication.

_____ Initials. INJECTABLE FEES: Fees for in-office treatments such as Botox®, Dysport®, Restylane®, Juvederm®, chemical peels, and other similar procedures are payable in full at the time of your appointment and are non-refundable.

_____ Initials. SURGICAL FEES: For cosmetic procedures, a 50% deposit of the physician's fee is due at the time of scheduling surgery. The remaining 50% is due two weeks prior to the procedure or the surgery will be cancelled.

_____ Initials. CANCELLATION/NO-SHOW FOR APPOINTMENTS: Cancellation notice of 24 hours is required for all in-office appointments. If proper notice is not given you may be subject to a rescheduling fee of $100.

_____ Initials. CANCELLATION/NO-SHOW FOR IN-OFFICE PROCEDURES: Due to the large block of time reserved for in office procedures, cancellation notice of 3 business days is required or forfeiture of 50% deposit may occur.

_____ Initials. We accept Visa, MasterCard, American Express, Discover, Debit, Cash and Check. Checks returned for insufficient funds (NSF) will incur a $50 charge (cash only). Payment for NSF funds must be made within 2 business days. We do not accept post-dated checks.

_____ Initials. RELEASE OF INFORMATION: I may authorize the use or disclosure of my protected health information to an individual or entity. A Medical Records Release form will be provided upon my request.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____ _____

Signature of Patient or Parent/Legal Guardian/Authorized Representative Date

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the related consumer disclosure. (required)