Associated Plastic Surgeons & Consultants, P.C.

Cosmetic & Reconstructive Plastic Surgery
Diplomates American Board of Plastic Surgery
www.associatedplasticsurgeons.com
864 West Jericho Turnpike
West Hills, NY 11743.
Tel: 631-423-1000
Fax: 631-271-6900

Date _____

Name (First, Last) _____

Address _____

City, State, Zip _____

Home Phone _____

Business Phone _____

Date of Birth _____

Social Security # _____

E-Mail _____

Sex _____ Marital Status _____

Referred by _____

Address _____

Phone # _____

Family Physician _____

Address or Phone # _____

If you have recently been treated by our doctors in the Emergency Room please fill in below:

Date of Emergency Room Visit _____

Hospital _____

Name of Treating Physician _____

Guarantor Insurance Information

Name of Guarantor _____

Address of Guarantor _____

Place of Employment _____

Employment Address _____

Employer Telephone _____

Insurance Company _____

Plan _____

Group # _____

Insured's Name _____

Insured Party ID# _____

Relationship _____

Insured Party SS# _____

If injury or consultation stems from a **work related** (compensation) injury, **car accident** (no-fault), or **third party insurance company** please notify the receptionist.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.

We accept cash, checks, Visa or MasterCard. We will be happy to assist you in the processing of your insurance claim form. Any such request must be accompanied by a completed insurance form.

Returned checks and balances older than 30 days will be subject to additional collection fees. Charges may also be made for broken appointments and appointments canceled without 24 hours advance notice. All legal fees associated with a delinquent account are the responsibility of the patient, parent or guardian. In the event that your account goes to collection, you will be responsible for a service fee of $250.00 or 33% on the unpaid balance. This fee is in addition to all legal fees previously mentioned. On all delinquent accounts greater than 60 days from the date services are rendered, interest may be charged at the rate of 1.25%/month.

You must realize, however, that if we do not participate with your insurance:

1. Your insurance is a contract between you, your insurance company and/or employer. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of the usual, customary and reasonable fees as determined by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits of all contracts. Some insurance companies arbitrarily select certain services that they will not cover. Cosmetic procedures are usually not a covered expense.
4 If you are insured with a company with whom we currently participate, please have your insurance ID card available for our information. Should this insurance company, for any reason, not reimburse us directly, or if we should not hear from this company in reference to a claim, you will be responsible for full payment.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Please be advised that a referral is needed for each visit. If your primary care physician has informed you that a referral is "in the system" be advised that if it cannot be retrieved, you will be held personally responsible for payment.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read all the information on this sheet. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I will notify you of any changes in my health insurance status.

I have received/been offered a copy of Privacy Regulations and Patient's Rights.

Signature _____

Please Print Name _____

Date _____

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Patient Name: _____ **Date of Birth:** _____

Date: _____

Are you currently under the care of, or have you ever been treated by a medical physician for any significant illness other than colds, flu or virus? No ☐

Yes ☐ (Please Complete)

_____

_____

_____

Have you ever had any surgical procedures in the past?

Date	Type of Surgery	Doctor's Name	Hospital

Do you have any allergies to medications?

	No	**Yes**
• Penicillin	☐	☐
• Local Anesthesia	☐	☐

• Other (please specify) _____

_____

Are you presently taking any medications?

	No	**Yes**
• Aspirin	☐	☐
• Oral Contraceptives	☐	☐
• Blood Thinners	☐	☐

• Other (please specify) _____

_____

Do you have history of

•Bleeding tendencies?	☐ No	☐ Yes
•History of diabetes?	☐ No	☐ Yes
•History of hepatitis?	☐ No	☐ Yes

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Patient Name: _____ **Date of Birth:** _____

Date: _____

Are you currently under the care of, or have you ever been treated by a medical physician for any significant illness other than colds, flu or virus? No ☐
Yes ☐ (Please Complete)

_____

_____

Have you ever had any surgical procedures? (please use the back to continue as necessary)

Date	Type of Surgery	Doctor's Name	Hospital

Do you have any allergies to medications?

Date								
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Penicillin	☐	☐	☐	☐	☐	☐	☐	☐
Local Anesthesia	☐	☐	☐	☐	☐	☐	☐	☐
Other								

Are you presently taking any medications? (Check if indicated)

Date								
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Aspirin	☐	☐	☐	☐	☐	☐	☐	☐
Oral Contraceptives	☐	☐	☐	☐	☐	☐	☐	☐
Blood Thinners								
Other								

Please include below any Vitamins, "Herbal" or "Over-the-counter" medications as some of these may sensitize you to anesthesia or promote bleeding.

Do you have history of
Bleeding tendencies? ☐ Yes ☐ No
Diabetes? ☐ Yes ☐ No
Hepatitis? ☐ Yes ☐ No

Do you smoke cigarettes ☐ **Yes** ☐ **No** **Packs/Day** _____
Do you use alcohol in other than a social situation? ☐ **Yes** ☐ **No**
If yes, how frequently? _____
Would you like to bring anything else to the doctor's attention? No ☐ **Yes** ☐ ***(please specify)***

_____

If any history of use of controlled substances, please bring to your doctor's attention

Patient's or Guardian's Signature: _____

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Signature on File

I hereby authorize:

- use of this form on all my insurance submissions
- release of information to all my Insurance Companies
- my doctor to act as my agent in helping me obtain payment from my Insurance Companies
- payment direct to my doctor
- that a copy of this form be used in place of the original

Guarantee of Payment

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, and co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary."

I have read and understand this information. I understand that my insurance company may deny coverage. Therefore, I authorize Associated Plastic Surgeons & Consultants, PC (APS) to perform medical services on my behalf. I agree to be fully responsible for all charges. I understand that APS is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

HIPAA

I have been given the opportunity to read the above regulations a copy of which is on file at the front desk or with the office manager.

Permission is granted for Associated Plastic Surgeons & Consultants to speak to the following individual(s) about my treatment. This permission will continue until it is revoked in writing.

_____

_____

By my signature below, I agree to all items (Signature on File, Guarantee of Payment and HIPAA outlined above.

_____ _____
Signature Date

_____
(Please Print Name)