*****PLEASE COMPLETE EVERY ITEM*****

**PLASTIC & COSMETIC SURG GRP of NJ, P.C.** ___F.B. LaVan, M.D. ___ T. J. Steffe, M.D. ___ Cosmetic ___ Insurance

PT. NAME: ________________________________________ SEX: M / F ETHNICITY/RACE:__________/_________
(government-mandated)

BIRTH DATE: ____________ AGE: ______ S.S.#: ___________________

ADDRESS: St:_________________________________________City: ________________ State: ____ Zip: ________

HOME PHONE: (____)________________ CELL: (____)_______________

EMPLOYER: ___________________WORK PHONE: (___)_______ EXT: _____ OCCUPATION/POSITION: ____________

**PREFERRED METHOD OF PHONE CONTACT: HOME__YES __NO CELL__YES __NO WORK __YES __NO**

**YOUR COMPLETE MEDICAL RECORD WILL BE MAINTAINED IN PAPER/CHART FORM**. We're not currently required to maintain electronic health records.

If you don't have an email address, we suggest you provide email address of your emergency contact/authorized representative.

__Decline/Initial____

**E-MAIL ADDRESS (REQUIRED):** _________________________________ __Self _Other:_ __________________

__ **EMERGENCY CONTACT(S)** and/or __ **SURROGATE DECISION MAKER(65 YRS & OLDER)**: **REQUIRED**

NAME: _________________________________RELATIONSHIP:______________ PHONE: ___________________

**Please provide a number in addition to home, if above is home:**

NAME: _________________________________RELATIONSHIP:______________ PHONE: ___________________

**PHARM NAME/LOCATION**: ___________________________________________________PHONE:_______________

**RX MEDICATIONS/DOSAGES:** ________________ _________________ ________________ _________________

________________ _________________ ________________ _________________

**OVER COUNTER MEDS/DOSAGES:** ________________ _________________ _________________ ________________

**ALLERGIES TO MEDICATIONS**: _____________________ Adverse Reactions: ________________________

_____________________ ________________________

_____________________ ________________________

**ALLERGIC TO**: **LATEX** YES NO **LIDOCAINE** YES NO **EPINEPHRINE** YES NO

**SMOKER: __Never __Former __Current Everday __Current Some Days __Heavy __Light**

**COMPLETE** PRIMARY DR NAME: _______________________________ PHONE:___________ FAX:___________

**COMPLETE** ADDRS: ______________________________________________________________________________

REFERRING PHYSICIAN: ________________________________________ PHONE:__________ FAX:___________

ADDRESS: _____________________________________________________________________________________

**INSURANCE INFORMATION**

**HMO patient must provide referral for each visit, or will be responsible for charges incurred, or will be reschuled.**

**PRIMARY INSURANCE** CO. NAME: __________________________________________________________

**Is this a Health Insurance Exchange plan? (Obama Care/Affordable Care Act) ___ Yes ___No**

Identification #: _________________________________ Group #: ______________ Effective Date: _____________

Subscriber (if not patient): _________________________________Birthdate: ___________ SS#: _______________

Subscriber's Employer: _____________________________________ **FSA/HSA ACCT:** _______________________

**LABORATORY for your ins.: __LabCorp/Dianon __Quest __Inst. Dermatopath. ___Other:_________________**

**SECONDARY INSURANCE** CO. NAME: _______________________________________________________

Identification #: __________________________ Group #: ________ Effective Date: _______ FSA/HAS:___________

Subscriber(if not patient): _________________________________Birthdate: ____________ SS#: ________________

**IF APPLICABLE** – CIRCLE ONE > **WORKER'S COMP** **AUTO ACCIDENT**

NAME OF INSURANCE COMPANY: ________________________________________________________

ADDRESS: ______________________________________________________________________________

PHONE:_________ ADJUSTOR:____________________ ACCIDENT DATE: _________CLAIM #: ______________

**PATIENT NAME (PRINT): ________________________________________**

******GUARANTOR AGREEMENT - PLEASE READ THOROUGHLY - INITIAL/SIGN WHERE INDICATED******
**AUTHORIZATION / OFFICE POLICY-ACKNOWLEGEMENT OF PATIENT FINANCIAL RESPONISBILITY**

**** WE DO NOT ACCEPT CREDIT or DEBIT CARDS **** **Initial: _____**
****FEES PAYABLE BY CASH OR CHECK (or CARE CREDIT for COSMETIC PROCEDURES)****

Your health insurance policy is a contract between you and your insurance company. We are not a party to that contract. We confirmed with you at the time of scheduling your appointment whether or not we participate with your plan. If you will be scheduled for a procedure that involves another facility or physician/provider, those entities will verify prior to their service that they accept your insurance. You should, also, verify that facility or physician/provider accepts your plan by calling them or your insurance carrier. These may include other physician specialists, laboratories, hospital or surgical center, anesthesiologist, etc., over which we have no control.You may ask us for a list of insurance carriers with which we participate. Be advised, coverage and participation status can change without prior notice. You are responsible to know your benefits and to provide correct, eligible insurance information or you will be responsible for all charges for services provided. Proper referrals are your responsibility and must be presented at time of service or we will reschedule your appointment. Before services are rendered, coverage /eligibility will be verified. The fact that you have insurance for which you pay a premium does not imply that you will not be responsible for payment of co-pays, co-insurance and deductibles. **Co-pays are due at time of service. We reserve the right to require prepayment for any recommended procedures. You will be responsible for payment of your deductible and co-insurance based on our best efforts to determine the "reasonable and customary" reimbursement rates your plan would be expected to pay. We will file a claim with your insurance carrier and adjustments will made following claim processing by your insurance carrier. You will be responsible for any difference between your prepayment and the patient balance indicated on the explanation of benefits. We will reimburse or credit any difference if you have prepaid more than the patient balance indicated on the explanation of benefits. If your plan has limits /maximums, you will be responsible for charges in excess of those limits/maximums. Post-operatively, co-pays are generally not collected within the 90-day follow-up period (surgical global period), unless there are complications, or you are seen for other than the surgical follow-up. After the 90-day surgical follow-up period, you will be responsible for co-pays.** **Initial: ______**

**Outstanding balances will be due prior to scheduling further appointments. Unpaid balances will be sent to "collections" at our discretion.** **Initial: ______**

If you have an insurance related procedure for which we obtain pre-certification, be aware that "this is not a guarantee of payment". Your insurance carrier may ultimately deny your claim, in which case you would be responsible for payment. Prepayment is required for cosmetic procedures. **Initial: _____**

SIGN: ________________________________________ DATE: __________________________

I authorize payment of medical benefits directly to provider for services rendered to me. I authorize provider to release information/medical records/documentation to insurance companies, third party payers, and anyone assisting them in obtaining payment, including billing, coding and collection agents, their attorneys and consultants for services rendered to me as needed to obtain benefits. I further authorize this provider, and other providers involved in my care as it relates to treatment I receive here, to release information, medical records and/or documentation to other physicians, medical facilities, insurance companies, for quality assurance, peer review, consultations, diagnostic studies. I permit copy of this authorization to be used in place of the original.

SIGN: __________________________________________ DATE: __________________________

****PAYMENT ACCEPTED IN CASH OR CHECK (as well as CARE CREDIT for COSMETIC PROCEDURES)**, is required at time service is rendered. Bounced checks will incur bank charges and an additional $25 handling fee. We will complete an initial disability form should this be required. However, with the exception of Medicare patients, a $25.00 fee per form will be charged for additional forms, and we will not be able to complete the form(s) at the time you present them.

SIGN: __________________________________________ DATE: ___________________________

During the course of your care, photos may be taken for the purpose of insurance authorization for treatment or surgery. They may also be used for scientific or educational purposes, for which you will not be identified by name, nor will anything personally identifiable be apparent in any photos. Photographs of your face will not be used without a separate, specific authorization.

SIGN: __________________________________________ DATE: ____________________________

Be advised that completing preliminary health/ insurance questionaires does not establish a physician-patient relationship with this practice. Our doctor will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient. If accepted into our practice, you agree to follow physician recommendations regarding treatment, therapy, medications, specialty referrals, and return visits to help promote continuiity of care. Failure to follow physician isntructions or meet financial obligations may be grounds for termination from the practice.

SIGN: ___________________________________________ DATE: ____________________________

**PATIENT NAME (PRINT):** ________________________________________

## WE HAVE SUSPENDED USE of ELECTRONIC HEATH RECORDS until further notice.

### CONFIDENTIALITY - PLEASE READ CAREFULLY

**In addition to release of information authorized under AUTHORIZATIONS & OFFICE POLICY ,** and in compliance with HIPAA (Health Insurance Portability and Accountability Act), your careful consideration as **to whom we may release information on your behalf is required. This may be the same as your Emergency Contacts, listed on the first page. I authorize the release of information (health and demographics) as it pertains to my care only to:** (It is not necessary to provide as many names as there are lines, and you may list more if necessary. You may contact our office should you wish to make changes to this authorization at any time.)

| Name | Relationship | Phone |
|---|---|---|
| ________________ | ________________ | ________________ |
| ________________ | ________________ | ________________ |
| ________________ | ________________ | ________________ |

________________________________ ________________

PATIENT SIGNATURE DATE

### ACKNOWLEDGEMENT of RECEIPT of PRIVACY NOTICE

I have been presented with a copy of PLASTIC & COSMETIC SURGICAL GROUP OF NEW JERSEY, P.C.'s **Notice of Privacy Policies (available on our website, also, by clicking on Read Notice of Privacy Practices at the bottom of each page)**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) (if any) concerning the use of my personal medical information:

________________________________________________________________

________________________________________________________________

**Signed:** ________________________________ **Date:** ____________________

If not signed by patient, please indicate relationship to patient (e.g., spouse)

**Relationship:** ____________________ **Witnessed by:** ____________________

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**Internal use only:**
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on: Date: ____________________ Time: ____________________

By: Name: ____________________ Title: ____________________