



Whom May We Thank for Referring You?

Name: _____

Other: Newspaper ___ Radio ___ TV ___ Seminar ___
Staff ___ Yellow Pages ___ Other _____

Primary Care Physician

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Insured/Responsible Party

Insured's Name: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone : _____

Date of Birth: _____ Sex: ___ Marital Status: _____

Social Security Number : _____ - _____ - _____

Employer: _____

Insurance Carrier: _____

Insurance Phone Number: _____

Policy #: _____ Group #: _____

Is this Plan a: PPO _____ POS _____ HMO _____

Are Referrals Required? _____ Are we in network? _____

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also have received a Notice of Privacy Practices and Disclosure of Investment from the Center for Breast and Body Contouring, P.A.

Signature: _____ Date: _____

Update Signature: _____ Date: _____

Update Signature: _____ Date: _____

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

Preferred Method of Contact: _____

Date of Birth: _____ Sex: ___ Marital Status: _____

Social Security Number: _____ - _____ - _____

Student: Y N Occupation: _____

Employer: _____

Patient's Spouse/Guardian

Spouse/Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Reason for Consultation

Patient Medical History continued

Pregnancy Overview:

Have you ever been pregnant? Yes No If yes, please provide details.

Date(year)	Single/Multiple Birth	Delivery method	Breast Fed
_____		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No

Health Maintenance History:

Have you ever had a mammogram? Yes No If yes, when was the most recent exam? _____

Have you ever had an abnormal mammogram? Yes No

If yes, please explain: _____

When was your most recent complete physical? _____

Have you had a Chest X-ray or EKG within the past year? Yes No If yes, when was this performed? _____

Social History:

Do you currently smoke? Yes No Have you smoked in the past? Yes No If yes, provide details: _____

Cigarettes ___ PPD x ___ years Cigars ___ Per day x ___ years Other: _____

Do you drink alcohol? Yes No If yes, what type? Wine Mixed Drinks Beer Liquor How often? Daily 1-2 x week 1-2 x month 1-2 x year

Do you live alone? Yes No If no, who lives with you? Spouse Children Significant other Other relative Other: _____

If you were to have a surgical procedure, who would assist you at home during your recovery?

Family History:

Have any blood relatives had:

Condition	If yes, who had this?	Please indication maternal or paternal (mother or father) relative.
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Breast Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Problems with Anesthesia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

I am adopted and do not know my family history.

Additional:

Ethnicity: Caucasian/White African American/Black Asian Hispanic/Latino Native American Middle Eastern Other _____

Are you right or left handed?

Height: _____

My Normal Weight: _____

Please list any additional medical conditions, illnesses, or handicaps you may have: _____

The information I have provided about my medical history is accurate and complete to the best of my knowledge.

Patient's signature: _____ Date: _____



Financial Policy

We are committed to providing you with the best possible health care, and we are pleased to discuss our professional fees with you at any time. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies. Please ask if you have any questions about our fees, your responsibility, or the financial policy.

All patients must complete our Patient Information Form and inform our office of any changes in address or insurance. In order for us to treat and care for our patients, we must have complete and correct information.

Payment for services rendered is **due at the time of service**. We accept cash, check, Mastercard, Visa, Discover, and American Express. There will be a \$25.00 service charge for any returned checks.

We expect TOTAL PAYMENT two weeks prior to all aesthetic procedures unless you have been pre-approved with one of our financial plans.

The charges on your account with our office will reflect **our** doctor's fees only, *unless otherwise noted*. Any hospital, x-ray, laboratory, anesthesia, pathology, etc. will be billed by the provider performing the service.

Insurance policy:

We will gladly answer questions regarding your insurance. If the proposed services are medically necessary, we will attempt authorization from your insurance company. You must realize, however, that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in your contract. Some insurance companies arbitrarily select certain services they will not cover and these are a patient responsibility.
- If your insurance coverage is through a plan that we are **not** contracted with, regardless of your carrier's rate of reimbursement, you will be responsible for the **FULL** balance of your account. This includes any amount over the "reasonable and customary".

We must emphasize that as a medical care provider, the 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. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, you are encouraged to contact us promptly for assistance in the management of your account.

"I hereby assign, transfer, and set over to The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy with my current insurance company."

_____ **Initials**

As part of your treatment, we require both before and after treatment photographs for which the fees are included in our charges.

If at any time after your initial surgery you feel that you need a revision surgery, facility and anesthesia fees will be applicable. Surgeons' fees are at the discretion of your surgeon.

"I authorize The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids and personnel of their choosing to photograph me prior to, during, and following any surgery. I understand these photographs will be a part of my medical records and are vital to my quality of care and post surgical result."

Signature: _____ Date: _____



Photography Release

Dated: _____

I, _____ (patient's name) hereby give The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids the absolute and irrevocable right and permission, with respect to photographs they have taken of me and/or in which I may be included with others:

- a. To copyright the same in their own name or any other name they may choose.
- b. To use, re-use, publish and/or re-publish the same in whole or in part, individually, or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not limited to) illustration, promotion and/or advertising and/or trade.
- c. To use my name in connection therewith if they so choose.

I hereby release and discharge The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

This authorization and release shall also ensure to the benefit of the legal representatives, licensees, and assignees of The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids as well as the person(s) for whom they took the photographs.

I have read the foregoing and fully understand the contents thereof.

(patient signature or legal guardian if minor)

(witness signature)

(legal guardian relationship to patient if minor)

(patient address)