Carolina Plastic Surgery
2356 John Smith Road #201
Fayetteville, NC 28303
Phone: 910-323-1234 Fax: 1-866-493-3103

Saira Saini, MD
Board Certified Plastic Surgeon

Name: _____Gender: M/F

SSN:_____ DOB:_____ Age:_____

Home Address: _____

City/State/Zip:_____

Home Phone: (____) _____ Work Phone:(____)_____ Cell Phone: (____)_____

Employer: _____ Email Address: _____

How did you hear about our office? _____

Referring/Family Physician: _____

Address: _____

Emergency Contact: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____)_____ Cell Phone: (____)_____

Responsible Party: _____ Relationship: _____

INSURANCE INFORMATION: **Please indicate if this is to be billed to your insurance - ☐ Insurance ☐ Liability Case ☐ Auto Accident ☐ Cosmetic/Self Pay**

Primary Insurance: _____ ID#: _____

Name of Subscriber: _____ Relationship: _____

Secondary Insurance: _____ ID#: _____

Name of Subscriber: _____ Relationship: _____

Other: _____

Our office will file insurance (based on the information you have provided) for covered insurance services. Please remember that you are responsible for all deductibles, co-pays and non-covered service amounts. I authorize Carolina Plastic Surgery of Fayetteville to release pertinent medical information to my insurance company, state and federal agencies, referring physicians, workers compensation carriers, when requested, or to facilitate payment of a claim.

There will be a processing fee charged ($2.50 after the first statement), if multiple mailings are required on outstanding account balances. Refunding requested after a charge card payment, will be paid minus the fees incurred by the bank and facility.

There is a No Return Policy on any products. If you have had a severe reaction to a product, the return policy will be addressed on an individual basis.

_____ _____

Signature of Patient Date

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Financial Policy and Assignment of Benefits

This document is to inform you of the financial policy established by Carolina Plastic Surgery of Fayetteville.

Your insurance plan is an agreement between you and the insurance carrier. You are ultimately responsible for all your medical expenses, and we will look to you for payment of any balances not covered by your insurance. It is the patient/guarantor's responsibility to follow and abide with the policy established by their insurance plans. If your plan requires that you select a specific provider of services, then it is your responsibility to do so and to notify your insurance company of such. If we are participating providers with your insurance plan, all insurance deductibles, copayments and coinsurances are due at the time of service. If we are not a participating provider with your insurance plan you are considered a self-pay patient, and responsible for all charges. If your insurance plan requires you to have an **authorization** for a visit to a specialist office, please make sure your primary care physicians obtain such authorization for the initial visit and subsequent visits. **We are unable to provide service to you without a valid authorization.**

We except cash, personal checks, money orders, MasterCard and VISA for payment of services rendered. As a service to our patient's we will bill your charges to your insurance company if you have provided us with the appropriate information. If you have a policy that pays to the patient only, the patient will be responsible for filing the claim. Should there be any unusual financial situations which would make payment difficult, please feel free to discuss this with the Office Manager. Any patient payment will be first applied to the current co-pay/coinsurance and deductible, and after that the remainder of the payment will be applied to the oldest outstanding balance. All outstanding balances must be paid before any subsequent/staged surgery will be scheduled. Any past to balance (90 days) may be subject to additional collection fees. We reserve the right to refer any account to our collection agency if the account is in default of payment obligation or compliance of this policy. The collection agencies fee will be added to the outstanding balance.

If your claim is related to a motor vehicle accident, or any other liability claim, we will file your claim only if all information has been provided; however, ultimately the patient is **responsible for any medical expense incurred.**

PLEASE NOTE: Unsatisfactory results are possible, although most patient are pleased with the results of our services. As with any procedure, there is no guarantee that you will be satisfied. In these situations, please note that no refunds will be given for service rendered.

REFUNDS: Refunds requested will be paid 30-days after the request is made, if applicable. Credit card refunds will be minus the fees incurred by the bank and facility. **RETURN CHECK:** There is a $50.00 charge for returned checks
RETURN POLICY: There is a No Return Policy on new or used products. If you have a severe reaction to a product, the return policy will be addressed on an individual basis.

MISSED/RESCHEDULED APPOINTMENTS–If you are unable to keep an appointment, A 24-hour notice is **REQUIRED!** If a second scheduled appointment is missed or rescheduled less than 24 hours, a $35.00 fee will be charged to reschedule your next appointment. Medical emergencies or other unforeseen problems could delay your appointment or cause your appointment to be rescheduled. We apologize for any inconvenience this may cause. Appointment reminder calls are a courtesy. Should you not receive a call, it is still your responsibility to remember your appointment.

I hereby authorize Carolina Plastic Surgery of Fayetteville to submit appropriate information to my insurance company for processing of my claim(s). I understand that the insurance benefits are paid directly to Carolina Plastic Surgery of Fayetteville Furthermore, I agree to and understand that I am directly responsible for all financial obligations to Carolina Plastic Surgery of Fayetteville If for any reason I fail to meet my financial obligations forcing Carolina Plastic Surgery of Fayetteville. to seek further actions as a means of collecting the balance owed (i.e. collection agency/court) I understand that I will be responsible for the balance due on my account plus all collection fees. If my account should be turned over to a collection agency, I understand that until such time that my financial obligations are met, I may no longer be seen as a patient at Carolina Plastic Surgery of Fayetteville I further agreed to forever hold harmless. Carolina Plastic Surgery of Fayetteville, their physicians and staff for refusal to render further services in the event I do not honor this financial agreement. I understand that for any services I do not pay in full, at the time the service is rendered; I assign benefits for that claim to Carolina Plastic Surgery of Fayetteville.

_____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient or Patient Representative

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Name: Gender:

DOB: Age: Height: _____ Weight: _____

Drug Allergies: _____ Allergy to Iodine (X-Ray), Dye, or Shellfish: _____

Preferred Pharmacy: _____Pharmacy Phone Number: (___) _____

Reason for today's appt: ☐ Breast Lift ☐ Breast Reduction ☐ Cosmetic ☐ Other, please specify
☐ Breast Augmentation ☐ Breast Recon ☐ Abdomen
☐ Liposuction ☐ Skin Lesion ☐ Skin Problem

Number of Pregnancies: _____ Date of Last Mammogram: _____
Delivery: Vaginal / Caesarean Section Did you breast feed?: ☐ No ☐ Yes, How long _____

Prior Medical History (High blood pressure, diabetes, asthma, etc.):

Prior Surgical History (include dates):

Have you ever been unexpectedly admitted after surgery: ☐ No ☐ Yes
Details:

Medications you are currently taking: _____
_____
_____
Do you take a blood thinner such as aspirin, coumadin or Plavix? ☐ No ☐ Yes

Any allergies to <u>medication/s or any other substances?</u>

Are you allergic to latex? ☐ No ☐ Yes

Have you or a family member ever had a reaction to anesthesia? ☐ No ☐ Yes
If yes, give details: _____

Do you drink alcohol/wine/beer? ☐ No ☐ Yes How often? _____

Do you use tobacco? ☐ No ☐ Yes What type and how often?

If a former tobacco user, list type and duration of use:

Do you use other recreational drugs, such as cocaine, marijuana, etc? ☐ No ☐ Yes

Have you ever received a blood transfusion? ☐ No ☐ Yes
Do you have personal beliefs that would prevent you from receiving a transfusion? ☐ No ☐ Yes

Do you have obstructive sleep apnea? ☐ No ☐ Yes

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Name: DOB:

PAIN LEVEL TODAY (circle best answer) – none 1 2 3 4 5 6 7 8 9 10 (Severe)	
HEAD (headaches or cosmetic concerns, etc.)	EYES (double vision, glaucoma, cataracts, etc.)
NECK (mass which is growing in size)	CARDIOVASCULAR (chest pain, heart attack, etc.)
PULMONARY (cough, COPD/emphysema)	GI (difficulty swallowing, liver disease, etc.)
GU (kidney problems, dialysis)	ENDOCRINE (thyroid disease, diabetes)
SKIN (change in mole, eczema, use of retin A)	HEMO (immune disorder, bleeding/bruising)
MUSCULOSKELETAL (rheumatic, arthritis, fusions)	NEUROLOGIC (stroke, weakness in arms/legs)
PSYCHOLOGIC (history of psychiatric illness, etc.)	
Have you ever been treated for cancer? ☐ No ☐ Yes Details/Date: History of any radiation treatments?	
Any family history that you feel reflects your current condition? ☐ No ☐ Yes	
Have you ever had blood clots or deep venous thrombosis (DVT)? ☐ No ☐ Yes	
Any other information regarding your health that you feel is important?	
SIGNATURE: DATE:	

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Forms Completion Policy

Name: DOB:

Carolina Plastic Surgery, P.A. requires payment for the completion of forms the patient asks us to complete on their behalf. We receive many requests which require increase administrative time and financial resources in excess of what is normally needed to complete the medical records.

Instructions:

- Submit the form completion request well in advance of when they are needed. We will attempt to complete the forms as quickly as possible however, to properly address them we need adequate time to review the patient's records.
- Patient must complete all their information on the form prior to giving the forms to us.
- Provide a stamped, addressed envelope to expedite mailing of completed forms.

We will make every effort to complete these forms within 7-10 business days; however, we cannot make any assurance of completion with the patient' time frame(s). Payment is required prior to completion of all forms.

The following forms will be assessed a $25 fee for completion:

- FMLA
- Workers Compensation
- Disability
- Letter of Condition
- Miscellaneous Patient request
- Medical Records

Multiple page forms will be completed at no charge to the patient:

- DMV Disability Placard

By signing below, I attest that I have read and understand the above consent. I have been provided of copy of this document for my records.

_____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient or Patient Representative

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Consent for Use/Disclosure of Health Information

Name: _____ DOB: _____

Notice of Patient:

By signing this form, you grant us consent to use and disclosure protected health care information including photographs for the purposes of treatment, various activities associated with payment and healthcare operations. Our Notice of Privacy Practices provides more detail on our treatment, payment activities and healthcare operations. If there is not a copy of the Notice accompanying this consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your healthcare information.

As stated in our Notice a Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Noticed. Since revisions may apply to your healthcare information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our privacy officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent form after you have signed it.

To be completed by Patient or Patient's Representatives

I, _____, have read the contents of this consent form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclosed my healthcare information to carry out treatment, payment activities and healthcare operations.

I,_____, give consent for Carolina Plastic Surgery, P.A. to speak with _____, in regards to my payment options for patient responsibility. My relationship to this person is _____.

_____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient or Patient Representative Relationship

Our Privacy Officer can be contacted as follows:
Name of privacy officer: Trish Haynes
Practice address: 2356 John Smith Road #201, Fayetteville, NC 28303
Practice phone number: 910-323-1234 FAX: 866-493-3103

This form does not constitute legal advice and covers only had rolled not state laws.