Carolina Plastic Surgery of Fayetteville, P.C.
2356 John Smith Rd., Suite 201
Fayetteville, NC 28306
Phone: 910-323-1234 Fax: 1- 910-272-7180

Saira Saini, M.D.
Board Certified Plastic Surgeon

Name: ______________________ Gender: ☐ M ☐ F

SSN: ______________ DOB: ______________ Age: ______________

Address: ______________________

City: ______________ State: ________ ZIP: ________

Phone Number: ______________ Work Number: ______________

Cell Number: ______________ Email: ______________

Employer: ______________ Phone Number: ______________

How did you hear about our office? ______________________

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

(If you have Tricare, then the ID# will be the SSN of the sponsor/subscriber)

Primary Insurance: ______________ ID#: ______________

Name of Subscriber : ______________ Relationship: ______________

Secondary Insurance: ______________ ID#: ______________

Name of Subscriber: ______________ Relationship: ______________

Other: ______________________

Referring /Family Physician: ______________________
Address: ______________________

Responsible Party: ______________ Relationship: ______________

Emergency Contact: ______________ Relationship: ______________

Home Number: ______________ Relationship: ______________

Our office will file your 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 used products. If the product has not been opened and you have the receipt, you may return it to our office within 10 days. A restocking fee of 10% will be charged. If you have had a severe reaction to a product, the return policy will be addressed on an individual basis.

X ______________________ ______________
Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Information Portability and Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third party.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time, at the address above, to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out payment; payment or health care operations, I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________ Date: ______________

Office Use Only: I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:		
Date:	Initials:	Reason:

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Date:

NAME:

DOB:	AGE:	Height:	Weight:

Reason for today's appt: ❐Breast Lift ❐Breast Reduction ❐Cosmetic ❐Other – Please specify

❐Breast Augmentation ❐Breast Recon ❐Abdomen

❐ Liposuction ❐Skin Lesions ❐Skin Problems

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: Yes _____ No_____

Details:

Medications you are currently taking:____

____

____

____

Do you take a blood thinner such as aspirin, coumadin, or Plavix? Yes _____ No_____

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

Are you allergic to latex? Yes _____ No _____

Have you or a family member ever had a reaction to anesthesia? Yes _____ No_____

Give details if yes:

Do you drink alcohol/wine/beer? Yes_____ No_____ How often?

Do you use tobacco? Yes_____ No_____ 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.?

Have you ever received a blood transfusion? Yes_____ No_____

Do you have personal beliefs that would prevent you from receiving a transfusion? Yes_____ No_____

Do you have obstructive sleep apnea? Yes_____ No_____

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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 retina A)	HEME (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? Yes_____ No_____ DETAILS / DATE: History of any radiation treatments?	
Any family history that you feel reflects your current condition?	
Have you ever had blood clots or deep venous thrombosis (DVT)?	
Any other information regarding your health that you feel is important?	
SIGNATURE:	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 your insurance carrier. You are ultimately responsible for all your medical expenses, and we will look to you for payment of any balance not covered by your insurance. It is the patient/guarantor's responsibility to follow and abide with the policy established by their insurance plan. 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 a participating provider with your insurance plan, all insurance deductibles, co-pays, and co-insurance amounts 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 you insurance plan requires you to have an authorization for a visit to a specialist's office, please make sure your primary care physician obtained such authorization for the initial visit and any subsequent visits. We are unable to provide services to you without a valid authorization.

We accept cash, certified checks, money orders, MasterCard, and Visa for payment of services rendered. As a service to our patients, 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 situation 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/co-insurance and deductible amount, 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 due balance (90 days) may be subject to additional collection compliance of this policy. The collection agency's 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 patients 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 services rendered.

REFUNDING Charge Card Payment: Refunding requested after a charge card payment, will be paid minus the fees incurred by the bank and facility. **RETURN CHECK:** There is a $50.00 charge for returned checks. **FORM FEE**: There will be a minimal charge of $20.00 for completion of insurance/work forms.

RETURN FEE: There is a No Return Policy on used products. If the product has not been opened, and you have the receipt, it may be returned to the office within 14 days of purchase (the receipt is required). A restocking fee of 10% will be charged. If you have a severe reaction to a product, the return policy will be addressed on an individual basis.

MISSED APPOINTMENTS: If you are unable to keep an appointment, please notify us as soon as possible so that we may use that time for another patient. Medical emergencies and other unforeseen problems could delay your appointment or cause your appointment to be rescheduled. We apologize for any inconvenience this may cause.

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 to Carolina Plastic Surgery of Fayetteville, forcing Carolina Plastic Surgery of Fayetteville to seek further action 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 agree to forever hold harmless Carolina Plastic Surgery of Fayetteville, physician/s and staff, for refusal to render further services in the event that I do not honor this financial agreement. I understand that for any service I do not pay in full at the time service is rendered, I assign benefits for that claim to Carolina Plastic Surgery of Fayetteville.

Signature of Patient ________________ Printed Name of Patient ________________ Date ________________