Cosmetic and Plastic Surgery of Central Pennsylvania, LLC
425 North 21st Street, Suite 405, Camp Hill, PA 17011 Phone:717-695-6553, Fax: 855-383-3233

PATIENT INFORMATION

Account No: _____

Name: [Last] _____ [First] _____ [MI] _____ □ Male □ Female
Social Security Number _____ Age ____ D.O.B. ___/___/____ Ethnicity _____
Address _____ Race _____
City _____ Zip _____
Email _____ Home Phone(___)_____
Marital Status: □ Single □ Married □ Other Cell Phone(____)_____

IF PATIENT IS UNDER 18 (or a full time student)

Mother's Name _____ D.O.B.___/___/____ Father's Name _____ D.O.B.___/___/____
Employer _____ Phone _____ Employer _____ Phone _____

EMPLOYMENT INFORMATION

□ Full time □ Part time □ Student □ Retired □ Other Occupation _____
Employer/School _____ Work Phone (____) _____
Work/School Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT

Name: [Last] _____ [First] _____ [MI] ____ Mobile Phone (___)_____
Address _____ Home Phone (___)_____
City _____ State _____ Zip _____ Work Phone (___)_____

INSURANCE (cards scanned)

Primary _____ Secondary _____ Tertiary _____

Gaurantor _____, Gaurantor DOB _____

PHARMACY & LAB

Pharmacy Name _____ Street _____ City _____

Preop Lab (**CIRCLE ONE**): Fredrickson, Community General, or Other: _____

PHYSICIAN INFORMATION

Referring physician _____ Primary Care Doctor _____

AUTHORIZATION FOR CARE AND GENERAL ACKNOWLEDGMENTS

For the above patient, I authorize Cosmetic and Plastic Surgery of Central Pennsylvania, LLC to:

-provide necessary medical care
-acquire my prescription history from pharmacies and other physicians
-release applicable medical records to referring and/or family physicians and insurance companies
-use photography for pre- and post-operative analysis, peer review, educational and marketing
-contact you via your given email and phone numbers

I acknowledge full financial responsibility for services rendered by Cosmetic and Plastic Surgery of Central Pennsylvania, LLC whether or not paid by insurance. Furthermore, I authorize Cosmetic and Plastic Surgery of Central Pennsylvania, LLC to file my insurance company for payment and for such payments to be directly paid to this practice. I understand that payment of charges accrued is due at the time of service unless other specified financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection cost in the event of default of payment of my charges.

SIGNATURE` [PATIENT/RESPONSIBLE PARTY] _____ **Date** _____
Responsible Party Name (if applicable) _____

Cosmetic and Plastic Surgery of Central Pennsylvania, LLC

Name: [Last]_____[First]_____[MI] ____
Date_____ Account #_____

REFERRAL INFORMATION

Referring Physician or Patient:_____How did you hear about us? _____

Primary Health Care Physician's Name:_____Address: _____

Have you been to our web site [www.CosmeticPlasticsPA.com]? ☐ Yes ☐ No

If yes, was it helpful? _____

If no, please list the reason: _____

PROCEDURE INFORMATION

What is the reason for your visit? *(check all that you would be interested in talking about)*

FACE	BREAST	BODY	SKIN
☐ Face lift	☐ Breast augmentation	☐ Liposuction	☐ Botox
☐ Cheek lift	☐ Breast lift	☐ Tummy tuck	☐ Facial fillers
☐ Brow lift	☐ Breast revision/repair	☐ Mommy makeover	☐ Juvederm
☐ Neck lift	☐ Male breast	☐ Body lift	☐ Sculptra
☐ Liquid face lift	☐ Breast reduction	☐ Buttock augmentation	☐ Restylane
☐ Facial fat transfer	☐ Breast asymmetry	☐ Arm lift	☐ Fat injections
☐ Facial redness	☐ Breast reconstruction	☐ Thigh lift	☐ Chemical peel
☐ Brown spots/age spots/ freckles	☐ Breast implant exchange	☐ Fat transfer	☐ European facials
☐ Facial implants	Other: _____	☐ Cellulite reduction	☐ Spider veins
☐ Lip augmentation		☐ Vaginal rejuvenation	☐ Skin resurfacing
☐ Chin augmentation		☐ Hand rejuvenation	☐ Wrinkles
☐ Ear reshaping		☐ Hand surgery	☐ Acne treatments
☐ Upper eyelids		Other: _____	☐ Unwanted hair
☐ Lower eyelids			☐ Skin care
☐ Rhinoplasty			☐ Microdermabrasion
Other: _____			Other: _____

Cosmetic and Plastic Surgery of Central Pennsylvania, LLC

PATIENT MEDICAL INFORMATION PAGE 1 OF 2

Name: [Last]_____[First]_____[MI] Account#_____

☐ M ☐ F Age___Weight_____Height _____

Personal Medical History

Allergies: (*Penicillin, Latex, Novocain...list all and reactions*)_____

Last/Upcoming Mammogram: (*within 24 months, >40 years old*)_____

(Check all that apply)

□ High Blood Pressure	□ Diabetes	□ HIV or AIDS	□ _____
□ Previous Heart Attack	□ Kidney Disease	□ Hepatitis(A,B,C)	□ _____
□ Heart Disease	□ Liver Disease	□ Stroke	□ _____
□ Heart Failure	□ Psychiatric Disease	□ Emphysema	□ _____
□ Seizures	□ Easy Bleeding	□ Blood Clots	□ _____
□ Chest Pain	□ Gastric Reflux	□ Thyroid Disease	□ _____
□ Asthma	□ Cancer	□ Rheumatic fever	□ _____

Any family or personal problems with anesthesia?_____Yes_____No, Malignant Hyperthermia? ☐ Yes ☐ No

If yes, what happened? _____

Family Medical History

(Check all that apply) Which family members?

□ High Blood Pressure	□ Diabetes	□ HIV or AIDS	□ _____
□ Previous Heart Attack	□ Kidney Disease	□ Hepatitis(A, B, C)	□ _____
□ Heart Disease	□ Liver Disease	□ Stroke	□ _____
□ Heart Failure	□ Psychiatric Disease	□ Emphysema	□ _____
□ Seizures	□ Easy Bleeding	□ Blood Clots	□ _____
□ Chest Pain	□ Gastric Reflux	□ Thyroid Disease	□ _____
□ Asthma	□ Cancer	□ _____	□ _____

Personal Operations/Surgeries/Hospitalizations

_____ _____ _____

_____ _____ _____

Medications/Vitamins/Herbal supplements & Dosage

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy _____ Telephone _____ Address _____

Do you take:

Social History

☐ Yes ☐ No Blood thinners (Coumadin/Warfarin, Heparin, Plavix, Aspirin, Pradaxa/Dabigatran, Vitamin E, Fish oil)

☐ Yes ☐ No Diet Pills?

☐ Yes ☐ No Steroids in the last year? (injections such as Orthopedic joint injections or oral)

☐ Yes ☐ No Do you Smoke? If yes, number of packs per day:_____ Number of years_____Counselled to Quit____

☐ Yes ☐ No Have you used Recreational Drugs?

☐ Yes ☐ No Do you ever drink Alcohol?

If yes, what type:_____How much:_____How Often(daily/weekly/monthly,etc.): _____

Cosmetic and Plastic Surgery of Central Pennsylvania, LLC

PATIENT MEDICAL INFORMATION PAGE 2 OF 2

Name: [Last]_____[First]_____[MI] Account#_____

Review of Systems

Do you have any of the following?

CARDIOVASCULAR

High Blood Pressure	☐ Yes	☐ No
Previous Heart Attack	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Pacemaker/Defibrillator	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No
Irregular Heart Beat	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Leg Swelling	☐ Yes	☐ No
Do you take water pills?	☐ Yes	☐ No

Other: _____

RESPIRATORY

Asthma or Emphysema	☐ Yes	☐ No
Can you climb 2 flights of stairs?	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Recent Chest infection	☐ Yes	☐ No
CPAP Machine	☐ Yes	☐ No

GASTROINTESTINAL

Liver Disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Reflux	☐ Yes	☐ No

SKIN

Cancer	☐ Yes	☐ No
Radiation	☐ Yes	☐ No
new skin changes/lesions	☐ Yes	☐ No

ENDOCRINE

Diabetes	☐ Yes	☐ No
Frequent Urination	☐ Yes	☐ No
Drink a lot of fluids	☐ Yes	☐ No
Feel cold when others feel normal	☐ Yes	☐ No
Feel hot when others feel normal	☐ Yes	☐ No

PSYCHIATRIC

Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Do you see a psychiatrist	☐ Yes	☐ No

NEUROLOGIC

Stroke	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Dizzy	☐ Yes	☐ No

HEMATOLOGIC/ONCOLOGIC

Prolonged bleeding	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Blood clot in legs	☐ Yes	☐ No
Blood clot in lungs	☐ Yes	☐ No
Previous family hx of blood clots	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Sickle cell disease	☐ Yes	☐ No
Radiation treatment	☐ Yes	☐ No
Immunizations current?	☐ Yes	☐ No

EYES

Cataracts	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Contact lenses	☐ Yes	☐ No

Doctor's Signature _____

Date_____

Cosmetic and Plastic Surgery of Central Pennsylvania, LLC

ACKOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Description:
This acknowledgement of notice and consent authorizes Cosmetic and Plastic Surgery of Central Pennsylvania, LLC to use and disclose health information for the treatment, payment, and health care operations.

HIPAA Notice of Privacy Practices:
Cosmetic and Plastic Surgery of Central Pennsylvania, LLC has a HIPAA compliant "Notice of Privacy Practices" which describes how we may use and disclose your protected health information, and how may access it and other rights concerning its protection. You may review our current notice prior to signing the acknowledgment and consent.

Amendments:
We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information acquired prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer at:
Cosmetic and Plastic Surgery of Central Pennsylvania, LLC
Attention: Nicole Foley
425 North 21st Street, Suite 405
Camp Hill, PA 17011-2223

Acknowledgement and Consent:
I have received the Notice of Privacy Practices for Cosmetic and Plastic Surgery of Central Pennsylvania, LLC which is authorized to use and disclose health information about:

_____(Print Patient Name)
For treatment, payment, and healthcare operations purposes consistent with its said Notice of Privacy Practices.

_____ Date_____
Signature of patient or patient's personal representative

Personal Representative Information (if applicable):

_____Name of personal representative

_____Relationship to patient

Cosmetic and Plastic Surgery of Central Pennsylvania, LLC

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives patients the right to request restriction on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the patient's office instead of the patient's home.

I agree to be contacted in the following manner (check all that apply):

Home Telephone#_____ Written Communication____
_____O.K. to leave message with detailed info.
_____Leave message with call-back number only

Cellphone#_____
_____O.K. to leave message with detailed info.
_____Leave message with call-back number only

Work Phone#_____
_____O.K. to leave message with detailed info.
_____Leave message with call-back number only

My health information may be shared with:_____
Name Phone#
Relationship: spouse, parent, sibling, other

I further (do or do not opt) to allow all of my immediate relatives to access my PHI.
(circle one above)

_____ _____
Patient Signature **Date**

_____ _____
Print Name **Birth Date**

Effective Form Date: 05

Cosmetic and Plastic Surgery of Central Pennsylvania, LLC

Theodore T. Foley, MD

FINANCIAL POLICY

Overview

Thank you for choosing Cosmetic and Plastic Surgery of Central Pennsylvania, LLC. This information is provided to you for your understanding of our billing policies.

For Cosmetic Care and Self Pay Patients

Full payment is due before services are rendered. Surgical procedure fees are due two weeks prior to surgery and appointment fees are due upon scheduling. For cosmetic and self-pay patients, we accept cash, check, all major credit cards and up to 60 months CareCredit payment plans (description at reception area). Once care is given, payment is non-refundable. Partial refund may be given for the portion of packaged services which are not yet rendered.

For Participating Insurance Patients

Your insurance policy is a contract between you and your insurance company. We will submit claims for your care you have received, at our practice, to your insurance company if you have given us permission and the required information. Please know that some or all of the services you receive may be non-covered services according to your insurance policy. You will still be responsible for paying for these services.

We accept assigned payments for most major insurance companies whom have negotiated a lower rate for our services and therefore you are receiving our care at a discounted rate. You will still be responsible for payment of deductibles, co-pays, coinsurance, or non-covered services at the time of service.

All Patients

All credit card and CareCredit sales are final and are verified by patient signature. If contested, patient understands this office will provide documentation to the credit company or CareCredit to demonstrate care rendered.

Patient Initials _____

Patient Accounts (for insurance based patients)

A billing statement requesting payment for any remaining balance after insurance has been processed will be mailed to you. **Your payment is necessary within 30 days of that first billing statement**. **No further elective care will be rendered until balance is paid in full.** Full payment must be made before another appointment or surgery is scheduled. We accept cash, checks, all major credit cards, and CareCredit. In the event a personal check is returned unpaid from your bank, your account will be charged a $35 returned check fee. For insurance based claims, up to 6 months no-interest payment plan is available through CareCredit. **After 90 days from the first billing statment date, we place unpaid patient accounts in collections**. Patients are then responsible for any collection costs that are incurred which will include an additional fee of $25. Refusal to pay will adversely affect your credit and your tax liabilities.

Insurance

We file an insurance claim within ten business days of your date of service.

If we do not receive a response from your insurance company within 30 days, we will submit a second claim.

If we do not receive a response from your insurance carrier within 45 days, you will receive a standard statement and will need to contact your insurance carrier regarding payment. After 60 days the balance due for medical services rendered will be your financial responsibility. You may pay us directly and receive reimbursement from your insurance company directly.

Minor Patients (under 18 years of Age)

The parent/guardian/adult accompanying a minor child is responsible for payment. The practice requires pre-approval from a parent/guardian for an unaccompanied minor. Any child 18 or over is legally an adult and responsible for their bill. We therefore cannot release financial or medical information to a parent/guardian of a patient over the age of 18 without the patient's written permission. If both parents have separate insurance, please check your insurance policy to determine which company is primary before the appointment.

Collection Balances

If you had a previous collection balance or are presently in collection, you are required to pay your previous balance in full prior to scheduling an appointment or elective surgery.

Cancellation Policy

Please assist us serving you better by keeping your scheduled appointment. If you are unable to do so, please notify us at least 24 hrs in advance. Repeated missed or not cancelled appointments may result in discharge from the practice.

I understand and agree to this policy.

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name of Responsible Party (if applicable)

Effective Form Date: 05/25/2016
Billing Representative: Nicole Foley