Solomon Clinic of Plastic Surgery, PLLC

Registration Information:

Patient Last Name: _____ Home Phone: _____

First Name: _____Middle: _____ Work Phone: _____

Address: _____ Date of Birth: _____

Street *Apt/Unit No.* Sex_____ Marital Status: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Emergency Contact/Phone: _____ _____ Pharmacy:_____

Primary/Referring Physician/Phone: _____ Email Address: _____

Employer Name : _____ Phone: _____

Address: _____ Fax: _____

_____ Email: _____

City:_____ State: _____ Zip: _____Contact: _____

Provide the following information if guarantor is different than patient

Guarantor Last Name: _____ Phone: _____

First Name: _____Middle: _____ Social Security #: _____

Address: _____ Date of Birth (required): _____

City: _____ State: _____ Zip: _____ Patient's Relationship to Guarantor: _____

Primary Insurance- circle Self WC PPO HMO Medicare Medicaid Don't Know	***Secondary Insurance- circle WC PPO HMO Medicare Medicaid Don't Know***
Company Name: _____	Company Name:_____
Plan/Network Name: _____	Plan/Network Name: _____
Claims Address: _____	Claims Address: _____
City: _____ State: ____ Zip: _____	City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Policy/ID#: _____ Group#: _____	Policy/ID#: _____ Group#: _____
Insured Name: _____	Insured Name: _____
Address: _____	Address: _____
City: _____ State: ____ Zip: _____	City: _____ State: ____ Zip: _____
Phone: _____ **DOB**: _____ Sex: ____	Phone: _____ **DOB**: _____ Sex:____
Insured Employer: _____	Insured Employer: _____
Address: _____	Address: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Patient's Relationship to Insured: _____	Patient's Relationship to Insured: _____

Authorization for Treatment and Insurance Authorization:

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I permit **Solomon Clinic of Plastic Surgery, PLLC** to administer necessary and advisable diagnosis and treatment to me. I am aware that medicine is not an exact science and no guarantees have been made as to the results of the treatment and examinations.

I hereby authorize **Solomon Clinic of Plastic Surgery, PLLC** to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to **Solomon Clinic of Plastic Surgery, PLLC**. Our office files insurance claims as a courtesy and in no way releases the patient from responsibility of his/her bill. By signing below the patient agrees to accept responsibility for his/her bill in the event that insurance denies or partially pays for the claim. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date_____ Signature_____

Solomon Clinic of Plastic Surgery, PLLC

Disclosure For Acceptance Of Credit And Debit Cards

The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. Payment for services rendered is due at the time they are provided. For your convenience, The Solomon Clinic of Plastic Surgery accepts Credit/ Debit cards (VISA, MasterCard, and Discover Card). The choice of using a Credit/Debit card is given to our patients/customers as a convenience in lieu of using alternative forms of payment. The Solomon Clinic of Plastic Surgery does not mandate that any payment issued or due be made by Credit/Debit card. If you, the patient, does not wish to pay with your Credit/Debit card The Solomon Clinic of Plastic Surgery accepts payments in the form of Cash, Personal/Business Checks, Cashier's Check and Money Orders.

Please sign below to acknowledge this policy. Signing this acknowledgement in no way authorizes The Solomon Clinic of Plastic Surgery to process additional charges to your Credit/Debit card at any time.

INSURANCE

We cannot file your insurance unless all of your insurance information is given at the time of your visit. It is imperative that a current copy of your insurance card is provided for accurate billing. If your insurance company has not paid within 90 days, you may receive notification in the mail requesting assistance by you in determining if there is a problem, or if additional information is required in processing the claim. Insurance benefits will be obtained by our verification clerk. All patients will be responsible for their portion due at the time of service. Example: If your insurance pays at 80%, you must pay 20% at the time of service. Co-pays and deductibles are required at the time of service with no exceptions.

*It is extremely important for you to educate yourself about your individual insurance benefits. If you are scheduled for a procedure that could be considered a surgery, like a biopsy, cryotherapy, excision, etc, you could be responsible for these charges. To protect yourself, contact your insurance company prior to any procedure to be certain of your benefits and coverage.

NON-COVERED SERVICES

All cosmetic services are not covered by insurance and these services must be paid in full at the time of the visit.

LABS

If you are aware that your insurance carrier requires you to utilize certain labs for blood work or biopsies, it is your responsibility to inform our office prior to the lab being performed. Our office sends your insurance card information with the specimen to an outside facility. You will receive an explanation of benefits from your insurance carrier. Lab charges are separate charges from our office charges.

I have read the financial policy, and I understand and agree to this financial policy.

_____ _____

Signature of patient or responsible party Date

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILTY

I hereby assign all medical and/or surgical benefits to include Medicare, private insurance and any other health plans to: **Solomon Clinic of Plastic Surgery**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all services not paid for by my insurance company; including co-payments, deductible amounts, or services that are not a covered benefit by my plan. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize **Solomon Clinic of Plastic Surgery** to release any information acquired in the course of my exam or treatment to my insurance company, primary care physician, pediatrician or another physician. I recognize that I am responsible for all charges incurred whether or not paid by my insurance company. I also recognize and agree that I will pay any amount not paid by my insurance company within 30 days. In the event I fail to comply with this financial policy, I understand that my account will be turned over to a collection agency which charges a collection fee, accrual of interest and credit reporting. I UNDERSTAND and agree that, (REGUARDLESS OF MY INSURANCE STATUS), I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or health insurance. If I am a member of an HMO or PPO group and the insurance company has not paid the claim within 90 days of the visit, I understand I am responsible for the balance due. A photo static copy hereof is as valid as the original. I hereby state that all information provided is true and correct to the best of my knowledge.

_____ _____

Signature Date

IF YOUR INSURANCE REQUIRES REFERRALS

We are unable to make sure we have everyone's referral all the time. You are responsible for making sure that we have your referral. You are either to bring the referral with you to your appointment or call ahead to make sure we have it in our office before your appointment. Please do not ask our receptionists to call your primary care physician to obtain the referral for you. I have chosen _____ to be my primary care physician. I understand that if the above is not true, if I am not eligible under the terms of Medical Insurance Agreement, or my referral is not valid for this date of service, I am liable for all charges for the services rendered and if billed, I agree to pay in full for all services rendered within 30 days of receiving the bill. PCP's phone number: _____.

_____ _____

Signature of insured, member or guardian Date

PLEASE STATE THE REASON FOR YOUR VISIT WITH US TODAY:_____

_____

PRE-ADMISSION HISTORY

In order to provide the best quality care for your procedure, you or your family need to answer the following questions.

INFORMATION PROVIDED IN THIS FORM IS USED WHEN HAVING SURGERY,
PLEASE MAKE SURE ALL PERTINENT INFORMATION IS COMPLETED AND CORRECT.

Have you had:	**Yes**	**No**
Recently, a cold or flu		
Heart condition		
High blood pressure		
Low blood pressure or fainting		
Do you have any of the following? (Please circle) Asthma, Bronchitis, Emphysema or other lung disease		
Epilepsy or seizures		
Do you have any of the following? (Please circle) Jaundice, hepatitis, mononucleosis		
Cancer/Please Specify:		
Back or neck problems		
Recent Abnormal chest x-ray		
Recent Abnormal electrocardiogram		
Glaucoma		
Any mental or emotional problems		
Anticoagulant Therapy (blood thinners)		
Any blood disorders		
Kidney disease		
Fracture of facial bones		
Fracture of neck or back		
Muscle weakness, numbness, paralysis		
Blood transfusion		
Stroke		
Any prosthetic device		
Diabetes: 1 OR 2 : If so, controlled by: ☐Diet ☐Oral Meds ☐Insulin		
Other medical illnesses		
A positive HIV/AIDS blood test		
Motion sickness		
History of Sickle Cell Trait or Disease		
Thyroid problem		
M R S A / Staph Infection		
Reactions to Band-aids, balloons, tape, rubber gloves, or elastic products		
Do You:	**Yes**	**No**
Have false or loose teeth		
Have dental caps or bridges		
Wear contact lenses		
Smoke: How many pkg/day?		
Use alcoholic beverages		
Have a history of substance abuse		
Have any problems to discuss with the Anesthesiologist		
Have a pacemaker		
Have own blood donated		
Object to a transfusion		
Have any cultural/Ethnic practices affecting care		
Women Only: To the best of your knowledge, are you pregnant?		
Date of last menstrual cycle:		
Religious Preference:		
Support System (next of kin) Phone#:		

Age:_____ Height:_____ Weight:_____

Any conditions in which you are under the care of a physician
(please describe):

_____

_____

_____

_____

List previous surgeries (Starting with most recent):
Please give approximate date to the best of your knowledge

Month	Year	Description
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Anesthetic History:
Date of last anesthetic:_____ Abnormal reactions? Yes No
Relatives with abnormal reactions to anesthesia? Yes No
Comments:_____

_____

List all medications you are presently taking:

Medication Name	Dosage	Freq	Last Dose
_____			
_____			
_____			
_____			
_____			
_____			
_____			
_____			
_____			

Do you take aspirin? If yes, how often:_____

List Allergies (food or drugs) and reaction:

_____

_____

_____

_____

I certify that the above information is correct.

PRINT PATIENT NAME **PATIENT SIGNATURE/DATE**

Solomon Plastic Surgery

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Solomon Plastic Surgery, must have my consent. Therefore, I authorize Solomon Plastic Surgery to disclose my PHI as described in the above forms, to the recipients listed below:

Description of the information to be disclosed (check all that apply)

☐All Procedures ☐Test Results ☐Appointments ☐Other ☐Surgeries ☐Billing/Account information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. Physician other than your referring doctor, family members and other specified person/persons)

Name: _____Relationship:_____

Contact Information:

I authorize Solomon Plastic Surgery to contact me at the following number with results or questions:

Home_____Cell_____Work_____

May we leave a detailed message on your answering machine or voicemail?

Yes☐ No☐ Failure to check one of these boxes may delay results

By Patient: (Print and sign) _____ Date: _____

Or Patient's Representative (Print name, sign and relation to patient) _____ Date: _____

Informed consent patient before and after imaging

During the course of the consultation, I may have been shown before and after photos of actual patients. I understand that those pictures are solely for the purpose of illustration of possible outcomes. I understand that any type of surgical procedure is related to my individual characteristics and health. Because of the differences in how individual living tissues react to surgery, there may be no relationship between the images observed and my actual final result.

Please initial: _____

Photographic images

I authorize Dr. Solomon and his assistants to photograph relevant areas of my body for documentation of care. I understand that this will be part of my medical records and will be used for diagnosis, treatment or educational purposes.

Please initial: _____

In signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize, that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated authorization shall be as effective as the original.

A copy of our Privacy Practices will be provided at your request

Patient consent for use of Credit cards, Debit cards and Financing Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks and financing companies, when requested to facilitate your payment.

Services that are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Solomon Plastic Surgery to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment.

__ I will not challenge such credit, debit or financing company payments once services are provided. The practice encourages complete post-op care and follow up interaction to address any issues that might arise, which are further addressed in the revision policy.

__ I agree that this non credit card challenge agreement is irrevocable.

Signature of Patient or legal Guardian: _____

Print Patient's name: _____

Date: _____

Newsletter and e-mail promotions

We e-mail our newsletter and promotions for botox, fillers and skin care products from time to time. Please check the box below if you would like to be included in our e-mail list. You can always decide to safely unsubscribe at any time.

☐ I would like to subscribe to your e-mail newsletters/specials.