ADVANCED PLASTIC SURGERY CENTER

Lawrence D. Chang, MD

Name:_____ **Date**:_____

Address:_____**City/State/Zip**:_____

Home Phone:_____**Cell Phone**:_____Preferred: Home/Cell

Email Address:_____**DOB**:_____ Age:_____

SSN:_____ Circle: *Married/Single/Other* Sex*: M/F* Dominant hand**:** *Left/Right*

Race:_____ Ethnicity: _____ Language: _____

Referred By: Doctor:_____Friend:_____Med-Aid/ER:_____

Emergency contact Name:_____ Contact #:_____

Pharmacy:_____ **Pharmacy Phone:**_____

Family Doctor:_____ **Office Phone:**_____

Reason for Consultation:_____

Were your injuries from an: Auto Accident: *Yes No* Work Accident*: Yes No*

Primary Insurance Company Name:_____**Identification#:**_____ **Group#:**_____

Subscribers Name:_____ SS#:_____**Birth Date**:_____

Secondary Insurance Company Name:_____**Identification#:**_____**Group#:**_____

Subscribers Name:_____ SS#:_____**Birth Date:**_____

Please complete if applicable:

Workers' Compensation

Work Co. Insurance:_____**Claim Number:**_____

W/C Insurance Mailing Address:_____**Phone:**_____

Date of Accident:_____

Attorney's Name:_____**Phone:**_____

Please complete if applicable:

Auto Accident

Name of Auto Insurance Company:_____**Phone:**_____

Complete Claim Address:_____**Claim #:**_____

Adjuster's Name:_____

Date of Accident:_____ **Attorney's Name:**_____ **Phone:**_____

Height:_____ Weight:_____ Weight Gain or Loss (timeframe):_____

Smoking History: *Never* *Active* *Prior* Age Started:_____ Ended:_____ Packs Per Day:_____

Have you had your Influenza Vaccine? *YES / NO* **Have you had your Pneumococcal Vaccine?** *YES / NO*

Have you had a colonoscopy*?* *YES / NO*

Occupation/Job Description (to determine recovery time):_____

Date of Last Mammogram:_____ Normal:_____ Abnormal:_____ Bra Size (if breast related visit) _____

Are you pregnant? *Yes/No* Are you trying to get pregnant? *Yes/No*

Do you exercise and maintain a healthy diet?_____

Alcohol Use: *None* *Social* *Everyday* Frequency/type:_____

Drug Use: *None* *Social* *Everyday* Frequency/type:_____

Photograph Consent and Release Form: I, the undersigned, do hereby agree to the following. I am allowing Advanced Plastic Surgery Center to take photos of my treatment and/or treated areas to be used to the purpose of monitoring my progress and clinical chart documentation, & education.

Signature:_____ Date:_____

Witness:_____

List All Drug **ALLERGIES** (Including Latex):

Drug	Reaction	Drug	Reaction

Current **MEDICATIONS** (Include Aspirin & Supplements)**.**

Medication	Dosage	Medication	Dosage

Past **SURGERIES** with Dates**.**

Skin Cancer/Lesion History: Note if you've previously had any of the following and location/date(s) treated

Actinic Keratosis (pre-cancer)	
Basal Cell Cancer	
Squamous Cell Cancer (of skin)	
Dysplastic Nevus (abnormal mole)	
Melanoma	

Medical History **Family History:** Use **M**-Mother **F**-Father **S**-Sibling **C**-Child

Personal History of:	**Yes**	**No**	**Explain**	**Family History of:**	**Yes**	**Who**	**Explain**
Anemia				Adopted			
Asthma				Abnormal Bleeding			
Bleeding Disorder				Abnormal Clotting			
Breast Cancer				Autoimmune Disorder			
Depression/Anxiety				Brain Tumor			
Diabetes				Breast Cancer			
DVT/PE				Colon Cancer			
Heart Disease				Diabetes			
Hepatitis				Endocrine Disease			
High Blood Pressure				Heart Disease			
High Cholesterol				High Blood Pressure			
HIV/AIDS				Hemophilia			
Kidney Disease				Kidney Disease			
Liver Disease				Liver Disease			
Pacemaker/AICD				Lung Cancer			
Poor Circulation				Malignant Melanoma			
Psychiatric Care				Ovarian Cancer			
Respiratory/COPD				Prostate Cancer			
Skin Cancer				Skin Cancer			
Skin Disease				Thyroid Disease			
Stroke				Other Cancer			
Substance Abuse				Von Willebrand			
Thyroid Disease							
Other:							

<u>Review of Systems</u>: Please Circle Each Item "YES" or "NO" as They Relate to Your Health:

Constitutional:				**Genitourinary:**		
Unplanned Weight Loss	Yes	No		Burning/Frequency	Yes	No
Fever	Yes	No		Blood in Urine	Yes	No
Chills	Yes	No		**Hematology/Lymph**		
Eyes:				Easy Bruising	Yes	No
Glasses/Contacts	Yes	No		Enlarged Glands	Yes	No
Double Vision	Yes	No		**Musculoskeletal:**		
Cataracts	Yes	No		Joint Pain/Swelling	Yes	No
Ear, Nose, Throat:				Muscle Pain	Yes	No
Difficulty Hearing	Yes	No		**Skin:**		
Sinus Trouble	Yes	No		Rash/Sores/Itching	Yes	No
Nasal Stuffiness	Yes	No		Lesions	Yes	No
Cardiovascular:				Tears Easily	Yes	No
Chest Pain	Yes	No		**Neurological:**		
Murmur	Yes	No		Numbness	Yes	No
Fainting Spells	Yes	No		Weakness	Yes	No
Difficulty Lying Flat	Yes	No		Headaches	Yes	No
Palpitations/Heart Racing	Yes	No		**Endocrine:**		
Respiratory:				Loss of Hair	Yes	No
Cough	Yes	No		Heat/Cold Intolerance	Yes	No
Wheezing	Yes	No		**Allergic/Immunologic:**		
Shortness of Breath	Yes	No		Hives/Eczema	Yes	No
Gastrointestinal:				**Psychiatric:**		
Heartburn/Reflux	Yes	No		Anxiety/Depression	Yes	No
Abdominal Pain	Yes	No		Difficult Sleeping	Yes	No
Constipation	Yes	No		Mood Swings	Yes	No

Office Financial Policies: Advanced Plastic Surgery Center (PLEASE READ/SIGN)

HMO, PPO, COMMERCIAL INSURANCES AND MEDICARE

Insurance is a contract between the insurance carrier and the patient (or the employer on behalf of the patient). When we participate with an insurance carrier, we abide by the contract and accept insurance payments of their maximum allowable for the service we provide. When we do not participate with an insurance carrier, you may in advance or we will submit the claim to your insurance carrier as a courtesy. If we do not receive payment within **60 days**, we will bill you (responsible person) for payment of balance if not paid in full. If there is a dispute with the insurance carrier over the claim for any reason including coverage of specific services, **you (or responsible person) are responsible for payment**. If the insurance carrier reimburses you directly, we expect you will remit payment to us when you receive payment from your insurance. When you know your insurance carrier does not pay for office visits, you must pay on the day of your visit. **YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT**. If you do not have medical insurance, you will be responsible to make payment before any service will be performed.

Initials _____

COSMETIC VS. MEDICAL PROCEDURES

Traditionally COSMETIC consultations are $50. However, there are a few reconstructive procedures that have cosmetic benefits such as breast reduction, panniculectomy, blepharoplasty, or skin lesion removal that may be covered by your medical insurance carrier. If we are submitting a "cosmetic" procedure to your insurance carrier to determine if they will pay for the procedure, we are required to submit an office consult charge to the insurance as well. In this instance you **MAY BE RESPONSIBLE FOR DEDUCTIBLES OR COPAYS**.

Initials _____

REFERRALS

It is **YOUR** responsibility to provide the appropriate insurance information and referrals on the first and subsequent visits so we may assist you in processing your insurance claim. **IF THE APPROPIATE REFERRALS ARE NOT SUBMITTED, YOU REMAIN RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT.**

Initials _____

CO-PAYS AND DEDUCTIBLES

You are responsible for payment of any co-pay and/or deductible as determined by your insurance carrier contract. **ALL CO-PAYS MUST BE PAID AT TIME OF SERVICE.**

Initials _____

RETURNED CHECKS

Any checks returned for insufficient funds will be subject to a **$30.00 fee**. We will also refer the account to collections if the full balance isn't paid within **60 days**.

Initials _____

PAYMENTS

This office allows 60 days after insurance has been filed for the insurance company to make a payment or to receive a response. After this time, the **PATIENT** is responsible for making payments on the balance and also actively pursuing the insurance company to find out the delay in payment.

Payment for all office visits must be made at time of service. If you are involved in a legal matter, payments must still be received on a monthly basis to keep your account in good standing.

Work injuries will be filed to the workers' compensation carrier that has been provided to you. However, any balance not paid by your workers' compensation carrier will be billed to you directly and will be your responsibility.

Initials _____

COLLECTIONS

Advanced Plastic Surgery Center uses Transworld Systems to collect our past due accounts. There are 3 phases to our collections. If you are referred to Phase 1, you will receive a series of letters in an attempt to collect the debt. You will be charged an **additional $12.50** when referred to Phase 1. Any patients referred to Phase 2 will receive phone calls in an attempt to collect the debt. You will be charged an **additional 50%** of your total balance when referred to Phase 2. When there is no success in collecting the debt in Phase 1 and Phase 2, you will be referred to the **Legal Department**.

Initials _____

HIPAA CONSENT

With my consent, Dr. Chang, and their office staff may use and disclose protected health information (PHI) about me to carry our treatment, payment and healthcare operation (TPO). I also authorize them to call my home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. This includes appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, insurance questions, etc. With this consent, Dr. Chang may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements. By signing this form, I am writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Chang and may decline to provide treatment to me. I hereby authorize Dr. Chang to treat me or my child by the medical means they deem necessary or advisable. I further authorize payment of my medical benefits to Dr. Chang. I understand the above guidelines, have had the opportunity to ask questions, and will be given a copy of the privacy notice if I request it. Additionally please include the Name of Person(s) we can disclose information to:

_____ and/or _____ **Initials** _____

NO SHOW APPOINTMENTS

We schedule our appointments so that each patient receives the appropriate amount of time to be seen by our physicians and staff. To be respectful to our provider and other patients it is very important that you keep your scheduled appointment with us, and arrive on time. As a courtesy, and to help patients remember their scheduled appointments, Advanced Plastic Surgery Center sends text message reminders in advance of the appointment time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice**. If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $50.00 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.** After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you. I understand the "no-show" policy of Advanced Plastic Surgery Center. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show bill.

Initials _____

I HAVE READ THE POLICY AND AGREE TO ABIDE BY THE TERMS AS STATED ABOVE.

In addition, a copy of the notice of privacy practices was made available to view. A copy is also posted on our webpage at www.advancedplasticde.com . A printed copy will be made available upon request.

_____ _____ _____

Print Name of Patient or Representative Signature of Patient or Representative Date

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, or others to call and request medical and or billing information. Under the requirements of HIPAA we are not authorized to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent will authorize Advanced Plastic Surgery and Nouveau Cosmetic Center to release medical and or billing information to these family members.

You have the right to revoke this consent in writing.

I, _____ authorize Advanced Plastic Surgery and Nouveau Cosmetic Center to release my medical and/or billing information to the following individual (s):

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

3. _____ Relationship to Patient: _____

Patient Name (print):_____

Patient Signature: _____Date: _____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS OR ON ANSWERING MACHINES

Occasionally it is necessary for the staff of Advanced Plastic Surgery and Nouveau Cosmetic Center to leave messages for patients. The purpose of these messages may be regarding appointments, to notify the patient of test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of Advanced Plastic Surgery or Nouveau Cosmetic Center discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name (print): _____

Patient Signature: _____ Date: _____