

PLASTIC SURGERY AND DERMATOLOGY ASSOCIATES, LLC

Phone: 703.645.0077 Fax: 703.645.0130

Please print legibly and fill in or correct all fields.

Patient Name _____			
_____	_____	_____	_____
_____	_____	_____	_____
Parent/Legal Guardian Name _____			
_____	_____	_____	_____
_____	_____	_____	_____
Address _____			
_____	_____	_____	_____
_____	_____	_____	_____
Home Phone _____ Work Phone _____ Cell Phone _____			
Age _____	Birthdate ____/____/____	SS# ____-____-____	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married to: _____	Email: _____		
Spouse's Employer: _____		Primary Doctor: _____	
Referred to office by: _____ Patients Pharmacy name, address, and #: _____			
Emergency Contact _____			
_____		Relationship to Patient _____	
Home Phone _____ Work Phone _____ Cell Phone _____			
Address _____			
_____	_____	_____	_____
_____	_____	_____	_____
Patient's Employer _____			
(Or legal guardian if a minor) _____		Occupation _____	
Address _____			
_____	_____	_____	_____
_____	_____	_____	_____
Insured's Name _____			
_____		Relationship to Patient _____	
Birthdate ____/____/____	SS# ____-____-____	Employer _____	
Are you a member of the armed forces? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, are you currently on active duty? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have a healthcare Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No			

I understand that office visit charges are payable on the day service is rendered. I authorize Plastic Surgery and Dermatology Associates to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Plastic Surgery and Dermatology Associates, LLC and myself.

Signature _____ **Date** _____

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FINANCIAL POLICY

Thank you for choosing us as your health provider. We are committed to your successful treatment. The following is a statement of our financial policy, which we require that you read and sign prior to treatment. Anytime you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding.

REGARDING INSURANCE:

Ultimately, the person receiving the care is the one responsible for the account. Nevertheless, as a courtesy to you, we will bill your insurance carrier for you. If your insurance carrier fails to pay your claim within 45 days from the date of service, a second notice will be sent to your carrier, however, the balance will become patient responsibility and it is your responsibility to contact your carrier regarding unpaid claims. Effective October 1, 2008, any unpaid balances 60 days and over will be assessed a service charge equaling 1% of the outstanding balance each month that the account remains in outstanding. Accounts in arrears **will be submitted for collection and may result in court action if prior arrangements to pay have not been made or if you fail to make your agreed upon installment payments.** Please be aware some and perhaps all of the services provided may be "noncovered" services and are not considered reasonable and necessary under some medical insurance policies. If you are unable to pay in full, it is your responsibility to contact our billing department to setup a mutually agreeable payment plan. Kindly note that your insurance policy is a contract between you and your insurance company. We are not a party to that contract, and cannot be responsible for their failure to timely pay for services rendered.

We also charge a returned check fee. The current charge is \$40 per check. If you are notified by our office that your check was returned and not honored for payment, we will afford you a limited opportunity to replace the returned check with cash or a bank cashier's check in the amount outstanding plus the service fee. To avoid your account being referred to collections or reported to the authorities, you must present to us, at our offices, the replacement cash or bank cashier's check no later than close of business on the next business day immediately following the day you are notified by us of the returned check. Please note that persons who knowingly write bad checks may be prosecuted for fraud in the Commonwealth of Virginia. Patients acknowledge that they are responsible for any and all collections costs and/ or attorney fees, service fees, and court costs associated with the collection of outstanding balances on their account.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment possible for patients and we charge what we believe is appropriate, usual and customary for the area. You are responsible for payment in full regardless of any insurance company's determination of the usual and customary rates for similar procedures and treatment.

INJURIES AND ACCIDENTS INVOLVING LEGAL LITIGATION

We will not accept third party billing if your injury or accident involves litigation. **The services are provided to you, the patient, not your attorney.** Ultimately, the person receiving the care is the one responsible for the account. You are required to make payments on the charges even if they will be covered by a third party. You will promptly be reimbursed any fees that you have paid, if and when we be reimbursed by a third party at some point in the future for the same.

COMPLETION OF MEDICAL FORMS

A \$3 fee per page plus actual postage will be charged for completion of all forms by our office. These forms include all disability, life, credit, loan claims, cancer, etc.

REQUEST FOR MEDICAL RECORDS

Requests for medical records will be honored in a timely manner as required by applicable law. Additionally, a charge for copying medical records may be assessed per and only to the extent allowed by applicable laws. Should your attorney request medical records on your behalf, one invoice will be sent to the attorney for payment, however the bill is the responsibility of the patient regardless of who requested the records on the patient's behalf. Records will not be released without appropriate documentation of authorization of release.

WORKER'S COMPENSATION

Our office will submit worker's compensation claims to your employer for payment. However, if the claim is denied, unsettled, or unpaid within sixty days from the initial visit, we will request that you file a personal health insurance claim or pay the charges in full. If the situation becomes a legal matter, you are still ultimately responsible for the payment of the charges.

MEDICARE

We do accept Medicare assignment and will bill Medicare and your secondary insurance for you.

CO-PAYS/DEDUCTIBLES

Payment is expected at the time of office visit for co-payments and/or deductibles that are required by your insurance policy.

APPOINTMENT CANCELLATION/NO SHOW FEE POLICY

In an effort to assure scheduling efficiency, patients who fail to call within 48 hours of the appointment will be billed a cancellation fee. There is a \$40 no show/cancellation fee for office visits. There is an \$80 no show/cancellation fee for procedures or appointments scheduled for 30 minutes or longer. There will NOT be a cancellation fee if the office is notified 48hrs prior to the appointment or in case of emergencies. Although we will do our best to do courtesy reminder calls, it is the patients responsibility to remember the day and time of their appointment.

By signing this form below,

- . I acknowledge that I have read and understand the foregoing Financial Policy;
- . I agree to this policy as a condition of receiving services or treatment;
- . I hereby authorize my insurance benefits to be paid directly to Plastic Surgery & Dermatology Associates, LLC;
- . I realize I am responsible to pay any and all charges that exceed or that are not covered or paid by insurance;
- . I further authorize the release of pertinent medical information to insurance and worker's compensation carriers for all purposes necessary and appropriate for the submission and payment of claims for and on behalf of my account with Plastic Surgery & Dermatology Associates, LLC, and
- . I further authorize Plastic Surgery & Dermatology Associates, LLC to bill my secondary insurance carrier or Medigap insurance carrier for any account balance remaining after my primary insurance payment or Medicare part B payment has been received.

Patient or Responsible Party Signature

Date

Thank you for understanding our financial policy. If you should have questions or problems, please let us know and we will be happy to assist you in every way possible.

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PATIENT IMAGING POLICY

On occasion, Plastic Surgery & Dermatology Associates, LLC will desire to photograph a procedure, operation, or treatment conducted on you or the results of the same. We will only do so after you have been advised that a specific operation, procedure, treatment or result will be photographed and you have not indicated to the attending physician an objection to the same. In no event will your identity be revealed in or with the pictures.

By signing this form below,

- . I acknowledge that I have read and understand the Patient Imaging Policy, and
- . I consent to the photographing of the operation (s) , procedure (s) or treatments to be performed, including appropriate portions of my body for medical, scientific, or educational purposes providing my identity is not revealed by the pictures.

Patient or Responsible Party Signature

Date

Thank you for understanding our Patient Imaging Policy. If you should have questions or problems, please let us know and we will be happy to assist you in every way possible.

You may opt out of this Patient Imaging Policy at any time, in writing delivered to Plastic Surgery & Dermatology Associates, LLC even after signing this form.

Plastic Surgery & Dermatology Associates, LLC
Written Acknowledgement of Receipt

I, _____, acknowledge and understand the written Notice of Privacy Practices from **Plastic Surgery & Dermatology Associates, LLC**.

Patient or Personal Representative Signature

Date

If Personal Representative, describe relationship

The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

Acknowledgment was unable to be obtained. Reason: _____

Employee Signature

Date

Disclosure of Private Patient Information

The following person(s) may receive private patient information without my written or verbal consent:

1) _____
Name Relationship Date of Birth

2) _____
Name Relationship Date of Birth

I hereby consent for Plastic Surgery and Dermatology Associates, LLC, to leave a message at my:

Please check all that apply:

- Home phone () _____
- Cell phone () _____
- Work phone () _____
- Other () _____

Please check one:

- This authorization expires on _____(date)
- This authorization does NOT expire _____(patient initials)

Please be advised that if any of the above information is not complete in nature, private patient information will be released ONLY to the patient.

Patient or Personal Representative Signature

Date

PLASTIC SURGERY AND DERMATOLOGY ASSOCIATES, LLC.

Patient Name: _____ Date of Birth: _____

Date of Appointment: _____ How did you hear about our office? _____

Referring Physician: _____ Reason for visit: _____

Pharmacy Name and Phone #: _____

Pharmacy Street address and city: _____

CURRENT MEDICAL HISTORY

List any allergies to medication or substance (food, environment, latex, etc.)

List any current vitamins and medications and their dosages including over the counter medications (Advil, Tylenol, allergy medications, etc.)

Please list any past surgeries. Please include when the surgery was done and any difficulties.

Women Only: Are you pregnant? () Yes () No () Unsure
Are you breastfeeding? () Yes () No

SOCIAL HISTORY

Do you.....

Smoke cigarettes or use tobacco?

() Yes Daily Consumption _____ () No () Quit. When? _____ Daily consumption _____

Drink alcohol? Yes No

Consumption : _____/day or () socially (1-2 drinks)

Recreational Drug Use? Yes No

If yes, please list: _____

STD History: _____

Any High Risk Factors? _____

Do you exercise? Yes No If yes, how often? _____/wk

SKINHISTORY

Patient Medical History

If Family Members, Who?

Skin Cancer

Yes No

Skin Disease

Yes No

Other Not Listed _____

HEPATIC HISTORY

Hepatitis A

Yes No

Hepatitis B

Yes No

Hepatitis C

Yes No

Cirrhosis

Yes No

Jaundice

Yes No

Other Not Listed _____

RENAL HISTORY

Kidney Stones

Yes No

Renal Insufficiency

Yes No

Renal Failure

Yes No

Other Not Listed _____

GASTROINTESTINAL HISTORY

Bleeding Ulcers

Yes No

Non-bleeding Ulcers

Yes No

Constipation

Yes No

Diverticulitis

Yes No

GERD

Yes No

Hemorrhoids

Yes No

Irritable Bowel

Yes No

Other Not Listed _____

GENITOURINARY

Recurrent Urinary Tract Infections

Yes No

Incontinence

Yes No

Urethral/Pelvic Organ Structure

Yes No

Gall stones

Yes No

Other Not Listed _____

ENDOCRINE HISTORY

Diabetes Insulin Dependant

Yes No

Diabetes Oral Medication

Yes No

Diabetes Diet controlled

Yes No

Hyperthyroid

Yes No

Hypothyroid

Yes No

Other Not Listed _____

CARDIOVASCULAR HISTORY

Heart Disease	Yes	No	
High Blood Pressure	Yes	No	_____
High Cholesterol	Yes	No	_____
Pacemaker	Yes	No	_____
Murmur	Yes	No	_____
Other Not Listed _____			_____

INFECTIOUS DISEASE HISTORY

HIV	Yes	No	_____
Hepatitis B	Yes	No	_____
Hepatitis C	Yes	No	_____
Oral Herpes	Yes	No	_____
Genital Herpes	Yes	No	_____
Genital Warts	Yes	No	_____
Other Not Listed _____			_____

CANCER

Skin (BCC/SCC)	Yes	No	_____
Skin (Melanoma)	Yes	No	_____
Breast	Yes	No	_____
Ovarian	Yes	No	_____
Liver	Yes	No	_____
Colon	Yes	No	_____
Lung	Yes	No	_____
Stomach	Yes	No	_____
Other Not Listed _____			_____

OTHER MEDICAL HISTORY

Difficulty Walking	Yes	No	_____
Arthritis	Yes	No	_____
Mental Health _____	Yes	No	_____
Other Not Listed			

ASTHMA

Mild	Yes	No	_____
Moderate	Yes	No	_____
Severe	Yes	No	_____
Hospitalized within last 5 yrs	Yes	No	
History of Intubation within last 5 yrs	Yes	No	_____

Skin Transformation Questionnaire

Please let us know if you would like additional information on the following Cosmetic services and procedures that we offer:

-
- Skincare products for facial redness
 - Skin care products for acne control
 - Skin care programs for sun damage and wrinkles
 - Skin care programs for blotchy skin (freckles, sun damage, and uneven pigmentation)
 - Botox treatments for facial frown lines
 - Filler/collagen volume replacement therapy for lines/wrinkles
 - Chemical Peels for facial skin exfoliation and improvement
 - Liposuction for removal of unwanted fat deposits
 - Breast Reduction or Breast Augmentation
 - Abdominal Liposuction or Abdominalplasty (Tummy Tuck)
 - Eye lid, Facelift, or Ear Surgery
 - Sclerotherapy for Varicose Vein Treatment
 - Laser Treatment for:
 - Hair removal
 - Vein Treatment
 - Rosacea or facial redness
 - Acne Scars
 - Skin rejuvenation or tightening
 - Pigmentation

Other _____

Please let us know the best way to contact you:

Name _____

Phone (_____) _____ Best time to call: Day or Evening

Mailing Address _____

Email Address _____

Thank you for your time! A staff member will contact you soon to offer further assistance.