PARK & REBOWE CLINIC
FOR PLASTIC SURGERY

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PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname**

Date of Birth | **Gender**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Cell Phone** | **Email Address**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

Referral Source
____Established Patient – Name:
___TV - Station: **____Internet – Site:** **___Radio – Station:**
___Magazine – Name: **____Physician – Name:** **___Newspaper:**

EMERGENCY CONTACT INFORMATION

Name | **Relationship to Patient** | **Phone Number**

Please list all whom we can discuss medical care with

Marital Status | **Name of Spouse**

HOW MAY WE CONTACT YOU

May we contact you by email (i.e. appointment reminder)?	**Y**	**N**
May we contact you by text (i.e. appointment reminder)?	**Y**	**N**
May we add you to our email list for specials and promotions?	**Y**	**N**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ___**Self (if self, skip this section)** ___**Spouse** ___**Parent** ___**Other**

Last Name **First Name** **Middle Initial**

Date of Birth

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Cell Phone** **Email Address**

Employer **Occupation**

Primary Insurance **Policy Number** **Group Number**

Secondary Insurance **Policy Number** **Group Number**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION & ASSIGNMENT OF BENEFITS

I authorize **The Park and Rebowe Clinic for Cosmetic and Reconstructive Plastic Surgery** to furnish my insurance company(s) and/*or* other physician all information, which I may be requested concerning my health. I also assign the claim payments to be made payable to **The Park and Rebowe Clinic for Cosmetic and Reconstructive Plastic Surgery** and/or **Christopher Park, MD or Ryan Rebowe, MD.** Insurance co-payments are due at the time of service. Giving fraudulent insurance information could be considered theft of services. I understand that this account is my responsibility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at the legal rate. I agree, in order for the practice to service my account or to collect monies I may owe, **The Park and Rebowe Clinic for Cosmetic and Reconstructive Plastic Surgery** and or agents may contact me by telephone at any telephone number associated to my account, including wireless telephone numbers, which could result in charges to me. You may also contact be my test messages and by email using the email address I provided.
I understand methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, if applicable.
I/we have read this disclosure and agree that the practice's employees and/or agents, may contact me/us as described above.

Signature of Patient/Responsible Party Date

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MEDICAL HISTORY

Specific Reason for Visit

_____

_____

Your Own Personal Medical History/ Review of Systems

			IF YES
Abnormal/ Easy Bleeding	**Y**	**N**	**severity** _____
Clots/Emboli/DVT/PE	**Y**	**N**	**# /when** _____
Acid Reflux/Heartburn/Ulcer	**Y**	**N**	**medicated Y N**
Cancer _____	**Y**	**N**	**remission Y N**
High Blood Pressure	**Y**	**N**	**controlled Y N**
Diabetes	**Y**	**N**	**controlled Y N insulin Y N**
Arrythmias (A-fib)	**Y**	**N**	**controlled Y N**
Pacemaker / Defibrillator	**Y**	**N**	**when required last** _____
Heart Valve issues	**Y**	**N**	
Regurgitation/Leaking	**Y**	**N**	**treated Y N severity** _____
Mitral Valve Prolapse	**Y**	**N**	**premedicated for procedures Y N**
History of Anemia / Transfusions	**Y**	**N**	**#** _____ **how recent** _____
Heart Attack/Disease	**Y**	**N**	**controlled Y N #** _____
Heart Surgery/Stents	**Y**	**N**	**success Y N last** _____
Seizures, Epilepsy	**Y**	**N**	**controlled Y N last** _____
Breathing Trouble, Asthma, COPD	**Y**	**N**	**controlled Y N last** _____
Sleep Apnea	**Y**	**N**	**controlled Y N CPAP Y N**
Hepatitis/Liver Trouble _____	**Y**	**N**	**controlled Y N last** _____
TB exposure, diagnosis, cough, night sweats	**Y**	**N**	**Treated Y N current Y N**
Stroke /TIA	**Y**	**N**	**Recovered Y N last** _____
Glaucoma	**Y**	**N**	**Treated Y N current Y N**
Dry Eyes	**Y**	**N**	**Treated Y N current Y N**
HIV/AIDS	**Y**	**N**	**Treated Y N cd4** _____
Kidney Problems	**Y**	**N**	**Abnl Labs? Y N Dialysis Y N**
Current / Frequent Infections	**Y**	**N**	**Treated Y N current Y N**
Trouble Healing / Immunosuppressed	**Y**	**N**	**current Y N** _____
Psychiatric Conditions	**Y**	**N**	**Treated Y N current Y N**
Thyroid Disease	**Y**	**N**	**Treated Y N**
Any Other Illness Not Listed?	**Y**	**N**	_____

_____

Height: _____ **Weight:** _____

Medications – Please list **ALL** medications including Regular Vitamins and Herbal Supplements. Please mark through any medications you are no longer taking.

Medication Name / Dosage / Frequency	**Medication Name / Dosage / Frequency**

Regular Aspirin/NSAID use? **Y** **N**

Other blood thinners? **Y** **N**

Immunosuppressants? (steroids/injections) **Y** **N**
If YES, Why? _____

Are you allergic to Latex? **Y** **N**

Are you allergic to any medication(s)? **Y** **N**
If YES, What Medication(s) and What Reaction(s) do you have?

_____

_____

Gynecology History (If Applicable)

Number of Pregnancies	**Number of Births**	**Number of Miscarriages**	**LMP**

Date of Last Mammogram	**Result**	**Location**

Did you Breastfeed? **Y** **N** **in the last 6 months** **Y** **N**

Any plans for additional pregnancies? **Y** **N**

Previous Surgeries, Any Plastic Surgeries **When**

_____ _____

_____ _____

_____ _____

NICOTINE IS EXTREMELY IMPORTANT AND RISKY IN PLASTIC SURGERY

Smoking **Yes** **No**
Other Tobacco/nicotine **Yes** **No**
Vaping **Yes** **No**
Any Second hand nicotine **Yes** **No**
Amount: _____ **How Long:** _____
if quit, when? _____ **How much at max** _____
Alcohol **Y** **N** **Amount:** _____ **How Long:** _____

MANY ARE VERY RISKY IN PLASTIC SURGERY, PLEASE DISCLOSE

Illicit Drugs **Y** **N** **Amount:** _____ **How Long:** _____

Exercise **Y** **N** **Amount:** _____ **How Long:** _____

FAMILY HISTORY of Medical Issues			**Relationship**
Problems with anesthesia other than nausea	Y	N	
Abnormal/ Easy Bleeding	Y	N	
Clots/Emboli/DVT/PE	Y	N	
Acid Reflux/Heartburn/Ulcer	Y	N	
Cancer _____	Y	N	
High Blood Pressure	Y	N	
Diabetes	Y	N	
Heart Valve dz/ Heart Attack / Stents/ CABG	Y	N	
History of Anemia / Transfusions	Y	N	
Seizures, Epilepsy	Y	N	
Breathing Trouble, Asthma, COPD	Y	N	
Stroke /TIA	Y	N	
Kidney Problems	Y	N	
Current / Frequent Infections	Y	N	
Trouble Healing / Immunosuppressed	Y	N	
Psychiatric Conditions	Y	N	
Other	Y	N	
Any Other Illness Not Listed?	Y	N	

FINANCIAL POLICY

This financial policy contains important information about billing and payment for our professional services. It is intended to help us provide the best possible medical care while also controlling administrative costs. It outlines our responsibilities, and those of our patients, regarding billing and payment for our services. There will be a **$50** charge for each returned check.

INSURANCE CASES

Our practice participates with many health insurance companies and managed care programs. Our billing office will submit a claim for any services rendered to a patient who is a member of one of these plans. Patients must provide all necessary insurance information and complete any forms before leaving the office.
If a patient is a member of an insurance plan with which we do not participate, our office will also file the claim on the patient's behalf; however, the patient will be responsible for any remaining balance not covered by the carrier.
It is the patient's responsibility to make payment at the time of service for any co-payment or co-insurance due. Any services not covered by a patient's insurance plan are the patient's responsibility and payment in full is expected at the time of service**.**
Payment for professional services can be made by cash, check, credit card or debit card.
It is the patient's responsibility to ensure that any required referral for treatment is provided prior to the visit. If a referral is not obtained the visit may be rescheduled or the patient will be personally responsible for payment of services rendered.
It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit. If the patient does not have insurance coverage or their coverage will not cover the services being performed, payment in full is expected at the time of service.
Our staff is happy to help with insurance questions relating to a claim that has been filed, or to provide additional information required by the insurance carrier to process the claim. However, patients should direct questions about coverage for specific procedures to a representative of their insurance company's member services department. The phone number for member services is usually on the insurance card.
Each time a payment is made by your insurance carrier you will receive an EOB (Explanation of Benefits) from your insurance carrier. The EOB explains how the insurance carrier paid the claim, as well as the patient responsibility portion.
You, the patient, have a contract with your insurance carrier. It is important to note that the physician also has a contract with the carrier. It is part of your contract to pay all co-pays, co-insurance, and deductibles. It is part of the physician's contract that we will diligently collect co-pays, co-insurance, and deductibles**.** Repeated failure to pay the patient portion of a visit will be reported to your insurance carrier.

SELFPAY

$500 scheduling fee required to schedule surgery and hold surgery time (deposit). *Deposit fees are not refundable*. Full payment is preferred as soon as possible but due at your preop appointment which is approximately 3-4 weeks prior to your procedure. Cancellations prior to two weeks will be refunded less $500 (deposit fee). If rescheduling, a $500 rescheduling fee may be applied. Cancellations less than two weeks will be refunded less the greater of $500 or 20% of total fees. Cancellations within 48 hours of procedure are not eligible for any refund but may reschedule with a rescheduling fee. This includes any cancellations for medical reasons related to the patient including failure to obtain clearance, labs, tests or to take medications as prescribed or failure to abstain from requirement such as nicotine, drugs, etc.

Fees for anesthesia, OR, and overnight observation are set by the facilities and are estimates only, may change with timing, location, and other variables. The fees can be fully determined once procedure is scheduled. We are trying to provide you with a reasonable estimate but cannot be held responsible for other's fees. Combining procedures can widely alter these estimates due to discounts provided by the facilities. **They must be paid in advance to the facility/anesthesia, or the prepayment discount is not honored, and the cost will increase significantly.**

An adult accompanying a child under 18 and/or the parent or guardian of the child is responsible for payment according to the terms described above. Non-emergency treatment for unaccompanied children may be rescheduled unless charges and/or co-pays are made at the time of service.

It is our Financial Policy that patients whose accounts remain delinquent after multiple attempts will be turned over to a third party for collections. Patients signing our Financial Policy are waiving their privacy protection under HIPAA only for matters of dispute of payment.

I have read the above agreement and have received a copy of it. I fully understand and agree to the contents in full of the above policy.

_____ _____
Patient or Legal Guardian Signature Date

_____ _____
Witness Signature Date