PARK & REBOWE CLINIC

FOR PLASTIC SURGERY

Christopher A. Park, MD
Ryan E. Rebowe, MD
3700 Dauphin Street
Mobile, AL 36608
Phone: (251) 340-6600
Fax: (251) 479-7164
info@mprsd.com
www.mprsd.com

Today's Date:_____

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

Date of Birth **Social Security Number** **Gender**

PATIENT INFORMATION

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

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

Employer **Occupation**

Pharmacy Name/Location **Pharmacy Phone Number**

PATIENT REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

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

___Magazine **____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**

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 **Social Security Number**

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**

I authorize **The Park 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 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 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

The PR for Plastic Surgery Release of
Medical Records – Authorization Form
For Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth:_____Social Security Number: _____

By signing this Authorization Form, I understand I am giving my authorization to: _____

_____Phone:_____Fax: _____

Address:_____,

to release my protected health information including Medical, Psychiatric, Alcohol, HIV, Drug Abuse, and/or Financial Information contained in my records to:

The Park & Rebowe Clinic for Plastic Surgery

3700 Dauphin Street, Suite A, Mobile, AL 36608 | Phone: 251-340-6600 | Fax: 251-479-7164

Purpose of release: At the request of the individual_____Other reason _____

I understand that I can revoke this authorization at any time except to the extent that any action has been taken in reliance on this authorization. I can revoke this authorization by submitting a written request to the Mobile Plastic & Reconstructive Surgery and Dermatology, Release of Information Department.

I understand that the stated recipient may not be subject to privacy laws and that my protected health information may be further disclosed without privacy regulation protection.

I understand that I am not required to sign this form in order to receive treatment from Mobile Plastic & Reconstructive Surgery and Dermatology.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Authorized Representative) (Date)

_____ _____
(Signature of Witness) (Date)

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Patient Name:_____ **Date:** _____

COSMETIC INTEREST QUESTIONNAIRE

Filling this out is patient optional**.**

Areas of concerns and interests that you would like discussed or additional information:
Please circle the number(s) of topics you are interested in.

1. Skin care products for texture and pore size, tone, spots
2. Facials, Hydrafacial, Phytofacial
3. Injectables for folds and wrinkles
4. Skin resurfacing – Peels/Lasers/Dermbrasion
5. Eyelash length/texture – Latisse
6. Spider Vein treatment
7. Hair Removal
8. Skin lesions, birthmarks
9. Sagging/Loose skin
10. Eye rejuvenation
11. Cellulite – Cellulze
12. Facial Rejuvenation
13. Neck Rejuvenation
14. Brow Lift
15. Lip Augmentation
16. Nose job/Rhinoplasty
17. Breast Augmentation
18. Breast Lift
19. Breast Reduction
20. Tummy Tuck
21. Liposuction/Smart Lipo/Laser Lipo
22. Buttock Augmentation/Lift
23. Thigh Lift
24. Arm Lift
25. Hand Rejuvenation
26. Vaginal Rejuvenation
27. Tattoo Removal
28. Scar Care products
29. Medical Grade Sunblock
30. Spray Tan – safe, nontoxic, no sun damage
31. Other –

When I look at myself in the mirror, I believe I look:

Younger Than		**True Age**	**Older Than My True Age**	
0	**1**	**2**	**3**	**4**

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Specific Reason for Visit

_____

Your Own Personal Medical History (Please circle yes or no for each)

Abnormal Bleeding	**Y**	**N**	**Clotting Disorder**	**Y**	**N**
Acid Reflux/Heartburn	**Y**	**N**	**Cancer**	**Y**	**N**
High Blood Pressure	**Y**	**N**	**Diabetes**	**Y**	**N**
Mitral Valve Prolapse	**Y**	**N**	**Transfusions**	**Y**	**N**
Heart Attack/Disease	**Y**	**N**	**Seizures**	**Y**	**N**
Heart Surgery/Stents	**Y**	**N**	**Sleep Apnea**	**Y**	**N**
Hepatitis/Liver Trouble	**Y**	**N**	**TB**	**Y**	**N**
Stroke	**Y**	**N**	**Epilepsy**	**Y**	**N**
Bleeding Disorder	**Y**	**N**	**Glaucoma**	**Y**	**N**
Anemia	**Y**	**N**	**Ulcer/Hiatal Hernia**	**Y**	**N**
Asthma	**Y**	**N**	**Blood Clots**	**Y**	**N**
HIV/AIDS	**Y**	**N**	**Kidney Problems**	**Y**	**N**
Sickle Cell Disease/Trait	**Y**	**N**	**Current Infections**	**Y**	**N**
Psychiatric Conditions	**Y**	**N**	**Trouble Healing**	**Y**	**N**

Any Other Illness Not Listed?

_____

Please Explain All That You Answered "YES" To

_____

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

Previous Surgeries	Date

Tobacco/nicotine **Y** **N** **Amount:**_____ **How Long:** _____
if quit, when?_____ **How much at max** _____
Alcohol **Y** **N** **Amount:** _____ **How Long:** _____
Drugs **Y** **N** **Amount:** _____ **How Long:** _____
Exercise **Y** **N** **Amount:** _____

Family Medical History

Kidney Disease	**Y**	**N**	**Heart Attack/Disease**	**Y**	**N**
Diabetes	**Y**	**N**	**Tuberculosis**	**Y**	**N**
Cancer	**Y**	**N**	**Abnormal Bleeding**	**Y**	**N**
High Blood Pressure	**Y**	**N**	**Deep Vein Thrombosis**	**Y**	**N**
Anesthesia Issue	**Y**	**N**	**Other Not Listed**	**Y**	**N**

Please Explain All That You Answered "YES" To

Review of Systems **Please Explain All That You Answered "YES" To**

General:	**Weight Gain or Loss**	**Y**	**N**	**Recent Illness**	**Y**	**N**	**Fever/Chills**	**Y**	**N**
Neuro:	**Weakness/clumsiness**	**Y**	**N**	**Tingling/Numb**	**Y**	**N**	**Seizures**	**Y**	**N**
Cardiac:	**Chest Pain**	**Y**	**N**	**Irregular Beat**	**Y**	**N**	**Short of Breath**	**Y**	**N**
Lungs:	**Wheezing**	**Y**	**N**	**Cough**	**Y**	**N**	**Bloody Sputum**	**Y**	**N**
GI:	**Heartburn**	**Y**	**N**	**Nausea/Vomit**	**Y**	**N**	**Diarrhea**	**Y**	**N**
Kidney:	**Dehydration**	**Y**	**N**	**Painful Urine**	**Y**	**N**	**Bloody Urine**	**Y**	**N**
Endocrine:	**Diabetes**	**Y**	**N**	**Hair Loss/Gain**	**Y**	**N**	**Feel Hot/Cold**	**Y**	**N**
Extremities:	**Pain**	**Y**	**N**	**Stiff**	**Y**	**N**	**Disuse**	**Y**	**N**
Skin:	**Rash**	**Y**	**N**	**Lesions**	**Y**	**N**	**Dry/Wet**	**Y**	**N**
Other:	_____	**Y**	**N**	_____	**Y**	**N**	_____	**Y**	**N**

Height: _____ **Weight:** _____

The PR Clinic for Plastic Surgery Christopher A. Park, MD | Ryan E. Rebowe, MD

AUTHORIZATION FOR BEFORE & AFTER PHOTOGRAPHS

Please Initial. See below for explanations.

MEDICAL RECORD (required)	IN OFFICE	WEBSITE	PUBLICATIONS
_____	_____	_____	_____

_____

Date

Medical Record: The use of photographs is essential to the planning and evaluation of surgery. These photographs are a required and permanent part of your medical record and will never be shown to anyone without your consent. These photographs are useful in reviewing your own outcome.

In Office: Dr. Park and Dr. Rebowe are often asked to show before and after photos of patients considering the same surgery. This is voluntary. Names will never be used and identifying features will be avoided whenever possible.

Publications: Dr. Park and Dr. Rebowe as physicians give lectures and write articles/chapters to educate others and photos are used in these. Names will never be used and identifying features will be avoided whenever possible.

I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all representations. I understand that these consents have no bearing on medical care. These releases will remain in effect for 15 years unless revoked in writing.

**** Much of our patient growth relies on our ability to share success stories with others and we would love to be able to share yours. Please note that we may ask for an additional consent for photo use on our Social Media platforms ****

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____ _____

Name Date

_____

Signature

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 **$30** 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 atthe 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 due 2 weeks prior to procedure. Cancellations will be refunded less $500 (deposit fee). The patient will not be charged another deposit fee for rescheduling the service.

Fees for anesthesia, OR, and overnight observation are set by the facilities and are estimates only, may change with timing, location, and other variables. If used, these are to be paid directly to providers. 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 their 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

Credit Card on File FAQ's

We have implemented a convenient payment policy using a credit card to be held on file effective 02/01/2021. As you may be aware, the current healthcare market has resulted in insurance plans increasingly transferring costs to you, the patient. Many insurance plans require deductibles, coinsurance and copays in amounts that are unknown to you, or to us, at the time of your visit. Our patients will be asked for a credit card, debit card or HSA card at the time of check in. Your card information will be held securely until your insurances have paid their portion and notify us of the amount you owe. Any remaining balance owed by you will be charged to your card. We will reach out to you prior to charging the card.

Why the change?

Nothing is actually changing about how much you pay. When you come to our office and receive a service, you do so with the understanding that you are ultimately responsible for the cost of your care. Having this card on file makes payment easy. Statements are also expensive, and wasteful of paper, stamps and envelopes. This will simplify the collection process for us and for you. We want your participation in our Credit Card on File policy, but it is your choice to participate and you can withdraw at any time

What are the benefits to me?

Convenience: Patients who have a credit card will no longer have to worry about statements and mailing in payments. You can also use it to pay for future visits without having to bring your card to each visit, will make check in and checkout easier, faster and efficient for the patient.

How does this work?

At check-in we will ask you to sign a "card on file" agreement. We will only charge the amount that we are instructed to by your insurance plan in the Explanation of Benefits (EOB) that they send to us after your visit.

What about identity theft and privacy?

Under HIPAA, we are under strict state and federal guidelines to protect patient privacy and your card on file is considered protected health information. Complete Merchant services, our credit card processing vendor will store your information on a secure and encrypted site, which will enable us to run bank card transactions through our computer system. Office personnel will not have access to your card information. Only the last 4 digits will show in our system once your card is entered.

What if I need to dispute my bill or have questions?

We will always work with you to understand if there is a mistake, we will only charge the amount that we are instructed to by your insurance plan. Our staff is available to speak with you about your account at any time during regular business hours. Please contact us at 251-340-6600.

Authorization for Credit Card On File

Authorization:

Until further notice, I authorize The Park Clinic to keep my signature on file and to apply charges to the credit card listed below for patient-responsible balances on my account.

I understand that once insurance has paid their portion for my care, I will receive an Explanation of Benefits detailing any remaining portion to be paid by me from my insurance carrier, and that The Park Clinic will also receive an Explanation of Benefits. I agree that The Park Clinic may charge my credit card on file for the balance due once they receive the Explanation of Benefits from my insurance carrier. By signing below, I authorize my card to be run in lieu of receiving a statement. I will receive a receipt via email for any transactions posted to my card.

I understand that I must contact The Park Clinic if there are any changes to my credit card information to include, but not limited to, card expiration, lost/stolen cards, credit limit reached, card reissue, or any additional reason that might affect proper processing of the card on file. I understand that should attempts to charge my credit card for patient responsibility amounts as assigned by my insurance carrier be declined for any reason, I will receive statements for the balance due and, as with any negligent patient balances due to The Park Clinic, my account may become eligible for turnover to a collections agency if I fail to respond to statements in a timely manner.

Type of credit card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: _____

Expiration Date (MM/YY): _____

Printed Name _____

Patient signature _____ Date _____