cosmetic and reconstructive specialists of florida

Sunrise Intracoastal PLASTIC SURGERY CENTER

Patient Information Form

Name: Last:_____First:_____M.I.: _____

DOB:_____Age:_____SSN:_____Sex: M / F

Address: _____ Apt/Unit#_____

City: _____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Email: _____

Occupation:_____Employer:_____Work Phone: _____

Referred to office by: _____Reason for today's visit: _____

Name of emergency contact:_____Phone Number: _____

Relationship to patient: _____

Appointment with**:** □ **Dr. Low** □ **Dr. Cheung**

Our office sends text message reminders for appointments. Text message rates may apply.

Initials _____

INSURANCE PLEASE LIST ONE:

□ Self-Pay □ Health Insurance

Insurance company:_____Policy Number:_____Co-pay: _____

Patient's Relationship to subscriber: _____ Subscriber's Name: _____

Secondary Insurance Company: _____Policy Number: _____

□ **Worker's Comp**: Date of Accident:_____Employer: _____

Name of Adjuster:_____Phone number: _____

□ **Auto Accident:** Car Insurance:_____Claim number: _____Date of Loss:_____

Name of Adjuster:_____Phone number: _____

Access to my Protected health information (Read Carefully)

I authorize the following individual(s) to have access to my protected health information, make appointments and request records on my behalf. This authorization will be valid unless I otherwise notify CRS in writing.

Office Use ONLY

Name:_____ Relationship:_____ □ Revoke Date_____

Name:_____ Relationship:_____ □ Revoke Date_____

Patient Name _____ **Signature:** _____ **Date**_____

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Confidential Patient History Form (Please Complete in Detail)

Last:_____ First: _____Age: _____

REASON FOR VISIT TODAY: _____

Race: _____Ethnicity: _____ ☐ **I Decline to answer**

Height:_____ **Weight:** _____

Preferred Pharmacy: _____
Pharmacy Phone: ( ) _____-_____

Please list All Your Medical Conditions (**i.e**.: Diabetes, Thyroid, Asthma, Hypertension…):

_____ _____
_____ _____
_____ _____

Have you had any surgeries? ☐ **Yes** ☐ **No** If YES Please List Below:

SURGERY:	YEAR:	SURGERY:	YEAR:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING VITAMINS:

_____
_____
_____

PLEASE LIST ALL ALLERGIES BELLOW: OR ☐ **NO KNOWN ALLERGIES**

_____
_____

Social History

Tobacco:

☐ **Never smoked** ☐ **Quit smoking (Quit Date)**:_____

☐ **Current smoker**: Packs per day: _____ Since Year: _____

Alcohol:

☐ Never drank ☐ Social drinking ☐ Daily How many per week? _____

Recreational Drugs(including Marijuana):

☐ Yes ☐ No If yes, please list: _____

The above information is accurate and complete to the best of my knowledge.

Patient/Guardian Signature:_____ **Date:**_____
Reviewed By Signature (Office): _____ **Date Reviewed:** _____

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Our Office Policies

Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policy which we request you read and sign.

- All patients are required to complete our registration form, provide us with a valid medical Insurance card and photo ID, as well as new Insurance cards as they become available. **Initials _____**

- We accept assignment of insurance benefits as a courtesy to our patients; however the balance is your responsibility. Deductibles applied by your insurance, not covered by any another insurance, will also be your responsibility. Please be aware that some services may not be covered and may not be considered medically necessary, under Medicare and other insurances. Patients will be responsible for payment in full at the time of visit, unless valid insurance is presented. All copayments are to be paid at the time services rendered.
  Initials _____

- Some visits are performed by the nursing staff, without seeing a doctor, are considered an office visit and fees will be charged accordingly. **Initials _____**

- Our office requires 24-48 hours to process prescription requests and prescription refills. **Initials _____**

- Medical Forms such as FMLA and short term disability forms will be completed within 14 days of receipt.
  Initials_____

- **You are responsible for managing your health insurance plan and providing referrals for office visits. If your plan requires a REFERRAL and it is not available you may choose to be seen without proper authorization, BUT you will be given a waiver to sign stating you aware authorization has not been received and would like to be seen as a self-pay visit. You will be responsible for any charges your insurance denies because of un-authorized visit.**
  Initials _____

- **There is a fee for medical records.** We will notify you of the records fee and will require payment in full prior to the release of records. We require at least 5 business days to receive records and make copies**.**
  Initials _____

- Should you arrive late to your appointment, you may be asked to reschedule or you may have to wait to be seen between or after other patients who have arrived on time. **Initials _____**

I,_____have read, understand, and agree to the office policy of Cosmetic and Reconstructive Specialists of Florida, PLLC.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Date

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Sunrise Intracoastal PLASTIC SURGERY CENTER

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORMS

Cosmetic Reconstructive Specialists of Florida, PLLC

Financial Responsibility

I have requested professional services from Cosmetic Reconstructive Specialist of Florida, PLLC ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or mydependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

AUTHORIZATION/ RESPONSIBLE PARTY AGREEMENT

I authorize CRS Plastic Surgery/ SIPS Center to release pertinent medical information to my insurance company when requested, or in order to facilitate payment of a claim. I further authorize my insurance company to make payments directly to Cosmetic & Reconstructive Specialists of Florida for all medical/ surgical claims due under the terms of my insurance. I understand and agree to arrange for prompt payment of my outstanding bills and to pay any due deductibles/coinsurances and out of pocket costs.

Patient/Guardian Signature:_____ Date_____

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and(3) allow a photocopy of my signature to be used to process insurance claims I understand that any information disclosed pursuant to this authorization may be disclosed by the recipient pursuant to my providers Notice of Privacy disclosure and may not be protected by the federal privacy regulation. I understand that I have a right to revoke this authorization at any time by providing written notice to my Provider and my health benefit plan (or its administrator) via electronic mail, U.S. mail or facsimile. I further understand that there are no exceptions to my rights to revoke this authorization.

Therefore, this authorization will remain in force and effect for claims with date of service within **one year** of the signature date, or until revoked by me in writing, or until my healthcare claims are adjudicated to my provider's satisfaction**.**

ERISA Authorization and Limited Power of Attorney

I hereby designate, authorize, and convey to Cosmetic and Reconstructive Specialists of Florida's Billing Service for the claims assigned hereunder, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to sign any and all documents that require my signature, sent to or received from my health benefit plan (or its administrator) on my behalf, in the event that my health benefit plan (or its administrator) require additional information; (2) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan and assigned hereunder to Provider; and (3) the right and ability to act as my Authorized Representative to pursue any such claim, right, or cause of action in connection with said insurance policy and/or benefit plan including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines;

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

I acknowledge receipt and understanding of the items above listed.

_____ _____ _____

Patient Name: Signature Date

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PLASTIC SURGERY CENTER