la Belle vie
PLASTIC SURGERY™

**Patient Information and Financial Sheet**

Please Print

Patient Name (Last)_____ (First)_____

Address_____

City_____ State_____ Zip Code_____

May we contact you via email? Yes____ No____ Email Address_____

Home Phone (  )_____ Cell Phone (  )_____ Work Phone (  )_____

Date of Birth ____/____/_____ Sex M____ F_____ Social Security #_____

Occupation_____ Patient's Employer and Address_____

Marital Status _____ Spouse's Name_____

Emergency Contact Name & Phone # _____Relationship_____

Please tell us where you heard about LBV? _____

**Financial Responsibility** (if not patient's) Name (Last)_____ (First)_____

Relationship to patient _____ Social Security #_____ DOB ___/___/____

Mailing Address _____ City_____ State____ Zip Code_____

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Employer & Address_____

**Insurance Information**

**Primary** Insurance Company_____ ID#_____ Group #_____

Policy Holder's Name_____ DOB ___/___/_____ Social Security #_____

**Secondary** Insurance Company_____ID#_____ Group#_____

Policy Holder's Name_____ DOB ___/___/_____ Social Security #_____

***Assignment of Benefits*** *I authorize release of Medical information to my insurance company. I authorize payment directly to la Belle vie Plastic Surgery for any major medical benefits due to me. I hereby agree to pay any and all charges that exceed or are not covered by my insurance. I hereby agree to pay any and all charges incurred for nonpayment of charges for services received.*

*Signature*_____ *Date*_____

***Authorization for Photographs*** *I authorize la Belle vie Plastic Surgery to photograph me while I am a patient. I understand the photographs may be used in any manner considered proper by LBV but will be used primary for informational purposes, medical education, or medical illustration. It is understood and agreed that my name and face (unless facial surgery is being performed) will not be used or in any way be disclosed in connection with the use of the photograph unless specifically authorized. In the event that the above named patient is a minor, I certify that I am the parent or legal guardian of the above named patient and authorize these photographs.*

*Signature*_____ *Date*_____

**Health Information Sheet**

Name_____ Date of Birth ____/_____/_____

Reason for visit today_____

Do you have a latex allergy? Yes No

Do you have any drug allergies? Yes No If yes, please list_____

_____

List your current medications (including non-prescription i.e.—supplements, fish oil, vitamins, etc.)_____

_____

_____

_____

_____

Primary Care Physician_____

Pharmacy, Pharmacy Address & Phone #_____

**Social History (Circle answer)**

Do you drink alcoholic beverages? Yes No If yes, how often Daily Socially Special Occasions

Do you use illegal drugs? Yes No

Do you use tobacco? Yes No If yes, list type and frequency_____

**Female Questions**

Are you pregnant or lactating? Yes No

During pregnancy, did you ever get hyperpigmentation or masking? Yes No

What was the date of your last menstrual period? _____/_____/_____

Have you had any previous surgeries or hospitalizations? Yes No If yes, please list type and dates.

_____ Date _____/_____/_____

_____ Date _____/_____/_____

_____ Date _____/_____/_____

_____ Date _____/_____/_____

Height_____ Weight_____

Signature_____ Date _____/_____/_____

**Medical History**

Name_____ Date of Birth_____/_____/_____

| Please check all that apply | Yes | Details | Family History Yes | Family Member |
|---|---|---|---|---|
| None | | | | |
| Abnormal Bleeding | | | | |
| Anemia | | | | |
| Anesthesia Problems | | | | |
| Angina | | | | |
| Arthritis | | | | |
| Asthma | | | | |
| Breast Cancer | | | | |
| Cancer | | | | |
| Cardiac Stent | | | | |
| Chest Pain/tightness | | | | |
| Diabetes | | | | |
| Eczema | | | | |
| Emphysema | | | | |
| Fainting Spells | | | | |
| Gastric bypass | | | | |
| Heart Attack | | | | |
| Heart Disease | | | | |
| Heart Murmur | | | | |
| Hepatitis | | | | |
| Hernia | | | | |
| High Blood Pressure | | | | |
| HIV | | | | |
| Hives | | | | |
| Home Oxygen | | | | |
| Jaundice | | | | |
| Kidney Stones | | | | |
| Liver Disease | | | | |
| Lung Disease | | | | |
| Lupus | | | | |
| Malignant Hyperthermia | | | | |
| MRSA | | | | |
| Multiple Sclerosis | | | | |
| Nervous Illness | | | | |
| Other | | | | |
| Pacemaker | | | | |
| Reflux | | | | |
| Rheumatic Heart Disease | | | | |
| Seizures | | | | |
| Shortness of breath | | | | |
| Skin Cancer | | | | |
| Skin Disease | | | | |
| Sleep Apnea | | | | |
| Stomach Problems | | | | |
| Stress Test | | | | |
| Stroke/ TIA | | | | |
| Thyroid Disorder | | | | |
| Ulcers | | | | |
| Use of CPAP | | | | |

**Authorization for Release of Medical Information**

Patient Name_____ Date of Birth ____/_____/_____

la Belle vie Plastic Surgery is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping the patient's instructions.

**Check each person/entity you approve to receive information**

- Voicemail—LBV may leave a message on your phone numbers listed
- Employer—appointment absentee information
- School—appointment absentee information
- Spouse
- Parent (name)_____
- Other (name)_____

**Right of the Patient:**

*I understand I have the right to revoke this authorization at any time, and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to la Belle vie Plastic Surgery. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.*

*I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

*I understand that I have the right to refuse to sign this authorization, and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.*

Signature_____ Date ____/____/_____

Please be aware that our physicians will be unable to provide any pain medication after business hours or on weekends. Please make the necessary arrangements during regular business hours, Monday through Friday between 9am and 4:30pm.

Thank you.

Signature_____ Date____/____/_____

I have read and understand the Privacy Notice supplied (on the clip board) by la Belle vie Plastic Surgery.

Signature_____ Date____/____/_____

# Patient Financial Policy

We consider it a privilege that you have chosen us for your needs. We strongly believe that an informed patient is a good patient and that your clear understanding of our Patient Financial Policy is important to our professional relationship. Therefore, we strive to inform you of all the medical aspects of your needs and also would like to advise you on our financial policy for both cosmetic and medically necessary procedures.

**Cosmetic Procedures**

- Our consultations are complimentary
- Scheduling a surgery will require a scheduling fee equal to 15% of the surgeon's fee. This will be credited toward your surgery.
- Payment for the balance of the surgery is due at the pre-operative exam or 2 weeks prior to the operation, whichever comes first. If fees are not provided 5 business days before the scheduled procedure the surgery will be cancelled.
- We consider the pre-operative examination as a definitive final consultation prior to the operation. If the surgery is rescheduled after the payment for your surgery has been made there will be an additional non-refundable 15% rescheduling fee. This is done to maintain the continuity of a very valuable and busy surgical schedule. We reserve a considerable amount of discretion in implementing this difficult but necessary policy.
- Plastic Surgery is an art and occasionally revisions will be necessary. These will always be within one year of the original procedure date. The majority of the time no surgeon fees will be charged, however, facility and anesthesia fees will apply for the procedure. Our surgeons reserve the right to determine a revision versus a separate procedure that is being requested.
- We do not have in-office payment plans, but we do refer our patients to Care Credit at www.carecredit.com or Alphaeon at www.goalphaeon.com

**Medically Necessary Procedures**

- We are committed to providing you with the best care possible. Medically necessary consultation fees will be billed to your insurance company. It is our patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit to obtain a copy for our records. We will occasionally request a copy at a later date to update your records so please have your insurance card every time you come to the office. If current information is not obtained at the time of service, it will become the patient's responsibility to pay until current information is provided to the clinic.
- We participate with all major insurance networks. However, we only accept Medicaid for the following patients: 1. Patients under the age of 18, 2. As a supplement to Medicare, 3. Patients established before implementation of this rule, and 4. Patients referred to us by physicians of New Hanover Regional Medical Center.
- As a courtesy, we will file your claims for you with your primary and secondary insurance carriers (if Medicaid is secondary, see above rule). However, we will not become involved in disputes between you and your insurance carrier. We will supply all necessary information to assist you. Please remember that insurance is a contract

between you, the patient, and your insurance company. Ultimately, you are responsible for payment in full to la Belle vie Plastic Surgery.

- Some medically necessary procedures require pre-authorization from your insurance carrier. Our office is pleased to provide this service following your consultation. The authorization process may take 4 to 6 weeks. Surgery will not be scheduled until the authorization is received.
- Co-payments and deductibles are due at the time you see the doctor and will be collected at check-in.
- When your insurance company has paid their portion of the charge, a statement will be generated and mailed to you. Any balance due it your responsibility and is due upon receipt of the statement from our office.
- Completing Disability Forms or your 3rd insurance forms require office staff time, copies to be made, and time away from patient care for the physicians. Therefore, our charge for this service is $20, and we request 3 business days for completion of this task.
- SCAR CONSULTATIONS due to an accident that will require attorney reports will require a $350 payment from your attorney prior to seeing the doctor for the consultation.
- We accept cash, cashier's checks, personal checks (for services other than surgery), all major credit cards, Care Credit, and Alphaeon.
- We charge a $35 service fee for all returned checks.
- Unfortunately, should our billing office fail to collect the balance on a patient's account, we must then place the account with our attorney collections. Should that occur, an administrative fee will be added to your account balance.

I have read the above financial policies of la Belle vie Plastic Surgery and understand that if I have any questions, I may call the office at 910-338-5900 and someone will be available to discuss my concerns.

I _____ would _____ would not like a copy of this policy for my files.

Signature_____ Date____/____/_____

Tricare: All cosmetic procedures are paid in full up front, and if Tricare deems medically necessary from a presenting condition, a refund will be given within 30 days of receiving the EOB.