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 ____

Primary Care Last Visit____

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		Last EKG		
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

- o Voicemail—LBV may leave a message on your phone numbers listed
- o Employer—appointment absentee information
- o School—appointment absentee information
- o Spouse
- o Parent (name)____
- o 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 $600 deposit. 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 cancelled or rescheduled less than 14 calendar days prior to surgery, your $600 scheduling deposit will be forfeited. 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 EXCEPT BCBS Blue Value and Medicaid.
- 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, co-insurance 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 is 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.