GLASSMAN PLASTIC SURGERY, PLLC

LAWRENCE S. GLASSMAN, M.D.

PATIENT NAME:_____

FIRST NAME MIDDLE NAME LAST NAME

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP CODE_____SEX: M__F__

E-MAIL:_____

HOME PHONE:_____CELL PHONE_____

DATE OF BIRTH_____SS#_____MARITAL STATUS: S___M___D___W_____
REFERRING PHYSICIAN/FRIEND_____RACE:_____
EMPLOYER:_____WORK PHONE:_____
EMPLOYER ADDRESS_____
SPOUSE'S EMPLOYER:_____SPOUSE WORK PHONE_____
SPOUSE'S EMPLOYERS ADDRESS:_____
EMERGENCY CONTACT NAME_____PHONE#_____
PRIMARY INSURANCE:_____POLICY#_____
PRIMARY CARE PHYSICIAN_____GROUP#_____
ADDRESS:_____TELEPHONE#:_____
RELATIONSHIP TO INSURED:_____
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____
SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____
DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____
SECONDARY INSURANCE:_____POLICY#_____
ADDRESS:_____TELEPHONE#_____
RELATIONSHIP TO INSURED:_____
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____
DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROMPATIENT):_____
TERTIARY INSURANCE:_____POLICY#_____
RELATIONSHIP TO INSURED:_____DOB:_____
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____
DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO GLASSMAN PLASTIC SURGERY, PLLC, ATTORNEY FEES AND COSTS OF COLLECTION IN THE EVENT OF DEFAULT UP TO 33% ADDITIONAL CHARGE FOR COLLECTION FEE. INSURANCE IS NOT ACCEPTED AS PAYMENT IN FULL.

SIGNED:_____**DATE:**_____

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE MY INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE AND FINANCING ADMINISTRATIONS, ITS INTERMEDIARIES, CARRIERS INSURANCE COMPANIES, BILLING AND COLLECTION AGENTS OF THESE PHYSICIANS.

SIGNED:_____**DATE:**_____

YOUR INSURANCE

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company, there may be several programs with varying benefit requirements. There is no way that we can possibly know, or keep up to date, with each provision.

Some programs require that a specific facility be used for your x-ray's, ultrasound or blood tests.

Some programs require pre-authorization, while others do not.

Some insurance companies require PATIENTS to notify them of hospital admits or trips to the emergency

It is YOUR RESPONSIBILITY to know:

1. Whether this office is participating with your particular plan and program.
2. Advise this office of your program's requirements in advance, each and every time we provide a service. We will do our very best to comply with any reasonable requirements that your program may have.

Please understand that if we have not been advised in advance, of your programs requirement or conditions and we provide a service or use a laboratory that is outside of the program, you will be responsible for appropriate fees.

In addition, there are times that we may not be able to obtain a consultant or laboratory participating with your program. It will be up to you to work this out with your insurance company.

These are not our regulations, they are your insurance company's regulations and unless you follow them carefully, the insurance company may decline all or part of your claim. Your insurance company should have provided you with a phone number for you to use if you have any questions about your coverage. Please be sure to keep this page with your insurance papers for future references.

I acknowledge receipt of this information.

_____ _____

Signature Date

_____

Please print your name

NEW PATIENT INFORMATION SURVEY

Patient :Last Name:_____First Name:_____

Date of First Visit: **Month_____Day_____Year_____**

Reason For Visit: **Cosmetic/Type_____**

How did you hear about us (check all that apply)?

- ❑ **Internet: (Which Site) _____**
- ❑ **Friend/Relative**
- ❑ **Physician/Hospital**
- ❑ **Television**
- ❑ **Newspaper: (Which Paper)_____**
- ❑ **Radio**
- ❑ **Yellow Pages**

Thank You!

PATIENT HIPAA AWARENESS

With my permission, Drs. Glassman & Rosas may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Drs. Glassman & Rosas Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Drs. Glassman and Rosas reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Drs. Glassman & Rosas may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Drs. Glassman & Rosas may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Drs. Glassman & Rosas may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to a "request that Drs. Glassman & Rosas restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Drs. Glassman & Rosas to use and disclosure my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian (include relationship to patient)

SMOKING CONSENT

I UNDERSTAND THAT SMOKING BEFORE OR AFTER SURGERY WILL ADVERSELY EFFECT THE HEALING AND CIRCULATION AND WILL JEOPARDIZE MY SURGICAL OUTCOME.

PLEASE CHECK OFF WHAT BEST PERTAINS TO YOU.

_____ I NEVER SMOKED

_____ I HAVE NOT SMOKED IN OVER 5 YEARS

I STOPPED SMOKING ON _____

_____ DO YOU WEAR A NICOTINE PATCH?

_____ I STILL SMOKE

DATE: _____

PATIENT: _____