

PATIENT REGISTRATION FORM

Welcome to Freed Plastic Surgery
In order to assist you properly, we will need the following information.

TODAY'S DATE _____

PATIENT'S NAME (last) _____ (first) _____ (m.i.) _____

IF CHILD, PARENTS NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ (work / cell / emergency#) _____

BIRTHDATE _____ SEX _____ SOCIAL SECURITY # _____

OCCUPATION _____

WHAT IS YOUR CHIEF COMPLAINT/CONCERN? _____

WHOM MAY WE THANK FOR REFFERRING YOU? _____

EMAIL ADDRESS _____

***INSURANCE INFORMATION** (Non-cosmetic Procedures ONLY)

PATIENT STATUS:

Single Married Widowed Employed Retired Unemployed Full-time Student

PRIMARY INSURANCE _____ IDENTIFICATION# _____

PATIENT'S RELATIONSHIP TO INSURED: Self Spouse Child

Other _____

ADDRESS OF INSURED (if different from patient) _____

INSURED'S BIRTHDATE _____

SECONDARY COVERAGE _____ IDENTIFICATION# _____

***ALL HMO'S (health maintenance organizations) require prior-authorization from a primary care physician before being seen.**

PRIMARY CARE DOCTOR _____

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY INSURANCE COMPANY.

X _____ DATE _____
Signature of patient or parent if minor

PATIENT REGISTRATION FORM

PATIENT NAME _____ DATE OF BIRTH _____

Do you smoke? If so, the type and amount _____

If former smoker, date quit _____

Weight _____ Height _____

Drug Allergies _____

List previous surgeries or major illnesses and dates _____

List any medications you are taking. Including non-prescription drugs, vitamins and herbals

FAMILY HISTORY

Has any blood relative ever had the following?

High Blood Pressure.....	No	Yes	Melanoma.....	No	Yes	Stroke.....	No	Yes
Depression.....	No	Yes	Heart Disease.....	No	Yes	Kidney Disease.....	No	Yes

PAST MEDICAL HISTORY

Have you ever had the following?

Heart Disease.....	No	Yes	Cancer.....	No	Yes	Stomach Ulcer.....	No	Yes
Arthritis.....	No	Yes	Glaucoma.....	No	Yes	Kidney Disease.....	No	Yes
Rheumatic Fever.....	No	Yes	Asthma.....	No	Yes	Thyroid Disease.....	No	Yes
Anemia.....	No	Yes	AIDS or HIV+.....	No	Yes	Bleeding Tendency.....	No	Yes
Tuberculosis.....	No	Yes	Stroke.....	No	Yes	Mitral Valve Prolapse...	No	Yes
Diabetes.....	No	Yes	High Blood Pressure.....	No	Yes			
Hepatitis.....	No	Yes						

REVIEW OF SYSTEMS

Do you have now or have you had in the past year?

Weight Change.....	No	Yes	Joint or muscle pain.....	No	Yes	Chronic Cough.....	No	Yes
Dry Eyes.....	No	Yes	Swollen Lymph Nodes...	No	Yes	Jaundice.....	No	Yes
Skin Rash.....	No	Yes	Swollen Feet/Ankles.....	No	Yes	Easy Bleeding.....	No	Yes
Chronic Diarrhea.....	No	Yes	Rapid Heart Beat.....	No	Yes	Easy Bruising.....	No	Yes
Seizures.....	No	Yes	Depression.....	No	Yes	Chest Pain.....	No	Yes

Women Only

Approximate date of last mammogram _____ Number of pregnancies _____

Did you breast feed? _____ Breast lump or discharge noted? _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____
Signature of patient or parent if minor Date

FREED PLASTIC SURGERY MEDICAL CENTER

We have entered an age of extreme complexity in regard to the various insurance policies that each insurance company provides. Because of this, it has become necessary for our office to place the responsibility of understanding the requirements of your particular insurance policy on you. This includes, but is not limited to, knowing which facilities can be used for laboratory, hospitalization, or outpatient surgery. Also, it is critical that you notify our staff of any insurance changes you may have.

For surgical services, if the patient is responsible for co-payments, deductibles, non-covered services and/or amounts that insurance denies. If you have HMO insurance, we ask that you obtain a referral from your primary care physician before you schedule an appointment with our office. You may be held financially responsible if a referral/authorization is not obtained prior to your visit. Upon request, a payment arrangement may be discussed with our financial coordinator and reviewed for implementation.

After your consultation with Dr. Freed our Insurance Coordinator will contact your insurance company to determine if prior-authorization is required for the proposed procedure. **It can take up to 45 business days for your insurance company to process an authorization request.** Please do not schedule any further appointments or surgery prior to insurance approval.

Patients receiving cosmetic services must pay 10% down in order for our staff to schedule surgery. The remaining balance will be due 1-2 weeks prior to surgery.

After your cosmetic consultation with Dr. Freed our Patient Care Coordinator will send you a cost estimate along with a follow-up call to answer any questions or concerns that you may have.

Our staff is happy to assist you in any way that we can. However, if you are planning on utilizing your insurance company for any or all of the payment to Dr. Freed then please note that you are ultimately responsible for understanding your policy completely.

Please sign below stating that you understand this policy. Thank you for choosing Dr. Freed for your medical care. We are committed to providing the best possible care.

Patient Signature

Date

Printed Name

PATIENT CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby give my consent for Freed Plastic Surgery, A Medical Corporation, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare options (TPO).*

I have the right to review the Notice of Privacy Practices prior to signing this consent. Freed Plastic Surgery reserves 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 Freed Plastic Surgery, A Medical Corporation's Privacy Officer at 3180 Bell Road Suite 200, Auburn, CA 95603

With this consent, Freed Plastic Surgery may call my home or another alternative location and leave a message on voice mail or in person in reference to any items that may 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 this consent, Freed Plastic Surgery, A Medical Corporation may mail to my home or another alternative location, any items that may assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Confidential".

I have the right to request that Freed Plastic Surgery, A Medical Corporation 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 form, I am consenting to Freed Plastic Surgery A Medical Corporation's use and disclosure of my PHI to carry out 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. If I do not sign this consent, or later revoke it, Freed Plastic Surgery, A Medical Corporation may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patients Name or Legal Guardian Printed

Date

*Freed Plastic Surgery Medical Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures for patients that are interested in more detailed information.

PHOTOGRAPHY CONSENT FORM

It is standard procedure for Dr. Freed and/or his staff to take pre- and post-operative photographs of his patients. Some photographs are necessary for submitting to insurance companies in order to receive authorization prior to Dr. Freed performing a surgery (i.e. breast reduction). Other photographs are taken pre- and post-operatively to simply document the patients results.

Please consent to one of the following:

I consent to use my photograph for patient care only.

I consent to use my photograph for patient care, scientific presentations, or patient education.

Further consent will be obtained from patients prior to the use of photographs for advertising or marketing purposes.

Signature of Patient or Legal Guardian

Patients Name or Legal Guardian Printed

Date

SURGERY CANCELLATION POLICY

Please take time to read the following information regarding our surgery scheduling and rescheduling policy.

We realize that a situation may arise that could force you to postpone your surgery. Please understand that such changes affect not only Dr. Freed and our staff, but other patients as well. Before scheduling a surgery, please review carefully, then sign and date this form to show that you have read and understand this policy.

SCHEDULING AN IN-OFFICE PROCEDURE

In order to schedule your office procedure/surgery with Dr. Freed we require that you pay 10% (or \$500.00, whichever is greater) of your surgery/procedure fee. The remaining balance will be due in full **two weeks prior** to your procedure. Because of processing fees that are incurred when scheduling and coordinating an office procedure, \$500 of your payment will be non-refundable if you do not arrive at your scheduled appointment.

SCHEDULING SURGERY

To schedule your surgery with Dr. Freed you will be asked to pay 10% of your surgery/procedure fee (or \$500.00, whichever is greater). This will secure the surgery date you have chosen. Because there are processing fees that are incurred when scheduling a surgery, \$500 of this 10% deposit will be non-refundable if a surgery is cancelled *and not re-booked* fourteen days or more prior to your scheduled surgery date. Surgeries that are rescheduled will incur a \$100 charge as follows:

RESCHEDULING SURGERY

It is important that when you schedule your surgery with Dr. Freed you have thoroughly checked out your personal calendar to make sure that your scheduled surgery date is ideal for you. ***There is a \$100 charge for each time a surgery is rescheduled. This fee will not be applied towards your surgery and will be added as a charge to your surgical quote.*** This fee helps cover the administrative and staffing costs that it takes to reschedule your surgery and corresponding appointments along with any supplies, products, and staff personnel that have been specifically booked or ordered for your original surgery date.

CANCELLING SURGERY

If surgery is cancelled and not rescheduled 14 business days or more prior to your surgery, your 10% surgery deposit will be refunded however, the \$500 non-refundable fee will not. If your deposit was paid by credit card the refund will be applied back to the same account, however you will be charged a 5% credit card processing fee.

If surgery is cancelled OR rescheduled within 2-14 business days prior to surgery then you will be charged 50% of your surgery fee along with the \$500 non-refundable fee that was paid at the time of scheduling your surgery.

If surgery is cancelled OR rescheduled in less than 48 hours you will be charged the full amount of your surgery cost.

I have read, understood, and accept the above policies.

Patient: _____ Date: _____

Witness: _____ Date: _____