Wittenborn Plastic Surgery

William S. Wittenborn, MD
Board Certified Plastic Surgeon

FINANCIAL POLICY

USUAL AND CUSTOMARY FEES: Our practice is committed to providing the best medical care for our patients. We charge what is usual and customary for our area. All patients are responsible for providing accurate and complete personal and insurance information prior to being seen by the doctor. The charges made, for your visit and care provided, depend on the nature and the complexity of your problem.

FORMS OF PAYMENT ACCEPTED: Payment may be in the form of cash, checks, Master Card and Visa. Returned checks are subject to a service charge. Elective Cosmetic Surgeries may also be paid in full with a *Cosmetic Fee Plan* or *Patient Financing Services* account.

PAYMENT FOR SERVICES (SELF-PAY/NON-INSURED): Payment in full is expected before services are rendered unless prior financial arrangements have been made.

PAYMENT FOR SERVICES (PERSONAL HEALTH INSURANCE/MEDICARE): Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by your insurance company. In all cases, we require that the guarantor, the person who is financially responsible, is *personally* liable for all balances not covered by Medicare or other insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. All charges are your responsibility from the date services are rendered.

CO-PAYMENTS: Co-payments are due at the time of service.

PAST DUE ACCOUNTS: Any balances on your account after 90 days, including those that insurance has not paid, will be referred to a collection agency unless other financial arrangements have been made in advance. Legal fees that we pay to secure any past due balances will be added to your account. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

WORKERS COMPENSATION: If you are seeking medical care as a result of a work-related injury, we will assist you in verifying your claim for the coverage of your medical bills. If for any reason your worker's compensation is not verified, the full responsibility for payment of services rendered will be that of the individual receiving treatment.

PAYMENT FOR ELECTIVE COSMETIC SURGERY: Payment in full is expected before services are rendered. Aesthetic (Cosmetic) surgeries will not be scheduled until your financial obligation has been met. Our office requires a minimum deposit of $500 or 10% of the total surgeon's fee, whichever is greater, in order to schedule your surgery. This deposit will be applied to your "surgeon's fee" portion of the cost. Payment may be in the form of cash, checks, Master Card and Visa. If paying by credit card, the card must be presented in person by the authorized cardholder and a charge slip must be signed. Returned checks are subject to a service charge. Payment in full of the surgeon's fee must be received two (2) weeks prior to your scheduled procedure or we reserve the right to cancel or reschedule your surgery.

CANCELLATION OF ELECTIVE COSMETIC SURGERY: Should it become necessary for you to cancel or reschedule your surgery, we must receive notice of that change at least 10 days before your surgery date. If we receive notice of cancellation by that time, your deposit will be refunded in full. If you paid for your surgery with one of our financing companies offered, we will refund your financed portion of your payment minus 7%. If you should cancel your surgery three times, your deposit of $500 or 10% paid will not be refunded and we will require a new deposit to reschedule your surgery. Exceptions will be made for documented emergency or medical disability.

By signing this form, I fully understand and agree to the terms of the FINANCIAL POLICY.

Signed:_____ Print:_____ Date:_____

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Wittenborn Plastic Surgery

WILLIAM S. WITTENBORN, MD
Board Certified Plastic Surgeon

Thank You for Choosing Our Practice!

Please take a moment to complete all information on this record. The information you provide is treated as confidential.

PATIENT HISTORY

Patient Name:_____ Date:_____

Reason for your visit today:_____

Medical Problems:_____

Previous Surgeries:_____

Medications currently taken on a regular basis:_____

Do you have any of the following?

☐ Change in vision	☐ Difficulty swallowing	☐ Short of breath	☐ Numbness-_____
☐ Sinus problems	☐ Chest pain	☐ Leg swelling	☐ Fevers
☐ Headaches	☐ Convulsions	☐ Weight loss	☐ Anxiety
☐ Dizziness	☐ Palpitations	☐ Weight gain	☐ Depression
☐ Muscle weakness	☐ Wheezing	☐ Diarrhea	☐ Bleeding problems

☐ Other:_____

Allergies:_____

Do you smoke? ☐No ☐Yes How many cigarettes per day?_____

Other drug use? ☐No ☐Yes_____

Any recent hospitalizations? ☐No ☐Yes_____

Any problems with anesthesia? ☐No ☐Yes_____

Are you under the care of a physician at this time for any problem? ☐No ☐Yes_____

Have you ever consulted a plastic surgeon? ☐No ☐Yes

For the same reason as today? ☐No ☐Yes

Have you had previous plastic surgery? ☐No ☐Yes

Is there any additional information you are interested in? (Procedures, skincare, etc.)_____

Can we contact you via e-mail? Specials, newsletters, updates regarding our office. ☐No ☐Yes

Wittenborn Plastic Surgery

WILLIAM S. WITTENBORN, MD

Board Certified Plastic Surgeon

Welcome to Our Practice!

Please take a moment to complete this registration form so we can better assist you with your healthcare needs.
(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name: First: M:			❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Driver's License #	E-mail Address	Social Security #	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Home Phone:		Business Phone:		
City:	State:	Zip Code:		Cell Phone:		
Occupation/Employer:	Employer Address:			❑Full Time ❑Part Time		
Spouse's Last Name: First: M:			Spouse's Work Phone:	Spouse's Cell Phone:		
How do you wish to be addressed?						
Is your condition the result of a work injury? ❑Yes ❑No An auto accident? ❑Yes ❑No Date of Injury:						
INSURANCE INFORMATION						
Responsible Party (if different)	Birth date: / /	Address (if different):		Home Phone : ( )		
Occupation:	Employer:	Employer address:		Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No						
Please indicate primary insurance	❑ Medicare	❑ Blue Cross	❑ Aetna	❑ Cigna	❑ United	
❑ Web tpa	❑ Self Insured Plan	❑ AvMed	❑ None	❑ Other		
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
REFERRAL INFORMATION						
Referred By: ❑Doctor ❑ Family ❑ Friend ❑ Insurance Plan ❑ Hospital ❑ Internet ❑ Yellow Pages			If referred by friend, may we thank him or her? ❑Yes ❑No Friend or Doctor's Name:			
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):			Relationship to patient:	Home phone no.:	Work phone no.:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wittenborn Plastic Surgery or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Wittenborn Plastic Surgery

WILLIAM S. WITTENBORN, MD

Board Certified Plastic Surgeon

Patient Name:

CONSENT FOR TREATMENT

I hereby voluntarily consent to and authorize medical care/diagnostic treatment and /or minor surgical treatment by **William S. Wittenborn, MD** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the use and disclosure of any of my past/current medical records for treatment and healthcare operations.

Signed:_____ Date:_____

Print Name: _____

AUTHORIZATION AND ASSIGNMENT

I hereby assign all medical/diagnostic/surgical benefits payable for the services rendered, to include major medical benefits to which I am entitled, including Medicare, Private Insurance and other health plans to **Wittenborn Plastic Surgery.** I hereby authorize said assignee to release to CMS/Insurance Carriers and it agents all information needed to determine these benefits or benefits related to services. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/ procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services.

Signed:_____ Date:_____

Print Name: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

_____**(Initial)** I authorize discussion of my general medical condition and diagnosis (including treatment, payment and healthcare operations) with: *Please list the family members or significant others, if any, whom we may inform about your medical condition.*

Name:_____Relation:_____Phone Number:_____

Name:_____Relation:_____Phone Number:_____

Name:_____Relation:_____Phone Number:_____

Can **appointment reminders** be left on your telephone answering machine or voice mail? ☐Yes ☐ No

Can **other confidential messages** (lab results, etc.) be left on your telephone answering machine or voice mail? ☐Yes ☐No

If **YES**, please indicate what types of messages may be left on your machine. ☐Lab results ☐X-Ray Results ☐Follow-up Needed

CONSENT FOR TAKING AND/OR PUBLISHING PHOTOGRAPHS

I hereby grant authority to Wittenborn Plastic Surgery and/or his designated representatives to take photographs of myself/ my child (please circle appropriate identifier) with the understanding that such photographs are for confidential clinical purposes of evaluation and treatment, and that all photographs remain the property of Wittenborn Plastic Surgery. I understand that the said photographs are a permanent part of my medical record, and as such may be submitted to my insurance for the specific purpose of obtaining reimbursement for authorized services.

Signed:_____Print:_____Date:_____

In additional to the use of these photographs for above purposes, I consent for to their use for:

Educational purposes for professional journals or medical books knowing in such publication I shall not be identified by name. ☐ Yes ☐ No

For use in patient education knowing it may be seen by others. It is specifically understood you shall not be identified by name. ☐Yes ☐ No

Signed:_____Print:_____Date:_____

PRIVACY NOTICE

_____**(Initial)** I have received a copy of WILLIAM S. WITTENBORN, MD's office *privacy notice* as required by HIPAA that provides a complete description of *personal health information* uses and disclosures. I have been provided an opportunity to review it.