aiken plastic surgery

. . . in search of the new you

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

PATIENT INFORMATION

Patient's Name	Sex M F	Birth Date ____/____/_____ (Age_________)	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]

Patient's address City State Zip	Home Phone:	Cell Phone:

Emergency Contact Person and Phone Number:	Patient's Social Security #

How did you hear about our office? ☐ Friend ☐ Internet ☐ Yellow Pages ☐ Newspaper ☐ Magazine ☐ Other ________________________________	Primary Care Physician: _____________________________

Reason for visit:	Date of Accident:	If due to accident, was accident due to: ☐ Accident on the job ☐ Other _______________ ☐ Automobile Accident _____________________

RESPONSIBLE PARTY'S INFORMATION

The patient is the responsible party if he or she is at least 18-years-old.

Person financially responsible for this account:	Relationship ☐ Spouse ☐ Parent	Responsible Party's Birthdate ____/____/_____	Responsible Party's Social Security #

Responsible Party Driver's License Number: State:	Home Phone	How Long at current Employer?
Name of employer Address	Business Phone	Occupation

INSURANCE INFORMATION

Primary insurance company Address	Is insurance through your employer?

Primary insurance subscriber's name	Subscriber birth date	Policy # or SSN	Group #

Secondary insurance company Address	Is insurance through subscriber'

Secondary insurance subscriber's name	Subscriber birth date	Policy # or SSN	Group #

Medicare and Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to Aiken Plastic Surgery, P.A. for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

____ _______________________
Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Aiken Plastic Surgery
3000 Woodside Executive Court
Aiken, SC 29803

PATIENT HISTORY FORM

Patient Name: ____________________ Birth Date: ____________________

Please answer all of the following questions as accurately as possible. If you do not understand the question please ask for assistance:

Physician who referred you to Dr. Page: ____________________

Patient's Primary Care Physician: ____________________

PATIENT'S PERSONAL MEDICAL HISTORY:

Smoking (type and amount per day) ____________ Alcohol (type and amount per day) ____________
If former smoker, date quit ____________

Drug Allergies: ____________________

List Previous Surgeries or Major Illnesses and Dates:
____
____

List ALL Medications you are taking including non-prescription drugs, vitamins and herbals:
____
____

Please check any of the following that apply to You:

☐ Heart Disease	☐ Stomach Ulcer	☐ Anemia	☐ AIDS or HIV
☐ Arthritis	☐ Glaucoma	☐ Kidney Disease	☐ Hepatitis
☐ Mitral Valve Prolapse	☐ Rheumatic Fever	☐ Stroke	☐ Bleeding tendency
☐ Heart Murmur	☐ Tuberculosis	☐ Asthma	☐ Cold Sores/Feverblisters
☐ High Blood Pressure	☐ Diabetes	☐ Thyroid Disease	☐ Glasses/contacts
☐ Cancer Type: ____________			

Review of Systems: Please check any of the following that you have now or you had <u>within the past year</u>:

☐ Weight Change	☐ Swollen feet/ankles	☐ Seizures	☐ Dry eyes
☐ Joint / muscle pain	☐ Chronic cough	☐ Chronic diarrhea	☐ Swollen lymph nodes
☐ Chest pain	☐ Jaundice	☐ Easy bleeding	☐ Easy bruising
☐ Rapid heart beat	☐ Depression	☐ Skin rash	☐ Breast Lump/Discharge

Women Only: Age period began ________ Number of pregnancies ________ Did you breast feed Yes☐ No☐
Date of last mammogram ________ Do you perform regular breast self-examinations Yes☐ No☐

FAMILY HISTORY: Please check any of the following that applies to relatives.

☐ Breast Cancer	☐ Diabetes	☐ Kidney Disease	☐ Melanoma
☐ Stroke	☐ Heart Disease	☐ Depression	☐ High Blood Pressure

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

____________________ ____________________
Signature of patient or guardian, if minor Date

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We are committed to providing you with the best care, and we are happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important. Please ask if you have any questions about our fees, financial policy, or your responsibilities.

CO-INSURANCE - Please pay any co-pay's or deductible amounts that you owe at Check-in. A minimum of $100.00 will be collected for office visits when insurance benefits cannot be confirmed, and a minimum of $50.00 when copay's or deductibles cannot be confirmed. A $5.00 fee will be added monthly to any account that has a remaining balance. Like most businesses, full payment for services is DUE AT THE TIME THE SERVICE IS RENDERED unless other arrangements have been made with this office. We accept cash, personal checks via TeleCheck, VISA, MasterCard and Discover.

It is our policy that if a check is returned or credit charge is rejected, you will be charged a $30.00 service fee. You will be contacted and asked to pick up the previous payment and pay by cash or certified check at that time. Any account with an outstanding balance will accrue a $5.00 billing charge each month until the account is paid in full. Delinquent accounts may be referred to a collection agency. You agree that if it becomes necessary to forward your account to our collection agency, in addition to the amount owed, you will also be responsible for the fee charged to us by the collection agency for costs of collections.

APPOINTMENT CANCELLATION POLICY - We require a 24-hour notice of cancellation for all scheduled appointments, or you may be billed for that appointment. A $50.00 charge will be applied for any missed office surgical procedure appointments or $200 for any Hospital or Surgery Center insurance only related surgeries. See the Aiken Plastic Surgery Financial Surgery Policy form for all cosmetic surgeries.

INSURANCE PROGRAMS THAT CONTRACT DIRECTLY WITH US - If you have health insurance it should be understood that this is a contract between you and your insurance company. Your doctor's bill is an agreement between you and your doctor. YOU ARE RESPONSIBLE FOR UNDERSTANDING THE HEALTH INSURANCE POLICY YOU HAVE CHOSEN and for providing our office with all necessary billing information. Please read the benefits of your individual policy. There are some services that may not be covered by your insurance. Payment is expected at the time of service for non-covered charges. Our office only bills PRIMARY insurance claims for services rendered, excluding Medicare patients. If you have a secondary insurance, please ask for a receipt for your services. COPAYMENTS, DEDUCTIBLES, AND CO-INSURANCE ARE REQUIRED AT THE TIME OF SERVICE.

REFERRALS - If your insurance plan requires a referral, PLEASE CONTACT YOUR INSURANCE COMPANY BEFORE SEEING THE PHYSICIAN. Referrals must first be authorized by your primary care physician and then called in to your insurance company if required. IT IS YOUR RESPONSIBILITY TO KNOW WHICH HOSPITAL AND LABORATORY YOU ARE REQUIRED TO USE WITHIN YOUR NETWORK. We use Professional Pathology Associates and Aiken Regional Medical Centers for laboratory and pathology services unless otherwise requested by you.

INSURANCE PROGRAMS THAT DO NOT CONTRACT DIRECTLY WITH US - YOU ARE EXPECTED TO PAY IN FULL FOR YOUR OFFICE VISIT. We will submit a claim to your insurance company as a courtesy to you. You are responsible for your bill regardless of the status of an insurance claim.

If unusual circumstances make it impossible for you to meet the terms of this financial policy, please discuss your account with our business office. This will avoid misunderstandings and enable you to keep your account in good standing.

I have read and I understand the above policies, and I agree to accept responsibility for any financial obligations incurred.

Signature____ **Date**________________

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, ____, have reviewed and/or received a copy
Patient/Guardian Name (Printed)

of Aiken Plastic Surgery's Notice of Privacy Practices.

________________________________ ________________
Signature of Patient/Guardian Date

____
Patient/Guardian Name [Printed]

________________________________ ________________
Witness Signature Date

____
Witness Name [Printed]

Email Information

From time to time we provide information to patients via email. If you would like to receive information via electronic means, please provide the information below so we may contact you through your email address. You may unsubscribe by notifying us at any time through our website or in writing to our office. We will not release your email address to ANYONE without your expressed written consent.

Email Address:

I would like to receive information and special offers from Aiken Plastic Surgery at the above noted email address.

________________________________ ________________
Signature of Patient Date

____
Patient Name [Printed]