

WELCOME TO AESTHETIC PLASTIC SURGERY CENTER, LLC

Patient Name: _____ Birthdate: _____ Age: _____
Social Security# _____ Home # _____ .HomePhone _____ Cell # _____
Address _____ City _____ State _____ Zip _____
Email Address: _____
Check appropriate box: Single Married Divorced Widowed Male Female
Patient's or parent's employer _____ Work Phone _____
Business Address: _____ City: _____ State _____ Zip _____
Spouse or parent's name: _____ Employer: _____ Work Phone _____
If patient is a student, name of school/college _____ City _____ State _____
Primary Care Physician _____ City _____ State _____
Referring Physician _____ City _____ State _____
Person to contact in case of emergency: _____ Phone _____
Pharmacy of Choice _____ City _____ State _____
How did you hear about us? _____

GUARANTOR

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home Phone _____
Social Security # _____ Birthdate _____
Employer _____ Work Phone _____
 Medical W/C MVA

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient _____ DOB _____ SS # _____
Name of employer _____ Work Phone _____
Address of employer _____ City _____ ST _____ Zip _____
Insurance company _____ ID# _____ Group# _____
Ins.co.address _____ City _____ ST _____ Zip _____
Do you have any additional insurance? Yes No

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient _____ DOB _____ SS # _____
Name of employer _____ Work Phone _____
Address of employer _____ City _____ ST _____ Zip _____
Insurance company _____ ID# _____ Group# _____
Ins.co.address _____ City _____ ST _____ Zip _____
Do you have any additional insurance? Yes No

AUTHORIZATION & RELEASE

I hereby authorize Aesthetic Plastic Surgery Center to furnish information to insurance carriers concerning my treatments and I hereby assign to Aesthetic Plastic Surgery Center all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by my insurance company. Additional forms/waivers may apply. A \$150.00 charge will be billed for missed appointments 24-hours or less. I may request a HIPPA privacy notice at any time. I have read and understand the information for be accurate and true.

SIGNATURE _____

Patient/Adult, Other Representative

DATE _____

MEDICAL HISTORY

Height ' " Weight Age For Breast patients-Current Bra Size

Medications (include nonprescription) _____

Allergies to medications _____

Other Allergies: Latex Metal Tape Other _____

Past Medical History

Review of Systems

****Please CIRCLE and CHECK below****

Diabetes, Thyroid problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Rashes	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Lung Disease (asthma, emphysema, bronchitis, other)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Frequent Urination, changes in stream, burning, or bleeding	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Bleeding disorder, Hemophilia, History of blood transfusion	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Change in Bowel function, frequency, blood in stools	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Liver disease (hepatitis, cirrhosis, other)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Muscle weakness	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Cancer (radiation, chemo)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Frequent Infections	No <input type="checkbox"/>	Yes <input type="checkbox"/>
History of Breast Cancer	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Chest Pain or Pressure	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Mammogram - Date:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Shortness of Breath, Wheezing	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Hypertension, Stroke, Heart Murmurs	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Anxiety or Depression	No <input type="checkbox"/>	Yes <input type="checkbox"/>
			Dentures/Veneers	No <input type="checkbox"/>	Yes <input type="checkbox"/>

Previous Hospitalizations/Surgeries/Serious Illness

When

PATIENT SOCIAL HISTORY

Use of alcohol: Never Rarely Moderate Daily
 Use of tobacco: Never Previously, but quit _____ Current packs/day _____ How long _____
 Use of drugs: Never Type/frequency _____

FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

<PersonalInfo.FullName>

Physician Signature: _____

B. Holburn MD

Date: <System.Date>

Patient Contact Consent

- Home Number** _____ Preferred Method Okay to Leave Message
 Okay to Leave Message with another person _____
 Best Time To Call AM PM Evenings Anytime Do Not Call

- Cell Number** _____ Preferred Method Okay to Leave Voicemail
 Okay to Leave Message with another person _____
 Best Time To Call AM PM Evenings Anytime Do Not Call
Carrier AT & T T-Mobile Verizon Sprint Nextel Rogers

- Work Number** _____ Preferred Method
 Okay to Leave Message with another person _____
 Best Time To Call AM PM Evenings Anytime Do Not Call

- Send Email** _____
 Okay Appointment Reminder Okay for Marketing Message

- Text Page** Okay for Appointment Reminder Okay for Marketing Message

Patient Name: _____ Date: _____

**Documentation of Good Faith Efforts
to obtain patient's acknowledgement that they received
Notice of Privacy Practices**

Patient Name: _____ **DOB:** _____

The patient presented to the office on <System.Date> and was provided with a copy of the practice Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of the patient's receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:
- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe below):
- I had the opportunity to review and or ask questions and receive copy

Signature Date

Authorization For Release of Patient Photograph

Name:

Address:

I consent to the taking of photographs by Dr. Boris Goldman or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be/prior performed by Dr.Boris Goldman.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property and retained of Dr.Boris Goldman's office at Aesthetic Plastic Surgery Center, LLC and/or released by Dr.Boris Goldman at Aesthetic Plastic Surgery Center, LLC for the limit purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identify recognizable.

I understand that I may refuse to authorize the release of my health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive from Dr.Boris Goldman.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it won't have any effect on any actions taken prior to my revocation.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA). I further understand that, because Dr.Boris Goldman at Aesthetic Plastic Surgery Center, LLC is not receiving the information in the capacity of a health care provider or health plan covered by HIPPA, the information described above may no longer be protected by HIPPA.

I release and discharge Dr.Boris Goldman at Aesthetic Plastic Surgery Center, LLC, and all parties acting under their license and authority from all rights that I may have the photographs and from any claim that I may have relating to such use in publication, including and claim for payment in connection with disctribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

(Signature)

(Date)

I have read the above Authorization and Realease. I am the parent, guardian and/or conservator of _____, a minor. I am authorized on his/her behalf and I give this authorization as a voluntary contribution in the public education.

(Signature)

(Date)

Aesthetic Plastic Surgery Center, LLC
Boris E. Goldman, M.D., F.A.C.S.
32 Imperial Avenue, 2nd Floor
Westport, Connecticut 06880
Phone (203) 222-3700
Fax (203) 222-3703

Financial Responsibility

I, Name: _____ accept full financial responsibility for any and all services rendered by Aesthetic Plastic Surgery Center LLC and Dr. Boris E. Goldman MD, FACS. I understand that if my insurance claim is sent to my insurance company and my insurance company denies the claim, I will be financially responsible for the amount due to Aesthetic Plastic Surgery Center LLC and Dr. Boris E. Goldman MD, FACS. All patients are responsible for knowing their own insurance policy with any deductibles and copays. Our insurance biller will precertify all insurance procedures.

If the insurance company pays you (the patient) directly and you do not forward the check in full immediately to our office, we will report you for fraud. In addition, if you (the patient) still keeps the check, you will be also responsible for any litigation fees incurred to Aesthetic Plastic Surgery Center and Dr. Boris E. Goldman along with the full amount of the claim billed to the insurance company. We will not set up payment plans for checks that were mailed to the patient directly.

If your insurance company denies your claim, we will send you written notification of the amount due. Late payments will be assessed at 1.5% per month. Thank you.

Responsible Party Signature: _____

Print Name: _____

Date: _____

Relationship: _____

