

Vivek Bansal, MD Inc

Advanced Dermatology, Laser, and Plastic Surgery Institute

Date: _____

Welcome To Our Office: Cosmetic Patient Registration Packet

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Age: _____ Sex: M F Social Security: _____ - _____ - _____

Marital Status: _____ Spouse's/Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____ Work Phone: (____) ____ - _____

Preferred Contact Number: Home Cell Work Email: _____

If we need to reach you, may we leave confidential voicemail messages? Y N

Would you like to receive appointment reminders/promotions/complimentary treatments via email? Y N

To receive a text message for appointment reminders, please chose your Cell Phone Company:

Alltel ATT Nextel Qwest Sprint T-Mobile Verizon Virgin Mobile Other

To qualify for certain discounts, please let us know how you heard about us: Check as many as apply.

My Physician – Name: _____ Insurance Plan – Name: _____

Family/Friend – Name: _____ Other: _____

Publication – Name: _____

Radio/Internet: Wolf 95.7 1800MySurgeon Other: _____

Television: KRON 4 CBS 5 ABC/KGO 7 FOX/KTVU Show/Segment Name: _____

Occupation: _____ Spouse/Guardian Occupation: _____

If retired, previous occupation: _____ Employer: _____

Primary Physician: _____

Address: _____ Phone: (____) ____ - _____

Medical Emergency Contacts:

Name: _____ Relation: _____ Phone: (____) ____ - _____

Name: _____ Relation: _____ Phone: (____) ____ - _____

Patient Cosmetic and Medical History

Date: _____

Last Name: _____ First Name: _____ Sex: M F

Age: _____ DOB: _____ Height: _____ Weight: _____

Reason for Visit: _____

List all conditions you are currently being treated for by a physician: _____

List any past serious illnesses or injuries that you have had: _____

List all medications you are now taking (vitamins, birth control pills, blood thinners, aspirin, etc.): _____

List all medications you are allergic to: _____

List all kinds of tape you are allergic to: _____

Are you allergic to latex? Y N Have you been tested for HIV? Y N If Yes, what year _____

Do you have Hepatitis? Y N If Yes, what type? A B C Other _____

What is your approximate daily consumption of: Alcohol _____ Tobacco _____

Do you wear: Contact Lenses Eye Glasses False Teeth Hearing Aid

Date of Last Physical Exam: _____ Date of Last EKG: _____

Are you pregnant? Y N Date of Last Mammogram: _____

Previous Operations/Surgeries/Cosmetic Procedures:

Name of Surgery	Year	Type of Anesthesia (Local or General)	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Financial and Miscellaneous Policies of Elite MD, Inc

1. Insurance Patients - PPO/HMO/Medicare:

- a. We are required to make a copy of your insurance and driver's license.
- b. If your insurance requires a referral/authorization from your primary care physician (PCP), you must present your authorization prior to your exam. If you are unable to provide us with your authorization, we will gladly contact your PCP for you, or if he/she is unavailable, will reschedule your appointment for a time that is convenient for you.
- c. You will be responsible for services denied by your insurance or for any balances that remain after insurance coverage is applied. Please be aware of your deductible (if any), as you are responsible for any remaining balances.
- d. If you are unable to provide your insurance information or we are unable to confirm your insurance status, you will be treated as a Private Pay Patient (PPP) at the time of your visit and you will be responsible for payment at the time of service (please see Section 3 below). After your insurance has been verified, we will refund the difference to you.

2. Co-Pays:

- a. All co-pays are due at the time of the visit. Our co-pay fee is \$25 if you are a patient who is unaware of your co-pay amount or if the co-pay amount is not stated on your insurance card. If your co-pay is determined to be less than \$25, Elite MD will gladly refund you the difference. If the co-pay amount is greater than \$25, Elite MD will bill the balance to you through our billing service. Co-pays cannot be waived as we are a contracted provider.
- b. If your copay is not paid at the time of the visit, you will be assessed a \$20 surcharge.
- c. There may be an additional co-share amount billed to you if the doctor performs a procedure.

3. Self/Private Pay Patients:

- a. If we are not contracted with your insurance, or you do not have insurance, you are responsible for payment at the time of service. As a professional courtesy, we will submit claims to your insurance, but you will be responsible for any services that are denied.

4. Surgical Patients:

- a. We require patients to place a \$1000.00 deposit to hold their surgery. This deposit is completely non-refundable.
- b. Payment of surgery is due in full 2 weeks prior to the surgery date. If full payment is not received by the date, the surgery will be cancelled, and the deposit will be deemed non-refundable. If your surgery is within 2 weeks of your consultation, then payment is due in full at time of surgery scheduling.

5. Refund Policy/Cancellation Policy/Returned Checks/Collections:

- a. No refunds for medical/cosmetic procedures. Exchange or refund for products within 14 days of purchase. Prescription products are not refundable or returnable.
- b. To avoid \$50 fee, please call 24 hours in advanced to cancel or re-schedule your appointment.
- c. A charge of \$30 will be made for all returned checks.
- d. In the event that any action is brought to collection, you agree to pay any reasonable collection costs and/or fees and interest. All accounts are subject to a finance charge in not paid within 30 days of billing date. The finance charge is computed by a periodic rate of 1.5% per month, which is an annual percentage rate applied to current balance.

6. Assignment and Release of Insurance Benefits:

- a. I hereby assign my insurance benefits to be paid directly to Elite MD, Inc., and authorize Elite MD to release my insurance and any information required to process claims for services rendered. I understand if claims are denied due to any reason, I will assume full responsibility for all charges incurred by me and all dependents. Additionally, I will be financially responsible for any non-covered benefits, deductibles, or any co-payments for services, which have been provided to me. This assignment will remain in effect until revoked by me in writing.

7. Educational Photography:

- a. I consent to be photographed before and after treatment and these photos are the property of Elite MD.
- b. I give permission for medical photography to be taken and they may be used for educational purposes such as teaching and academic works. I may chose to opt out to Section 7, Clause B by initialing here: _____

All information I have filled out is correct. My signature indicates my understanding/responsibility for all statements on this page. A copy/scan of this page is considered to be as valid as the original.

Date of Birth: _____ Printed Name: _____ Signature: _____ Date: _____

HIPAA/Communication Consent:
Patient Consent for Use and Disclosure of Protected Health Information

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our clients review and sign this Communication Consent Form.

Elite MD will not release confidential and/or other Protected Health Information (PHI) by home mailing, home telephone, answering machine, work telephone, voice mail, cell phone and or/email. When we place telephone calls and an answering machine responds, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If I do not sign this consent, Elite MD Inc may decline to provide treatment to me.

I, _____ authorize Elite MD to contact me and or named authorized person(s) and to convey PHI by the following methods and assume responsibility to notify Elite MD whenever this information changes:

Cell Phone	____ Yes	____ No	Home Telephone	____ Yes	____ No
Work Telephone	____ Yes	____ No	Email	____ Yes	____ No
Home Mailing	____ Yes	____ No	Fax	____ Yes	____ No
Answering Machine	____ Yes	____ No	Voice Mail	____ Yes	____ No

List names of other people/physicians authorized to receive information about your care:

Spouse: _____ Parent: _____
Friend: _____ Other: _____

I also understand that Elite MD will release PHI to the individual entrusted to my post-surgical care, specifically the individual responsible for my transportation after my surgery. I may chose to opt out by initialing here: _____

This authorization will remain valid unless revoked by the patient or legal guardian. This authorization applies for all episodes of care and treatment. The authorization applies to all medical information physically or electronically stored at any office/location of Elite MD, Inc.

Patient Printed Name: _____ Date of Birth: _____

Date: _____ Patient Signature: _____

Parent/Guardian Signature (as needed): _____

Witness/Physician Signature: _____ Date: _____