THE BRESSLER CENTER

FACIAL PLASTIC SURGERY AND SKIN CARE

SCHEDULED APPOINTMENT DATE: ____

PATIENT INFORMATION

ACCOUNT # (Leave Blank):

NAME: ____

ADDRESS: STREET: ____
CITY: ____________________ STATE: ______ ZIPCODE: ____________________
COUNTRY: ____

PHONE NUMBERS: (H): ______________________ **(W):** __________________ **(EXT):** _______
(Mobile): ______________________ **(Email):** ______________________________

PREFERRED METHOD OF CONTACT: (H): (W): (Mobile): (Text): (Email):

SOCIAL SECURITY NUMBER: ____

DATE OF BIRTH: _______________________ **AGE:** _______ **SEX:** (M): (F):

MARITAL STATUS: (S): (M): (D): (W):

EMERGENCY CONTACT:
Name: ____ **Relationship:** _ ___________________
Address: ____ **Phone:**___________________________
City: ___________________________________ **State:** _______________ **Zip:** ________________

PATIENT'S EMPLOYER: ____
POSITION: ____
LENGTH OF TIME WITH EMPLOYER: ____

HOW DID YOU HEAR ABOUT US?: ______________________________

REFFERING PHYSICIAN: ______________________________

PRIMARY CARE PHYSICIAN: ______________________________

REASON FOR TODAY'S VISIT:

____

DO YOU HAVE NOW OR A HISTORY OF (click or check each one that applies):

- ALCOHOL/DRUGS
- ANEMIA
- ASTHMA
- BLEEDING TENDENCY
- CFIDS
- DIABETES
- DIFFICULTY BREATHING THROUGH NOSE
- EARACHES
- HEADACHES
- HEART ATTACKS
- HEART TROUBLE
- HEPATITIS: A: B: C:
- HIV/ARC/AIDS
- HYPERTENSION
- NASAL ALLERGIES
- NOSE BLEEDS
- POST-NASAL DRAINAGE
- PSYCHIATRIC ILLNESS
- SCARRING
- SINUS INFECTIONS
- SMOKING ________ PACKS PER DAY
- SNORING
- STROKE
- ULCERS

PLEASE LIST CURRENT MEDICATIONS:

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PLEASE LIST KNOWN DRUG ALLERGIES:

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PLEASE LIST PREVIOUS SURGERIES OR MAJOR ILLNESSESS WITH DATES:

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PRIMARY INSURANCE INFORMATION:

INSURANCE COMPANY: ____

ADDRESS: ____

PHONE NUMBER: ____

POLICYHOLDER: ____

I.D. NUMBER: ____

GROUP NAME: ____

GROUP NUMBER: ____

TYPE OF PLAN: HMO: PPO: POS: MEDB: MEDICAID: PRIVATE:

FOR OFFICE USE ONLY:

IN NETWORK OUT OF NETWORK

EFFECTIVE DATE: ______________________

ANNUAL DEDUCTIBLE: $______________________

OUT OF POCKET: $______________________

AFTER MET PAYS: % ______________________

O/V COPAY: $______________________

VERIFIED WITH: ______________________

PRE-EXISTING CLAUSE: ______________________

IS PRE-CERT NEEDED FOR:

O/P SURGERY	Y	N
SLEEP STUDY	Y	N
CT SCANS	Y	N
MRI	Y	N

SECONDARY INSURANCE INFORMATION:

INSURANCE COMPANY: ____

ADDRESS: ____

PHONE NUMBER: ____

POLICYHOLDER: ____

I.D. NUMBER: ____

GROUP NAME: ____

GROUP NUMBER: ____

TYPE OF PLAN: HMO: PPO: POS: MEDB: MEDICAID: PRIVATE:

I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL INFORM DR. BRESSLER, DR. FUNK, OR HIS STAFF OF ANY CHANGES IN MY HEALTH STATUS OR REGARDING ANY OF THE ABOVE INFORMATION.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE ____ **DATE** _____________________________

FINANCIAL INFORMATION AND PHOTOGRAPHIC CONSENT

Thank you for the opportunity to participate in your health care concerns and goals. We are committed to providing quality healthcare. In cases involving insurance, our staff can be invaluable in the processing and completion of appropriate forms. Our office may also assist you by verifying insurance benefits and explaining the particular financial responsibilities of your policy. This financial information form may answer many of your questions. Please feel free to ask about any information pertaining to billing and account activities. Kindly read this information carefully and sign where indicated below.

-All patients must complete our *patient information form*

- Professional fees for offices services is due at the time of service(except medicare).
- Payment of required insurance co-payments and deductibles are due at the time of service.

-A walkout statement receipt of payment is available following each visit. You may submit this form to your insurance company. If a check is issued to this office resulting in an overpayment on your account, you will receive a prompt refund.

- Fees for cosmetic procedures are payable in advance and due one week prior to surgery. A 50% surgery reservation deposit is required to schedule a surgery date.

-The surgical fee for all cosmetic procedures includes post-operative visits for one year from the date of surgery.

- Non-cosmetic surgery includes post-operative office visits for the specified global period of each procedure.
- Credit card payments on Visa/MasterCard/American Express/Discover are accepted
- Financing is available from care credit, capital one, and chase health care finance. please inquire with the bressler center staff for details.

ASSIGNMENT OF BENEFITS: I hereby authorize payment to be made directly toThe bressler Center of all benefits payable to me under the terms and conditions of my insurance policy with respect to professional services. I understand that insurance companies are quite different from one another and that Fred j. bressler, m.d., p.a., cannot predict if my insurance company will reimburse me for services performed. This is true even if the insurance company authorizes approval for surgery. Therefore, i understand that i am financially responsible for my account balance. In the case that my insurance company does not remit payment within 45 days, the claim will then become my responsibility.

CONSENTS FOR PHOTOGRAPHS/VIDEOS/COMPUTER IMAGING: I hereby give permissionfor photographic or video documentation taken during the course of consultation and treatment. Such photos remain the property of The Bressler Center and are a part of the permanent medical record. I understand that these photographs/videos may be used for, but not limited to, purposes of education, public relations, general information, books , scientific journals and lectures.

Additionally, the use of a computer-imaging device may be part of an office consultation. This adjunctive technique is utilized to facilitate an open discussion with the patient about external changes they may desire. I understand that because of significant individual characterisitics and the difference in how living tissue reacts to surgery, there may be no relationship between these images and the final surgical result.

Signature ____ **Date** _________________________________