# THE BRESSLER CENTER

## FACIAL PLASTIC SURGERY AND SKIN CARE

**SCHEDULED APPOINTMENT DATE:** ______________________________

**PATIENT INFORMATION**

**ACCOUNT #** (Leave Blank):

**NAME: (First):** ____________________ **(Last):** ____________________

**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:**

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

**PLEASE LIST KNOWN DRUG ALLERGIES:**

_______________________________________________________________________

**PLEASE LIST PREVIOUS SURGERIES OR MAJOR ILLNESSESS WITH DATES:**

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

**CHECK ANY COSMETIC TREATMENT YOU MIGHT LIKE TO DISCUSS WITH YOUR PHYSICIAN.**

- RHINOPLASTY
- FACELIFT
- NECK LIFT
- BLEPHAROPLASTY (EYELID LIFT)
- BROWLIFT
- CHEEK AUGMENTATION
- CHIN AUGMENTATION
- BOTOX
- DYSPORT (BOTOX ALTERNATIVE)
- RESTYLANE
- JUVEDERM
- RADIESSE
- SCULPTRA

**WHAT CONCERNS DO YOU HAVE REGARDING YOUR SKIN? (check all that apply)**

- BROWN SPOTS
- WRINKLES
- FACIAL HAIR
- ACNE SCARRING
- PHOTODAMAGE
- SAGGING SKIN
- LARGE PORES
- ROSACEA

**WHAT TYPE OF SKIN TREATMENTS INTEREST YOU? (check all that apply)**

- FACIAL PEELS
- MICRODERMABRASION
- SKIN TIGHTENING
- LASER HAIR REMOVAL
- DERMAPLANING
- PHOTOFACIAL (IPL)
- LASER RESURFACING
- WRINKLE REDUCTION

**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, 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 CONSENTS

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

**ASSIGNMENT OF BENEFITS:** I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO THE 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.

New Text

**CONSENT 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.

**CONSENT REGARDING WEB POSTINGS AND BLOG**: The integrity of your Protected Health Information (PHI) is important to us. You are hereby notified that any self-publication (including the posting, broadcast or transfer) of your PHI, that reveals or otherwise contains individually indentified provider information posted on a blog, internet website, or other printed/electronic form or forum, constitutes a waiver of any protections afforded such PHI under Health Insurance Portability Accountability Act of 1996, as well as any other applicable regulations, rules or laws. Further, any self-publication of your PHI permits provider to respond to the original publications to the extent necessary to defend, limit and challenge the factual assertions contained within such publications. Any and all comments and publications will be considered self-disclosed/waived protections of your PHI to the extent such publication is made.

**SIGNATURE** ________________________________________ **DATE** ____________________________