FUNK FACIAL PLASTIC SURGERY

FACIAL PLASTIC SURGERY

EAR, NOSE, AND THROAT SURGERY

SCHEDULED APPOINTMENT DATE:

PATIENT INFORMATION

NAME:

ADDRESS:

PHONE NUMBERS: HOME: WORK: MOBILE:

EMAIL:

PREFERRED METHOD OF CONTACT (CIRCLE ONE): (H) (W) (MOBILE) (TEXT MESSAGE) (EMAIL)

SOCIAL SECURITY NUMBER:

DATE OF BIRTH: AGE: SEX:

MARITAL STATUS: S M D W

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____PHONE:_____

CITY: _____STATE: _____ZIP: _____

PATIENT'S EMPLOYER: _____

POSITION: _____

LENGTH OF TIME WITH EMPLOYER: _____

0000

HOW DID YOU HEAR ABOUT US?

REFFERING PHYSICIAN:

PRIMARY CARE PHYSICIAN:

REASON FOR TODAY'S VISIT:

PLEASE CIRCLE AND ADD ANY MEDICAL CONDITIONS YOU MAY HAVE:

ALCOHOL/DRUGS
ANEMIA
ASTHMA
BLEEDING TENDENCY
CHRONIC FATIGUE SYNDROME
DIABETES
DIFFICULTY BREATHING THROUGH NOSE
EARACHES
HEADACHES
HEART ATTACKS
HEART TROUBLE
HEPATITIS A B C
HIV/ARC/AIDS
HIGH BLOOD PRESSURE
NASAL ALLERGIES
NOSE BLEEDS
FIBROMYALGIA
POST-NASAL DRAINAGE
PSYCHIATRIC ILLNESS
SCARRING / KELOIDS
SINUS INFECTIONS
SMOKING_____ PACKS PER DAY
SNORING
STROKE
ULCERS

PLEASE LIST CURRENT MEDICATIONS:
_____
_____
_____
_____

PLEASE LIST KNOWN DRUG ALLERGIES: _____

PLEASE LIST ANY SURGERIES OR OTHER MAJOR ILLNESSES:_____

CIRCLE ANY COSMETIC TREATMENT YOU MIGHT LIKE TO DISCUSS WITH DR. FUNK.

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

WHAT CONCERNS DO YOU HAVE REGARDING YOUR SKIN? (CIRCLE ALL THAT APPLY)

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

WOULD YOU BE INTERESTED IN DISCUSSING FINANCING OPTIONS SUCH AS CARE CREDIT FOR YOUR COSMETIC SURGERY? Y / N

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

SECONDARY INSURANCE INFORMATION:

INSURANCE COMPANY:_____

ADDRESS: _____

PHONE: _____

POLICYHOLDER:_____

I.D. NUMBER: _____

GROUP NUMBER: _____

GROUP NAME: _____

TYPE OF PLAN: HMO PPO POS MEDB MEDICAID PRIVATE

(CIRCLE ONE)

I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL INFORM 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 _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

PHOTOGRAPHIC AND VIDEOGRAPHIC 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 10% NONREFUNDABLE 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.
- THE FEE FOR ALL COSMETIC OR RECONSTRUCTIVE PROCEDURES IS NON-REFUNDABLE ONCE THE PROCEDURE HAS BEEN PERFORMED.
- NON-COSMETIC SURGERY INCLUDES POST-OPERATIVE OFFICE VISITS FOR THE SPECIFIED GLOBAL PERIOD OF EACH PROCEDURE.
- DR. FUNK MAY RECOMMEND SURGERY AT AN OUT OF NETWORK FACILITY IN WHICH HE IS A PARTNER. YOU AS THE PATIENT HAVE THE OPTION TO CHOOSE AN IN NETWORK FACILITY.
- CREDIT CARD PAYMENTS ON VISA/MASTERCARD/AMERICAN EXPRESS/DISCOVER ARE ACCEPTED
- IF THE ACCOUNT BECOMES DELINQUENT, I AM RESPONSIBLE FOR PAYING ALL COLLECTION COSTS AND/OR ATTORNEY'S FEES OR ANY ADDITIONAL FEES TO COLLECT THE DEBT

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO ETAI FUNK MD FACS PA 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 ETAI FUNK MD FACS PA, 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.

CONSENT FOR PHOTOGRAPHS/VIDEOS/COMPUTER IMAGING: I HEREBY GIVE PERMISSION FOR PHOTOGRAPHIC OR VIDEO DOCUMENTATION TAKEN DURING THE COURSE OF CONSULTATION AND TREATMENT. SUCH PHOTOS REMAIN THE PROPERTY OF ETAI FUNK MD FACS PA 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, WEBSITE PUBLICATION, 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 POSTING, BROADCAST, OR TRANSFER) OF YOUR PHI, THAT REVEALS OR OTHERWISE CONTAINS INDIVIDUALLY IDENTIFIED 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.

I UNDERSTAND THAT AS PART OF MY HEALTHCARE, THIS ORGANIZATION ORIGINATES AND MAINTAINS HEALTH RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION AND TEST RESULTS, DIAGNOSES, TREATMENT, AND ANY PLANS FOR FUTURE CARE TREATMENT.

I UNDERSTAND THAT THIS TREATMENT SERVES TO:

- CONDUCT, PLAN, AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THE TREATMENT DIRECTLY OR INDIRECTLY.
- OBTAIN PAYMENT FROM THIRD-PARTY PAYERS
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS

I UNDERSTAND THAT I HAVE THE RIGHT:

- TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS – AND THAT THE ORGANIZATION IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED.
- TO REVOKE THIS CONSENT IN WRITING, EXCEPT TO THE EXTENT THAT THE ORGANIZATION HAS ALREADY TAKEN ACTION IN RELIANCE THEREON.

SIGNATURE_____ DATE _____