KOLE PLASTIC SURGERY CENTER REGISTRATION FORM

Patient Information: Today's Date: _____

Who can we credit for your visit today? (Physician, friend, internet, etc..)	Primary Care Physicians Name and Address		
Patient Legal Name	Date of Birth	Sex Age	
Dr. Mr. Mrs. Miss Ms. please select by circling	Marital Status	Home Phone	
Address	City, State, Zip		
Cellular Phone	Email Address		
Employer	Occupation		Employer Phone
Employer Address			

Person Responsible for Payment/Policy Holder:

Legal Name (First, MI, Last)	Relationship	Date of Birth
Address (if different from above)	Home Phone #	SS#
City, State, Zip	Work Phone #	Occupation

Emergency Information: Relative/Friend, <u>not living with you</u>
(if we can't contact you or need to contact someone regarding your care in an emergency)

Contact Name	Phone #	Relationship to Patient
Address	City, State, Zip	

Insurance Information:

	Primary Insurance	Secondary Insurance
Insurance Carrier Name		
ID Number		

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Patient Name: _____ Age: _____ Height: _____ Weight: _____

Reason for Visit: _____ Referred By: _____

MEDICATIONS:

List all drugs you are taking including non-prescription, vitamins & herbals with dosages:

_____

_____

ALLERGIES:

List all drug allergies, food, tape, latex, or anesthesia reactions including post-operative nausea:

_____

_____

PERSONAL HISTORY:

Smoking (how much): _____ Alcohol or drugs (how much & how often): _____

PAST SURGICAL HISTORY:

List all operations (including plastic surgery) & serious injuries:

YEAR	OPERATION or MAJOR INJURIES	PHYSICIAN NAME

PAST MEDICAL HISTORY (Have you ever had the following)

	Yes	No		Yes	No		Yes	No
Migraine	☐	☐	Asthma or Lung Disease	☐	☐	Ulcers	☐	☐
Glaucoma or eye problems	☐	☐	Liver or Gastrointestinal problems	☐	☐	Irritable bowel	☐	☐
Cancer history	☐	☐	Heart disease or Angina	☐	☐	Hepatitis	☐	☐
Thyroid disease	☐	☐	Heart murmur	☐	☐	Gout	☐	☐
Received a blood transfusion	☐	☐	High blood pressure or Hypertension	☐	☐	Kidney Stones/Urine Infection	☐	☐
Diabetes	☐	☐	Anemia	☐	☐	Arthritis	☐	☐
Stroke	☐	☐	Bleeding Disorder	☐	☐	Skin Cancer	☐	☐
Emotional Disorders	☐	☐	Lyme Disease	☐	☐	HIV+ or TB	☐	☐

Other: _____

REVIEW OF SYSTEMS (Do you have any of the following)

	Yes	No		Yes	No
Dry Eyes	☐	☐	Palpitations	☐	☐
Dizziness/Blackouts	☐	☐	Daily Aspirin Use	☐	☐
Deafness	☐	☐	Vascular Disease	☐	☐
Cough	☐	☐	Abdominal Pain	☐	☐
Painful urination	☐	☐	Low blood sugar	☐	☐
Bruise easily	☐	☐	Depression	☐	☐

WOMEN ONLY

Number of pregnancies: _____

Number of living children: _____

Did you breastfeed? _____

Last Mammogram _____

Last Pap Smear _____

Breast lump or discharge ☐Y ☐N

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____

Signature of Patient or Parent Date

Kole Plastic Surgery Center

Patient Consent for Use and Disclosure or Protected Health Information

I hereby give my consent for the Kole Plastic Surgery Center to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare operation (TPO). The Kole Plastic Surgery Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Kole Plastic Surgery Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Kole Plastic Surgery Center's Privacy Officer at 1003 Street Road, Southampton, PA 18966.

With this consent, the Kole Plastic Surgery Center may send by regular mail or e-mail to my home or alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Kole Plastic Surgery Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to the Kole Plastic Surgery Center's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice had already made disclosures in reliance upon my prior consent.

If I do not sign this consent, or later revoke it, The Kole Plastic Surgery Center may decline to provide treatment to me. I have reviewed a copy of The Kole Plastic Surgery Center's Notice of Privacy Practices and was provided a copy if requested.

Preferences for Appointment Reminders

How would you like to be contacted?

☐ Email address: _____

☐ Telephone: Home: ( )_____ Cellular: ( )_____
May we leave a voicemail reminder about your upcoming appointment? ☐Yes ☐No

_____	_____	_____
Signature of Patient or Legal Guardian	**Print Name**	**Date**

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Name:_____

KOLE PLASTIC SURGERY CENTER FINANCIAL POLICY

We are here to assist you in any way we can in regards to your insurance coverage. However, due to recent insurance company changes and the multitude of plans, we may not be aware of the insurance regulations of every patient.

We do participate with many insurance companies such as Medicare, Aetna U.S. Healthcare, Keystone Health Plan East, Personal Choice and Blue Shield of PA as well as many others. However, some plans do not cover specialist consultations or office visits. It is your responsibility to know the benefits provided by your insurance. It is also your responsibility to know if you need a referral for your office visit.

Please understand that you are responsible for any deductibles, co-payments or non-covered services under your plan regardless of your insurance carrier.

If your insurance requires a referral, and you arrive at our office without one, your visit will have to be rescheduled. Please do not ask us to make any exceptions. We are restricted by your insurance company from providing services without the proper referral.

If you have forms to be completed by Dr. Kole for your employer, or disability insurance, there is a $15.00 fee and they will be completed within five business days.

A return check fee for any checks returned for any reason is from your bank is $25.00 in addition to the amount of the check.

Payment for services is due at the time of service. It is not our policy to bill for services rendered. Co-pays are due at the time of service. A $10.00 administration fee will be added to any co-pays that need to be billed. We accept cash, personal checks, Visa, Mastercard, Discover and American Express.

I understand the above and agree to abide by the regulations of my insurance company as well as the policies of The Kole Plastic Surgery Center.

My signature below will also serve as authorization to release information to my insurance company.

_____ _____

Signature of patient **Date**