AYDIN PLASTIC SURGERY PATIENT REGISTRATION

Date _____

Patient's Name _____
First Middle Last

Address: _____

Home Phone: _____ Cell Phone_____ Email: _____

Any restrictions for contacting you? Yes No Please list _____

DOB _____ Soc. Sec No.: _____ Sex: Female Male

Marital Status: _____ Race _____

Patient's Employer: _____ Occupation_____

Address: _____

INSURANCE INFORMATION – Please give your insurance card and ID to the Front Desk

_____
Primary Insurance Address of Ins. Co. Ins. Phone

_____
Subscriber's Name Subscriber's DOB Group No. Policy No.

Patient's relationship to subscriber (Circle One) Self Spouse Other_____

EMERGENCY CONTACT

Name_____ Relationship to Patient_____

Home Phone _____ Cell Phone_____ Work phone_____

Address:_____

PHARMACY INFORMATION

Name_____

Phone _____

Address:_____

How did you hear about us? Check one and please be as specific as possible

____Physician _____
____Magazine _____
____Radio/Pandora _____
____Instagram _____
____Google
____RealSelf

___Family Member/Friend _____
___Billboard _____
___Train/Bus _____
___Facebook _____

___Other _____

PROCEDURE YOU ARE INTERESTED IN? _____

Height _____ Weight _____

Patient Name: _____

What stage are you in the consultation process?

- ○ I am gathering information
- ○ I am sure I want the procedure. I am selecting the correct doctor for me
- ○ I know I want Dr. Aydin as my surgeon

I am interested in having my procedure: (month and year) _____

I am interested in learning more about financing my procedure (circle one) Yes No

OTHER AREAS OF INTEREST (please circle)

Botox/Fillers	Nose Surgery	Liposuction
Hair Removal	Facelift	Brachioplasty
Pigmentation/Spot Treatments	Eyelid Surgery	Thigh Lift
PhotoFacials	Brow Lift	Buttock Lift with Aug
Facial Skin Tightening	Chin Augmentation	Mommy Makeover
Facial skin lift	Breast Surgery	Cellulite Treatment
Skin Care/Anti-aging Products	Tummy Tuck	SculpSure Non-invasive Fat Reduction

MEDICAL HISTORY: It is important that you answer all of the following completely and honestly. Circle where appropriate.

Primary Care Physician _____ **PCP Phone** _____

Please list any Allergies/Sensitivities along with associated reaction _____

_____

Egg Allergies? Yes No **Milk Allergies?** Yes No

Have you been exposed to the sun in the past 3 weeks? Yes No

Have you been treated with chemical peels, lasers or Accutane? Yes No

Are you taking any medications at this time? Yes No

Please list all medications/supplements you take on a regular basis, including blood thinners such as aspirin, Motrin, fish oil, Plavix, etc: _____

_____

Do you smoke? Yes No **How Much?** _____

Alcohol Consumption? Yes No **How much?** _____

Coffee Tea Consumption? Yes No **How much?**_____

Are you on a restricted diet? Please explain:_____

Are you currently pregnant? Yes No **Are you currently breast feeding?** Yes No

Are you planning a pregnancy? Yes No

Please list your pregnancy history _____

Patient Name: _____

Please list your surgical history/complications _____

_____

Cardiac History – Please circle

Have you ever suffered from the following? Heart Attack Chest Pain Heart Disease
Stroke TIA (Mini Stroke) High Blood Pressure

Do you have a pacemaker? Yes No

Have you ever had: Cardiac Stents? Yes No **Bypass Surgery?** Yes No

Do you suffer from Asthma? Yes No **How is it managed?**_____

Have you ever suffered from DVT or Pulmonary Embolism (clots in lungs/legs)? Yes No

Do you suffer from Epilepsy or have ever experienced seizures? Yes No

Do you suffer from Diabetes? Yes No

How is your diabetes controlled? Diet Tablets Insulin injections

Please check any of the pertinent medical conditions/issues below:

Anemia	
Bleeding Tendency	
Cancer	
Leukemia	
Kidney Disease	
Liver Disease	
Multiple Sclerosis	
Depression	
Bipolar Disorder	
HIV/AIDS	
Colitis	
Tuberculosis	
Hepatitis	

Migraines	
Emphysema	
Hay Fever/Sinus Problems	
Recent Weight Change	
Change in appetite	
Wheezing/shortness of breath	
Swollen Legs/Feet	
Abdominal Pain	
Fatigue/Weakness	
Keloid Scarring	

Please list any other medical conditions and/or history that we should know about:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

***I hereby acknowledge that all of the above information has been answered honestly and to the best of my ability. I will update the doctor with any medical changes that may occur.**

Signature: _____ Date: _____

Printed Name: _____

***RELEASE OF MEDICAL RECORDS:** I hereby authorize Dr. Aydin to release my medical information to my insurance company if requested.

Signature_____Date: _____

***IF PATIENT IS A MINOR:**

I give permission for _____to receive treatment from Aydin Plastic Surgery
Name of Patient

Signature Parent or Guardian_____Date:_____

Patient Name: _____

PRIVACY PRACTICE AND ACKNOWLEDGEMENT

- I agree that I can be contacted regarding my appointments, prescription renewals, lab results, and all other Protected Health Information ("PHI"), at the telephone and/or emails provided.
- I understand that it is your policy to not reveal Protected Health Information ("PHI") on voicemail systems, with the exception of appointment reminders.
- I understand that it is your policy to email information and confirmation messages to the email address(es) I provided you. I also understand that this method of communication is not intended to communicate "PHI" with you.
- I understand that it is your policy, in compliance with the law, to reveal "PHI" with my other physicians.
- I understand that it is your policy not to reveal "PHI" to my spouse, partner, unless I enter his/her name below.
- I agree that my "PHI" may be shared with the following other people (please indicate relationship):

_____ ph (___)___ -____

_____ ph (___)___ - ____

_____ ph (___)___- ____

- I understand that it is your policy, when you receive telephone calls to discuss my medical care or test results, all callers, including myself, will have to supply information that uniquely identifies me, such as the last 4 digits of my social security and/or my birth date and that without such a match no "PHI" will be revealed.
- I understand that I can change any of the abovementioned agreement, at any time, by giving written notice.

I have read the above and understand the information above as it pertains to my privacy.

Patient Name (print): _____

Signature: _____ **Date :** _____

If the patient is a minor, the responsible parent or guardian must sign above and fill in the information below.

Parent/Guardian Name (print): _____ **Relationship:** _____

FINANCIAL AGREEMENT, CANCELLATION POLICY and CHARGE DISPUTE

I agree that I am responsible for all charges incurred at this office. I will be made aware of any charges prior to receiving any treatment. I acknowledge that your cancellation policy requires 24-hour notice for any appointment cancellations or rescheduling of my visits, after my initial consultation. If I do not give adequate notice, a $50 charge will be made to my credit card that is on file. This charge is considered valid and authorized without a signed charge slip. If a valid credit card is not on file, I will be billed and will pay this bill upon receipt. All outstanding balances must be paid prior to being given another appointment. I agree that any dispute regarding any charges will be addressed with Dr. Aydin's office directly and not my financial institution(s). This specifically means, that I will not attempt to resolve my dispute by reversing any credit card charges or cancelling any checks.

I have read the above and, am in agreement with the above policies.

Patient Name (print): _____

Patient Signature: _____ **Date:** _____

140 N. Route 17
Suite 200
Paramus, NJ 07652

311 North Street
Suite 103
White Plains, NY 10605

Photographic Consent

Date_____

Clinical Photography will be taken to track the progress of your care. These include pre-operative, operative and post-operative photographs and/or videos as deemed necessary for the complete documentation and illustration of the case involved. We reserve the right to refuse treatment in the event that you do not consent to these photos being taken. These photos will become a part of your confidential medical record.

It is understood that photos may appear in publications, conferences and/or the internet for the purposes of medical education, knowledge, research, advertising, trade, editorial usage, and any other lawful purposes, including but not limited to social media site, office photograph book, brochures, other internet exposure, or other advertising items. All images used for purposes other than the medical records are de-identified. Names are not used and as far as possible, identifying factors are masked.

- o I consent to having photos taken as part of my medical record _____ Initial
- o I consent to having my photos used in office only for the purpose of educating patients provided that they are de-identified and my name is not used. _____ Initial
- o I consent to having my photos used in publications for the purpose of education and advertising provided that they are de-identified and my name is not used. _____ Initial
- o I consent to having my photos used digitally in website, social media, internet exposure, and the like for the purpose of education and advertising provided that they are de-identified and my name is not used. _____ Initial

_____ (Print name)

_____ (Signed)

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any payments) under my health insurance policy or benefit plan to **Dr. Nebil Aydin** and **Aydin Plastic Surgery** (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service. It is specifically intended by this assignment of benefits to assign to the fullest extent permitted under the law any and all of my rights, including without limitation, the right of one or more of the Providers to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State law rules, regulations and requirements, (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator to timely produce or respond to requests (including appeals) for all information relating to any plan documents describing the rights under any insurance policy or benefit plan as required by any applicable Federal or State law, (iii) to endorse for me any checks made payable to me for benefits and claims collected toward my account, and/or (iv) to bring any appeal, lawsuit or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination of benefits under any insurance policy or benefit plan.

Should this assignment be prohibited under my policy/plan, please disclose to Provider in writing such anti-assignment provision, otherwise this assignment shall be effective notwithstanding any anti-assignment clause in any policy/plan.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including the Law Offices of Cohen and Howard) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits from any third-party payor under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and private health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPPA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: _____ Date: _____

Patient Signature: _____

AYDIN
CENTER FOR PLASTIC SURGERY
SKIN CARE AND LASERS

Patient Name _____ ***DOB*** _____ ***Date*** _____

YOUR FACE

1. When looking at my face in the mirror, I believe I look younger than, the same as, or older than my true age.

Younger than		True Age		Older Than
1	2	3	4	5

2. When looking at my face in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my age (including wrinkles, sagging skin, dark spots, etc).

Not Concerned		Somewhat		Very
1	2	3	4	5

3. What, if any, are the areas of your concern regarding your face?
   Of the areas you have checked off, how much to these areas bother you? On a scale of 1-5, 1 being not much, 5 being very much

- ○ Thin Lips _____
- ○ Sparse Eyelashes _____
- ○ Sagging skin _____
- ○ Lines between eyebrows _____
- ○ Lines in the forehead _____
- ○ Lines around the eyes _____
- ○ Lines around nose and mouth _____
- ○ Frown Lines _____
- ○ Bags under eyes _____
- ○ Dark circles under eyes _____
- ○ Rosacea _____
- ○ Broken capillaries_____
- ○ Uneven skin texture ____
- ○ Dark spots _____
- ○ Large Pores _____
- ○ Blackheads _____
- ○ Acne Scars _____
- ○ Acne _____
- ○ Freckles _____
- ○ Facial Hair

In office use only

- ○ **Visia® Skin Analysis Prepared by** _____
- ○ **Copy given to patient**