MATTHEW BRIDGES MD
FACIAL PLASTIC SURGERY

Patient Information

Referring Physician _____ Primary Care Physician _____

Patient's Full Name _____ Date of Birth _____

Marital Status: _____ Sex: □Male □Female Social Security _____

Address _____ Apt. # _____

City _____ State _____ Zip code _____

Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____

Email Address _____

Preferred Method of Contact □ Home Phone □ Work Phone □ Cell Phone □ Email

Pharmacy Name _____ Pharmacy Loc. & Phone# _____

Race _____ Ethnicity _____ Language _____

Emergency Contacts

Name	Relationship	Contact#

Responsible Party

If you are providing the information above for a patient under the age of 18 years old, please complete this section below:

Name _____ Relationship to Patient _____

DOB _____ Phone (__) _____

Address (If different from above) _____

Insurance Information

Primary Insurance Company _____ Policy ID# _____ Group# _____

Policy Holder's Name _____ DOB _____/_____/_____

Employer (If GHP) _____ Phone _____ Relationship to Patient. _____

Secondary Insurance Company _____ Policy ID# _____ Group# _____

Policy Holder's Name _____ DOB _____/_____/_____

Employer (If GHP) _____ Phone _____ Relationship to Patient _____

Is today's visit pertaining to a **motor vehicle accident or a worker's compensation injury?** ☐ **Yes** ☐ **No**

If you answer yes, please complete the following information:

Insurance Company Name _____

Agent Name/Contact Name _____ Phone (___) _____

Claims/Billing Address _____

Claim# _____ Date of Accident or Injury _____

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Please read, initial, and sign acknowledging that you have read and understand each policy below.

Acknowledgement of Financial Responsibility

_____I hereby authorize Commonwealth ENT Specialists, P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service, I understand that I am financially responsible for charges not covered by my insurance company. A photocopy of this authorization shall be valid as the original.

Referral Policy

_____If your insurance carrier requires a referral for you to see a specialist, it is your responsibility as the patient and insured party to contact your prima1y care office and notify them of your upcoming appointment with the Commonwealth ENT Specialists, at least 72 hours in advance so that an insurance referral can be generated in a timely manner. If no referral is provided, then the patient will be held responsible for any payment of services rendered.

Acknowledgement of Receipt of Notice of Privacy Practices

_____I acknowledge that I have received from the Practice a copy of a separate document, entitled, "Notice of Privacy Practices" which set forth this Practice's privacy practices and my rights regarding the privacy of my protected health information.

Consent for Use or Disclosure of Patient Information for the Purposes of Treatment, Payment, and Healthcare Operation

_____I hereby consent to Commonwealth ENT Specialists using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to cany out the Practice's healthcare operations. I also consent to Commonwealth ENT using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my protected health information for another provider or health care entity to conduct healthcare operations including but limited to quality assessment and reviewing the competence of healthcare professionals.

Patient's Consent for Provider to Disclose PHI to Authorized Persons

I hereby authorize you, my healthcare provider, to disclose any and all of my medical and protected health information (PHI) to the person(s) indicated below:

	Name	Relationship	Contact #
1.	_____	_____	_____
2.	_____	_____	_____

If you do not have anyone that you would like to have permission to, still sign and date below to acknowledge that you have read this.

_____ _____

Patient Name or Representative Date

_____

If a Representative signs, state the Representative Authority

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Cancellation and No-Show Fees for Doctor Appointments, Audiograms, VNG, Aesthetics and Surgery

Missed/Cancellation Appointment Policy: At Commonwealth Ear Nose and Throat Specialists and Facial Plastic Surgery, P.C., we are dedicated to serving our patients. It is our goal to service every patient in the same courteous manner; therefore, we require a **24 BUSINESS hour** notice prior to cancelling or rescheduling any appointments. If advanced notification is not given, Commonwealth Ear Nose and Throat Specialists and Facial Plastic Surgery, P.C., reserves the right to charge a cancellation fee (listed below). These fees are not covered by your insurance company. Under certain circumstances, Commonwealth Ear Nose and Throat Specialists and Facial Plastic Surgery also has the right to refuse care for future services and may result in being discharged from the practice.

Courtesy Reminder: Commonwealth Ear Nose and Throat Specialists and Facial Plastic Surgery, P.C., provides text, e-mail, and phone call reminders to its patients as a courtesy. In the event of issues or failure of technology, patients are still held responsible for attending their scheduled appointments.

Less than 24 business hour notice or No-Show:

Doctor Appointment: $75.00

Audiogram Appointment:$75.00

Esthetic Appointment: $75.00

VNG Appointment: $120.00

CANCELLATION/NO SHOW POLICY FOR SURGERY:

To consider the hospital staff and anesthesia staff, it is necessary for us to implement a cancellation/no show policy. If you need to cancel your surgery, we ask that you do so in a timely manner.

Cancellations less than seventy-two hours before surgery will be charged a two-hundred-dollar ($200.00) fee; this will not be covered by your insurance company.

Cancellations less than twenty-four hours before surgery will be charged a four-hundred-dollar ($400.00) fee; this will not be covered by your insurance company.

I have read, understood, and agree to the fees and payment obligations as listed above:

PRINT: _____ SIGN: _____ DATE: _____

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COLLECTIONS POLICY

Collection Agency/ Attorney Fees
In the event that your account is turned over to a collection agency or attorney, you agree that you will be responsible for a collection fee equal to 33.3% of the outstanding balance due on the date the account is turned over for collection.

Collection Costs
In the event that the account becomes delinquent and it is necessary to expend costs for the collection of the account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.

_____ _____

Patient/Responsible Party Signature Date

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Name_____DOB _____Age: _____
Referring Physician_____Primary Care Physician_____
Occupation_____Employer _____

Please specifically give the reason for your visit:_____
If your reason involves an injury, please describe the nature and give dates:_____

Do you currently have, or have you ever been treated for any of the following conditions:

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer Type:_____
- ☐ COPD or emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Gastroesophageal Reflux
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Low Blood Sugar
- ☐ Lupus
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ MRSA
- ☐ Nasal Obstruction
- ☐ Pneumonia
- ☐ Psychiatric Problems
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea
- ☐ CPAP
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Other:

In the past 6 months, have you experienced:

☐Weight loss ☐Chest Pain ☐Joint Pain
☐Nausea/Vomiting ☐Shortness of breath ☐Headaches
☐Fever/Chills ☐Nasal Obstruction ☐Depression
☐Night Sweats ☐Muscle weakness ☐Sore throat
☐Fatigue ☐Difficulty Swallowing ☐Heartburn

Social History

Do you currently use tobacco? ☐Yes ☐No
Packs per day _____How long? _____years
If you smoked previously, when did you quit? _____
Do you drink alcohol? ☐Yes ☐No
Indicate If drugs or alcohol ever posed a dependency problem for you: Drugs___Alcohol ___

SURGERIES ☐ Check if none
List all surgeries you have had, Including childhood surgeries such as tonsillectomy or ear tubes:

Surgery	Date	Surgeon/hospital

MEDICATIONS ☐ Check if none

List all medications you are currently taking (Including over the counter medicines, **aspirin or aspirin containing medicines, birth control pills, diet pills, Vitamin E, or** herbal preparations), along with the dosage and frequency:

Medication	Dosage	Duration (How long?)

ALLERGIES TO MEDICATIONS ☐ **Check if none**
List any medications to which you are allergic:

Medication	Type of Reaction

Do you or anyone in your immediate family have a history of bleeding problems? ☐No ☐Yes: explain, _____
Do you or anyone in your immediate family have a history of anesthesia reactions? ☐No ☐Yes: explain, _____
Do you have a history of bad scarring? ☐No ☐Yes: explain, _____
Are you pregnant or nursing? ☐No ☐Yes

For Office Use Only

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Cosmetic/Aesthetic Form

Name:_____Date: _____

What concerns do you have regarding your skin? (Check all that apply.)

____Acne
___Lines around mouth
___Wrinkles
___Photo-damage (sun damage)
___ Acne Scarring
___ Large Pores
____ Rosacea
____Sagging Skin/Volume Loss
____ Dullness
____ Brown Spots/ Pigmentation
____ Melasma
____ Texture

What products do you currently use as a skin care regimen?

Cleanser: _____
Eye Cream: _____
Retinol/Tretinoin: ___Yes ___No
Other: _____
Moisturizer:_____
Exfoliator: _____
If Yes, What% _____

Would you be interested in any of the following/ (Check all that apply)

- ☐ Botox/Dysport
- ☐ Sculptra Aesthetic
- ☐ Facial Fillers such as:
  - o Restylane/Juvéderm
- ☐ Nucil (for longer/thicker lashes)
- ☐ Lip Enhancement
- ☐ Skin Rejuvenation
- ☐ Facelift
- ☐ Browlift
- ☐ Eyelid Lift (Blepharoplasty)
- ☐ Nasal Surgery (Rhinoplasty)
- ☐ Mole Removal
- ☐ Facial Implants
- ☐ Other, Please Specify:
- ☐ _____

What cosmetic/aesthetic procedures, if any, have you had in the past? Were you pleased with the outcome? If not, why?

_____

_____

Would you like to be added to our e-newsletter list? _____Yes _____ No

For Esthetician Use Only:

Skin Type

I

II

III

IV

V

VI

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Photography Consent

I hereby authorize Matthew A. Bridges, M.D. and/or his staff to take pre-operative, intra-operative, and post-operative photographs(s) to assist in my evaluation and medical treatment. This is an additional form of documentation that corresponds with progress notes and/or operative reports.

Photographs may also be taken for additional procedures, such as but not limited to: Botox injections, injectables, skin care, peels, laser, etc. I understand these photos are protected under HIPAA guidelines and will not be released to anyone unless I give my written consent.

Agreement Concerning Computer Imaging

In the course of consultation, I may be shown pictures on a computer imaging device. This might include digital alteration of my photograph to discuss potential surgical changes. I understand that those pictures and alterations of those pictures are solely for the purposes of illustration and discussion. I understand that the outcome of the surgical procedure is directly related to my individual characteristics. I understand that because of the significant differences in how living tissue reacts to surgery, there may be no relationship between the electronic images and my final surgical results.

☐ I **am over eighteen (18) years of age,**

_____ _____

Signature Date

_____

Printed Name

☐ I **am a minor and my parent or guardian will sign this release on my behalf.**

_____ _____

Signature of Parent or Guardian Date

_____

Printed Name

_____

Relationship to Named Individual

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PATIENT CONSENT TO PHOTOGRAPHY AND AUTHORIZATION FOR USE OR DISCLOSURE FOR ACADEMIC PURPOSES

Patient's Name: _____ Patient's DOB: _____ MRN# _____

Terms of Patient Consent and Authorization

I hereby consent to myself/my child being photographed while at Commonwealth Ear, Nose, and Throat Specialists, P.C. ("Commonwealth"). The term "photograph" includes video, still photography, and sound transmission, in digital or any other format, and any other means of recording or reproducing images and/or audio. I hereby authorize the use or disclosure of the photograph(s) for all purposes related to academic and clinical research, clinical quality improvement, presentation materials for academia, medical association and journals, media, research, and education related to the foregoing, unless specified below.

I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to:

- Commonwealth affiliates, and contracted service, research, and academic organizations.
- Any and all entities dedicated to academia, clinical research, and clinical quality improvement, including, without limitation, medical associations and journals, even if not specifically associated with Commonwealth marketing.

This Authorization expires only upon revocation.

Patient Rights

- I may request cessation of photography at any time.
- I may revoke this Authorization, but I must do so in writing and submit it to the following address: Commonwealth Ear, Nose, and Throat Specialists, P.C., 1 Park West Circle, Suite 200, Midlothian, VA 23114.
- My revocation will take effect upon receipt, except that photograph(s) already released in good-faith reliance upon this Authorization will not be recalled.
- I may inspect or obtain a copy of the photograph(s) whose use or disclosure I am authorizing, upon request.
- I may refuse to sign this Authorization. My refusal will not affect my/my child's ability to obtain treatment or payment or eligibility for benefits.
- I have a right to receive a copy of this Authorization, upon request.
- Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by Virginia law and may no longer be protected by federal law governing protected health information (HIPAA).
- I understand that I will not receive any financial compensation and I hereby waive any right to compensation for the foregoing uses, even if the authorized party(ies) releasing the photograph receive compensation for such photos.
- I waive any liability and hold Commonwealth and its affiliates harmless from any injury that may result from pa11icipation in the photography production.
- I and my successors or assigns hereby hold Commonwealth, its employees, physician(s), agents, and its successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this Agreement/Consent to Photography and Authorization for Use or Disclosure for Academic Purposes.

TERMS AGREED TO AND CONSENT/AUTHORIZATION GIVEN BY:

Signature: _____ Date & Time: _____
(patient/parent/legal representative/spouse)

Print Name: _____
(patient/parent/legal representative/spouse)

*If signed by someone other than patient, indicate relationship to the patient: _____