CHAPIN
AESTHETICS

PLASTIC & RECONSTRUCTIVE SURGERY, P.C.

NAME: ______________________ **DATE OF BIRTH:** __________ **AGE:** __________

ADDRESS: ____

HOME PHONE: ____________________ **WORK:** ____________ **CELL:** ______________

EMAIL: ______________________ **SS#:** ____________________

PATIENT EMPLOYER: ____
EMPLOYER ADDRESS: ____
SPOUSE OR PARENT NAME: ____________________________________
REFERRING PHYSICIAN: ___________________________ **FAMILY PHYSICIAN:** ______________
NEXT OF KIN OR EMERGENCY CONTACT: ___________________ **PHONE:** ________________

ARE YOU THE PRIMARY CARDHOLDER? YES OR NO (PLEASE CIRCLE ONE)
***IF NO, PLEASE FILL OUT PRIMARY CARDHOLDERS INFORMATION BELOW UNDER PRIMARY INSURANCE INFORMATION**

PRIMARY INSURANCE INFORMATION

INSURANCE CO NAME: ___________________________ **PHONE:** ________________
INSURANCE ADDRESS: ____
ID#: ____________________ **GROUP #:** __________ **EFFECTIVE DATE:** ______________
NAME OF INSURED: ______________________ **BIRTH DATE:** ______________________
SS#: ____________________
RELATIONSHIP TO PATIENT: ____________________________________

ADDITIONAL (SECONDARY) INSURANCE INFORMATION

INSURANCE CO NAME: ___________________________ **PHONE:** ________________
INSURANCE ADDRESS: ____
ID#: ____________________ **GROUP #:** __________ **EFFECTIVE DATE:** ______________
NAME OF INSURED: ______________________ **BIRTH DATE:** ______________________
SS#: ____________________
RELATIONSHIP TO PATIENT: ____________________________________

INJURIES

WORKMAN'S COMPENSATION: YES OR NO
DATE OF INJURY: ______________________
PERSONAL INJURY? YES OR NO

AUTO ACCIDENT: YES OR NO
DATE OF INJURY: ___________________________
DATE OF INJURY: ___________________________

INSURANCE COMPANY: _____________________
ADDRESS: _________________________________
CITY, STATE, ZIP:_____________________________

CLAIM #: ____________________________
ADJUSTER: ___________________________
PHONE: ______________________________

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY & FRIENDS

I hereby authorize Chapin Aesthetics Center, Scott D. Chapin, M.D. Plastic & Reconstructive Surgery, P.C. Chapin Aesthetics to release my patient information described below to:

______ All of my family members
______ Spouse
______ Mother
______ Father
______ Children: ____
______ Other family members: ____
______ The following person: ____

DOCUMENTS/INFORMATION TO BE RELEASED: Appointment
______ dates/times relating to today's treatment. Biopsy/test
______ results relating to today's treatment. Other. Please
______ indicate: ____
______ You have my permission to leave messages regarding my treatment on my work and home answering machine.

PURPOSE OF DISCLOSURE (explain or indicate "at the request of the individual"):

______ At the request of the individual. ______ Other ____

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPPA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the expectations to the right to revoke and a description of how I may revoke this Authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

The Chapin Aesthetic Center
Scott D. Chapin, M.D. Plastic & Reconstructive Surgery, P.C.
253 West State Street
Doylestown, PA 18901

I understand that I am not required to sign this Authorization and that the Practice may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclose by the Recipient listed above and, in that case, will no longer be protected by HIPPA.

It is my responsibility to notify Dr. Chapin's office of any changes.

I hereby acknowledge receipt of a copy of this Authorization

____
Signature of Individual or Personal Representative

____
Description of Personal Representative's Authority

____
Date of Authorization

PATIENT ACKNOWLEDGMENT OF RECEIPT OF CHAPIN AESTHETICS CENTER, SCOTT D. CHAPIN, M.D. PLASTIC & RECONSTRUCTIVE SURGERY, P.C.'S NOTICE OF PRIVACY PRACTICES

By signing this acknowledgment, I am acknowledging that Scott D. Chapin, M.D. Plastic & Reconstructive Surgery, P.C. Chapin Aesthetics provided to me in information its "Notice of Privacy Prac-tices."

I was given the opportunity to ask questions about the Practice's privacy practices and my ques-tions were answered.

I received a copy of the Practice's "Notify of Privacy Practices."

Signed by: ______________________________ ______________________
Description of Personal Representative's Authority | Relationship to Patient

______________________________ ______________________
Patient's Name (print) | Date

______________________________ ______________________
Witness | Date

PLASTIC & RECONSTRUCTIVE SURGERY, P.C.

Scott D. Chapin, M.D
253 West State Street
Doylestown, PA 18901

PATIENT RELEASE

“I authorize the release of any medical information necessary to process this claim. In addition, I request payment of due benefits to the above named physician for the services rendered.

I understand that it is my responsibility to request a referral, if applicable, prior to my appointment. I also agree to pay any deductible , co-payment or coinsurance applied by my insurance company, in addi-tion to, any uncovered service rendered by Dr. Chapin.

I agree to have my photographs taken and released when required for payment for medical claims; in addition, I authorize the physician to use my photographs in medical settings when appropriate, or, re-quired for medical treatment.

______________________________ ______________________

Insured or Authorized Person Date

MEDICARE PATIENT RELEASE

“ I request that payment of authorized Medicore benefits be made either to me or on my behalf to Plastic and Reconstructive Surgery, P.C. , Scott D. Chapin, M.D. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the HealthCare Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.”

I agree to have my photographs taken and released when required for payment of medical claims, in addition I authorize the physician to use my photographs in medical settings when appropriate, or, required for medical treatment.”

Signature	Date

COSMETIC INTEREST QUESTIONNAIRE

NAME: ____

E-MAIL: ____

PHONE: ____________________________________

Chapin Aesthetics is constantly striving to offer you the safest most advanced procedures for facial reju-venation, body contouring, and overall physical improvement. Please check any of the following topics you would like to receive more information about. We will make sure to contact you regarding your interest.

( ) Breast Augmentation
( ) Breast Lift
( ) Tummy Tuck
( ) Liposuction
( ) Smartlipo
( ) Rhinoplasty
( ) Eyelid Surgery
( ) Facelift
( ) Forehead/Browlift
( ) Trunklift/Bodylift
( ) Arm Lift
( ) Cellulite Reduction
( ) Erbium Skin Resurfacing
( ) Botox Cosmetic
( ) Dermal Fillers
( ) Chemical Peels
( ) Acne
( ) Microdermabrasion
( ) Skin Rejuvenation
( ) Spider/Varicose Veins
( ) Age Sports
( ) Facial Pigmentation
( ) Laser Hair Removal
( ) Tattoo Removal

May we contact you with information about your expressed area of interest? ( ) YES ( ) NO

How did you hear about our practice? Please check all that apply.

( ) A friend or family members (please name) ____

( ) Interest (list search engine, website, etc) ____

( ) Physician or Hospital referral (please name) ______________________________________

( ) Advertisement ____

( ) other ____

Would you like to receive our eblasts, newsletters or information for special events via email? ( ) YES ( ) NO If yes, please list email address ____

Sign: ____________________________________ Date: ______________________

SCOTT D. CHAPIN M.D., F.A.C.S

CANCELLATION POLICY

Chapin Aesthetics strives to render excellent medical care to you and the rest of our patients. The cancellation policy enables us to better utilize available appointments for our patients in need of care.

Cancellation of an Appointment
If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance; certainly calling earlier in the day is most appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to a timely service.

How to Cancel Your Appointment
To cancel appointments, please call 267.880.0810. If you do reach the receptionist you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

No-Show Policy
Clients who miss appointment without canceling at least 24 hours in advance are considered “no-shows.” A “no-show” will result in a fee of $100 billed to the patients account.

Confirmation Calls
As as a courtesy we do make confirmation calls for appointments. Please provide us with accurate information so that you may be contacted in acceptable manner. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

Thank you from Our Staff at Chapin Aesthetics