



**Patient Information – Update Packet**

Full Name: \_\_\_\_\_ She/He/They (Circle One)

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Sex at birth (F / M) : \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number (Cell): \_\_\_\_\_ (Home): \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**For Office Use Only:**  
BMI \_\_\_\_\_  
BSA \_\_\_\_\_  
Schnur Scale  
\_\_\_\_\_

**What is the reason for your upcoming consultation?**

\_\_\_\_\_

Have you consulted any other physician/provider for this? **Yes** **No**

What additional services would you like to learn about? Please check all that apply.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Brow Lift                  | <input type="checkbox"/> Breast size                 | <input type="checkbox"/> Thin lips              |
| <input type="checkbox"/> Drooping eyelids           | <input type="checkbox"/> Breast shape                | <input type="checkbox"/> Skin care products     |
| <input type="checkbox"/> Under eye bags             | <input type="checkbox"/> Breast implant correction   | <input type="checkbox"/> Brown spots/age spots  |
| <input type="checkbox"/> Nose size or shape         | <input type="checkbox"/> Breast reconstruction       | <input type="checkbox"/> Laser hair removal     |
| <input type="checkbox"/> Facial fullness/drooping   | <input type="checkbox"/> Tummy tuck                  | <input type="checkbox"/> Aesthetician – facials |
| <input type="checkbox"/> Mole removal               | <input type="checkbox"/> Upper arm lift              | <input type="checkbox"/> Micro-needling         |
| <input type="checkbox"/> Facial fine lines/wrinkles | <input type="checkbox"/> Thigh lift                  | <input type="checkbox"/> Acne                   |
| <input type="checkbox"/> Ear size or shape          | <input type="checkbox"/> Butt lift or enlargement    | <input type="checkbox"/> Dermal Filler          |
| <input type="checkbox"/> Red or raised scars        | <input type="checkbox"/> Liposuction or fat transfer | <input type="checkbox"/> Neurotoxin injection   |
| <input type="checkbox"/> Vaginal rejuvenation       | <input type="checkbox"/> Other: _____                |   |

**Primary Care Physician/Provider**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**\*Do you see any other specialist providers to manage your health? Yes No**

(Example: Cardiology, Endocrine, Neurology, Pain management, etc.)

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Pharmacy Information**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**\*Do you consent for us to pull your medication history from all outside providers for your safety? Yes No**

**Emergency Contact Information**

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone

Number: \_\_\_\_\_

**Communication Authorization**

Please contact me regarding my treatment and care at the following number(s):

Cell: \_\_\_\_\_

Home: \_\_\_\_\_

Please contact me regarding my treatment and care at the following email:

\_\_\_\_\_

YES, it is ok to leave information on voicemail & receive text messages/emails.

NO, do not leave information on voicemail or receive text messages/emails.

**Health Habits:**

Consumption of the following?

<b>Aspirin</b>	YES	NO	Amount Daily? _____
<b>Alcohol</b>	YES	NO	Amount Daily? _____
<b>Tobacco</b>	YES	NO	Amount Daily? _____
<b>Have you smoked in the past?</b>	YES	NO	Amount Daily? _____ # of years smoked? _____
<b>Recreational drugs</b>	YES	NO	Amount Daily? _____

**Patient Name (Print):** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Plastic Surgical History**

Operation	Date	Complications?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Other Surgical History**

Operation	Date	Complications?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medications, Vitamins, & Herbal Supplements**

Medication Name	Dose	Taken How Often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Weight loss medications?  Y or  N Name of medication: \_\_\_\_\_

Patient Name (Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Allergies** (Medications, Substances, Foods, etc.) - Please list reaction with allergy

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<b>YES</b>	<b>NO</b>	Aspirin	<b>YES</b>	<b>NO</b>	Demerol	<b>YES</b>	<b>NO</b>	Erythromycin
<b>YES</b>	<b>NO</b>	Iodine	<b>YES</b>	<b>NO</b>	Penicillin	<b>YES</b>	<b>NO</b>	Sulfa drugs
<b>YES</b>	<b>NO</b>	Tape	<b>YES</b>	<b>NO</b>	Latex	<b>YES</b>	<b>NO</b>	Morphine

**Medical History**

**Personal Medical History** (please circle)

<b>YES</b>	<b>NO</b>	Abnormal bleeding	<b>YES</b>	<b>NO</b>	MRSA	<b>YES</b>	<b>NO</b>	Stomach ulcers
<b>YES</b>	<b>NO</b>	Heart murmur	<b>YES</b>	<b>NO</b>	Heart disease	<b>YES</b>	<b>NO</b>	Chest pain
<b>YES</b>	<b>NO</b>	Artificial valves	<b>YES</b>	<b>NO</b>	High blood pressure	<b>YES</b>	<b>NO</b>	Glaucoma
<b>YES</b>	<b>NO</b>	Asthma	<b>YES</b>	<b>NO</b>	Abnormal clotting	<b>YES</b>	<b>NO</b>	Cancer
<b>YES</b>	<b>NO</b>	Post-op nausea/vomiting	<b>YES</b>	<b>NO</b>	Previous surgical infection	<b>YES</b>	<b>NO</b>	Chemo/Radiation
<b>YES</b>	<b>NO</b>	Diabetes	<b>YES</b>	<b>NO</b>	Pacemaker/ICD	<b>YES</b>	<b>NO</b>	HIV
<b>YES</b>	<b>NO</b>	COPD/Emphysema	<b>YES</b>	<b>NO</b>	Seizures	<b>YES</b>	<b>NO</b>	Hepatitis B or C
<b>YES</b>	<b>NO</b>	Excessive sweating	<b>YES</b>	<b>NO</b>	Sinusitis	<b>YES</b>	<b>NO</b>	Stroke
<b>YES</b>	<b>NO</b>	Fever blisters	<b>YES</b>	<b>NO</b>	Skin condition	<b>YES</b>	<b>NO</b>	Migraines
<b>YES</b>	<b>NO</b>	Sleep apnea	<b>YES</b>	<b>NO</b>	Neck injury/surgery	<b>YES</b>	<b>NO</b>	Depression/Anxiety

Please explain any of the selections above: \_\_\_\_\_

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Please list below any other medical problems or medical conditions:

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**Patient Name (Print):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Bleeding Problems** (please circle)

Do you bruise or bleed easily? **Yes** **No**

Do you have a family history of bleeding problems? **Yes** **No**

Explain: \_\_\_\_\_

Have you ever had a blood transfusion? **Yes** **No**

**Female Patients:**

Are you /could you be pregnant? **Yes** **No**

# of pregnancies? \_\_\_\_\_ # of children? \_\_\_\_\_ # of breastfed children? \_\_\_\_\_

Approximate date of last mammogram? \_\_\_\_\_ Normal? \_\_\_\_\_ Abnormal?

If considering breast surgery, what is current bra size? \_\_\_\_\_

It is mandatory and medically necessary for patients who smoke to **QUIT A MINIMUM OF TWO WEEKS PRIOR TO SURGICAL PROCEDURES AND A MINIMUM OF TWO WEEKS AFTER THOSE PROCEDURES**; please discuss with surgeon if you cannot refrain from smoking or need assistance with cessation.

\_\_\_\_\_ YES, I can refrain from smoking \_\_\_\_\_ NO, I cannot refrain from smoking

*I affirm that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name (Print):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

## INSURANCE CONSENT TO RELEASE INFORMATION

I \_\_\_\_\_ (**name of patient**), give Coastal Cosmetic Center, PA/Coastal Surgery Center permission to release my medical records and photos to my insurance company if needed to help my case get authorized and approved for billing purposes. I give permission to release any information concerning the status of my health care including appointments, test results, photos, and operative notes to them if needed for medical necessity.

**Consent -- Patient Signature:** \_\_\_\_\_

Date: \_\_\_\_\_

### Insurance Information Questionnaire

Although your procedure may be cosmetic and not covered by insurance, Coastal Cosmetic Center requests to have your insurance information on file in the event you have a procedure eligible for insurance coverage in the future.

**Primary Insurance Company:** \_\_\_\_\_ Ph # \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of the Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber's Birthday: \_\_\_\_\_

**\*Secondary Insurance Company:** \_\_\_\_\_ Ph # \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of the Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber's Birthday: \_\_\_\_\_

### ACCIDENTS/INJURIES

Is your visit due to an injury? (circle one)      **YES**      **NO**

If yes (circle one):    **Work Injury**      **Auto Accident**      **Other** (please specify): \_\_\_\_\_

Where did your injury occur?    \_\_\_ Home    \_\_\_ Work    \_\_\_ Other (please specify): \_\_\_\_\_

Date of Injury: \_\_\_\_\_      Type of Injury: \_\_\_\_\_

Claims #: \_\_\_\_\_      Auto Adjuster: \_\_\_\_\_      Ph # \_\_\_\_\_

Workman's Comp Carrier: \_\_\_\_\_      Ph # \_\_\_\_\_

Workman's Comp Address: \_\_\_\_\_

**Patient Name (Print):** \_\_\_\_\_      **Date of Birth:** \_\_\_\_\_

## Patient Health Information Authorization and Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

### Information Disclosure Authorization

I \_\_\_\_\_ (**name of patient**) hereby give authorization to Coastal Cosmetic Center/ Coastal Surgery Center for the release of information concerning the status of my health care including appointments, test results, and operative status on surgery day.

- |  |                         |
|--|-------------------------|
| 1) _____   | _____                   |
| Name of authorized individual (i.e. friend or family member) | Relationship to patient |
| 2) _____   | _____                   |
| Name of authorized individual (i.e. friend or family member) | Relationship to patient |
| 3) _____   | _____                   |
| Name of authorized individual (i.e. friend or family member) | Relationship to patient |

Patient Name (Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

# Financial Disclosure and Authorizations

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

## Patient Identification

A current government issued photo ID, secondary ID with name, and insurance card (if you are requesting us to bill insurance) must be present at the initial visit. Failure to provide either of these may require us to collect our standard billed charges accrued on the day the services were rendered rather than the patient's out of pocket fees. It is our practice policy to photo copy your ID and insurance card(s) for our files. Patients must fill out patient information forms prior to seeing the physician.

## Referrals

If your insurance plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be required to pay for the services rendered at the time of service.

## Expected Amount Due

By law we must collect your carrier designated co-pay/co-insurance and/or deductible. This payment is expected at the time of service. Please be prepared to pay the expected amount due at each visit. We will not bill an insurance company if we do not have a copy of your current card and valid photo ID at the time of visit. We bill primary and secondary insurance only as a courtesy. If we are unable to verify your benefits, then you will be responsible for following up with your insurance company.

## Medicare

We will submit claims to Medicare for covered services. The patient will be responsible for the deductible and the 20% co-insurance for covered services, which can be billed to secondary insurance if you have one.

## Medicaid Recipients

Our practice does not participate with these programs; therefore, you are responsible for the services rendered.

## Consult Photos

Photos of the patient will be taken at consultation of the area in which you are requesting a consultation. These photos are specifically for before and after purposes and will not be used unless approved by you, the patient, during your preoperative visit should you choose to pursue surgery with Dr. Timothy Fee, MD, FACS.

## Follow Up Care

If you have a surgical procedure that is billed to your insurance company, that procedure could include up to 90 days of follow-up care dependent on the performed treatment. If you are seen for a condition other than the one treated, your insurance company may be billed for this added condition and in turn, you could be billed for the out-of-pocket fees.

## Out-Of-Network Plans

You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges, if the UCR is in accordance with the American Medical Associations Guidelines. Most patients will be responsible for their co-pay, co-insurance, and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 90 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the appropriate provider's office.

Patient Name (Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Patient Balances**

Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. All arrangements made for services will require an agreement signed by both patient and administrative staff. In the event you default on your account, collection proceedings will begin, and you will be responsible for any additional collection charges incurred.

**Short-Term Disability (STD) or Family Medical Leave Act (FMLA) Paperwork**

Effective November 1, 2012, there will be a \$25.00 fee for each disability and FMLA paperwork that requires our physician and/or staff to complete on your behalf. Unfortunately, due to the time-consuming nature of these forms, we have no choice but to impose this fee. Please feel free to speak with one of our staff members if you have questions regarding this matter.

**Plastic and Reconstructive Procedures**

Your insurance company requires that we bill our services to you using a coding system known as a CPT (Current Procedural Terminology). Many codes that surgeons use to describe the services performed are found in the "surgery" section of the CPT code book. This does not mean that you had an operation. This is merely the way the CPT book is organized for ease of use by both the insurance companies and physicians. Your Insurance Company may cover the care rendered for "surgical" codes differently than for office visits. Therefore, your insurance explanation of benefits may reflect that the service was paid as a surgical procedure, with deductible and coinsurance guidelines applied. We encourage all of our patients to check with your insurance company and verify your benefits. If a service is not covered by your insurance and you are billed for the service, your timely response to the bill is imperative due to filing limits. Should you request further appeal by our office, you acknowledge that our collection efforts are a courtesy and that you are ultimately responsible for the services rendered. You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges incur as a result of this.

We accept **cash, checks, Master Card, Visa, American Express, Discover, Care Credit and Alphaeon Credit**. **Fees:** There will be a 3.95% fee for any debit or credit card transactions. This fee is waived when paying ACH, cash, or check. **REFUNDS:** Payments made with cash or checks are refunded by check. Payments made by credit card are refunded to the same credit card used for payment. When using **Care Credit or Alphaeon** you can only make changes to the purchase within **30** days of the purchase date.

Thank you for taking the time to review our policies, please feel free to ask any questions or share with us any concern you might have.

**I have read and fully understand the above and authorize payment of the insurance benefits directly to Coastal Cosmetic Center/Coastal Surgery Center and Dr. Timothy Fee. I realize that I am responsible for any charges not covered by insurance. The signature furnished below shall suffice for all insurance forms on a continuing basis.**

**Patient/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Patient Name (Print):** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

## Authorization For the Use of Photographs

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

For various reasons, Timothy E. Fee, M.D., Jordan Bilezikian, M.D., are often asked to show before and after photos of patients. Many patients have given their permission to use their photos anonymously. We now ask that you do so as well.

### Consent for use of Before & After Photos

I understand pre- and post- treatment pictures will be obtained for medical records. **Initial:** \_\_\_\_\_

I hereby authorize Coastal Cosmetic Center to use my photos in their before and after presentation to other patients interested in the same procedures including but not limited to showing these images in-office, print, internet, social media, and electronic digital networks. I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all representations, including patient discretion by removing any identifying marks / features to maintain anonymity.

Consent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Refusal Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**For Office Use Only: Staff Witness Signature -** \_\_\_\_\_

**Patient Name (Print):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_