THOMAS TREY SANDS, M.D.

REGISTRATION ADDITIONS & UPDATES

Date _____

PATIENT INFORMATION

Full Last Name	First	Full Middle	Maiden	Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐
Street Address				Other Title _____
City	State / Country	Zip	Home Telephone No. (Area Code) ( )	
Pager No. ( )	Cell Phone No. ( )		Social Security Number	
E-Mail Address	Religious Preference		Date of Birth	Sex / Marital Status

PATIENT EMPLOYMENT INFORMATION

Employer Name	Occupation	Work Telephone Number ( )
Street Address	City	State / Zip

RESPONSIBLE PARTY INFORMATION - PERSON TO WHOM BILL IS TO BE SENT (IF MINOR, LEGAL GUARDIAN)

Last Name / First / Middle	Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐	Social Security No.	Home Telephone Number ( )
Street Address		Date of Birth	Relationship to Patient
City	State / Country		Zip
Employer Name	Occupation		Work Telephone Number ( )
Street Address	City		State / Zip

NEAREST RELATIVE OR EMERGENCY CONTACT

Last Name / First / Middle	Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐	Relationship
Address	City / State / Zip	Telephone Number ( )
Employer		Telephone Number ( )

Referred by: _____

AUTHORIZATIONS

Name: _____

Authorization is hereby granted to release to the respective insurance company (companies) and when applicable to the Social Security Administration and Health Care Financing Administrator or its intermediaries or carriers, (or to the billing agent or supplier), such information as may be necessary for the completion of insurance claims.

I hereby authorize the respective insurance company (companies) to pay directly to Thomas T. Sands, MD all medical benefits under my insurance policy (policies) including major medical benefits.

I permit a copy of this authorization to be used in place of the original

Primary Insurance Company: _____

WAIVER OF USUAL, CUSTOMARY AND REASONABLE CLAUSES

I understand that charges may be in excess of Usual, Customary and Reasonable insurance plan coverage I may have. In such events, unless a contractual arrangement exists between Dr. Sands and my insurance company, I agree that I will pay the fees in full, even though the amount may be greater that what I may be entitled to receive from my insurance company. Any balance upon the bill which is not expected to be reimbursed by insurance shall be payable by me.

_____ _____

Date *Patient/Debtor Signature*

PATIENT'S RIGHTS AND RESPOSIBILITIES

Patient's Rights

- You have the right to privacy and confidentiality regarding your office visits and records.
- You have a right to adequate education and counseling regarding your medical condition.
- You have the right to have all procedures, risks, benefits and alternatives explained and your questions answered in lay language.
- You have the right to have medications' effectiveness and possible side effects explained to you.
- You have the right to see results of tests and have the meaning of tests explained.
- You have the right to participate in decisions made regarding treatments, medications, procedures and surgery.
- You have the right to refuse treatment to the extent permitted by law and the right to receive information on alternatives and consequences of refused treatment.
- You have the right to view your medical records and have them explained.
- You have the right to have all fees explained.
- You have the right to decide whether or not to participate in clinical research studies.

Patient's Responsibilities

- Patients have the responsibility to give honest, accurate and complete medical history information.
- Patients have the responsibility to make sure they understand what the doctor is saying and if not, ask questions for clarification.
- Patients have the responsibility to follow their doctor's medical advice and instructions.
- Patients should report any significant changes in their health to their doctor.
- Patients should respect office policies and procedures.
- Patients should keep appointments or cancel in advance.

PATIENT'S SIGNATURE: _____ **DATE:** _____

THOMAS TREY SANDS, M.D.
3100 Galleria Drive, Suite 302, Metairie, LA 70001

OFFICE POLICY REGARDING PERSONAL HEALTH INSURANCE AND FINANCIAL POLICY

(Please read and Sign)

Aesthetic (Cosmetic) Surgery

These procedures are not covered by Insurance; therefore they must be prepaid in full two weeks prior to surgery. A $300.00 non-refundable deposit is required to reserve your surgery date.

Personal Health Insurance

Patients who have medical or surgical insurance whether it is an indemnity, PPO, POS, HMO, Managed Care plan, Affordable Care Act insurance or supplemental health insurance will be fully responsible for the **total fee** of any **cosmetic procedure** quoted to you by the patient coordinator. We will verify coverage of benefits as well as payment of premiums by the patient. If patient is delinquent in their premiums payment to their insurance company, we will cancel all non-emergency procedures until we get your insurance verification that your premiums have been satisfied. We will make every attempt to **pre authorize** any non cosmetic surgery, and we will find out if your surgery is a covered procedure under your plan. We will also **pre certify** your hospital admission or out-patient procedure. Pre-certification means that your insurance company allows your admission as a medical necessity but does not mean they will pay for your surgery. **Pre certification and pre-authorization are not a guarantee of payment. You are responsible for the total fee quoted to you, if your insurance denies coverage after the procedure is performed. Please remember your insurance contract is between the patient and the insurance carrier, not with the physician. If your surgical procedure is being pre certified and you choose to schedule your surgery prior to having the authorization; we will not file with your insurance afterwards, even if the surgery is approved.**

Your insurance company may have a standard fee that will pay for any specific surgical procedure. This **usual and customary** fee is a fee that is generated by your insurance company. This is what they are willing to pay for that specific surgical procedure. You are responsible for the fee quoted by our patient coordinator. You need to cooperate with our office staff to expedite the precertification and pre authorization process as well as take active participation in the payment of your bill by your insurance carrier. **Any appeals before or after surgery are your responsibility, but we will assist you with the information and the paperwork necessary.** There is a fee associated with the appeal and you will be notified prior as what the cost will be.

I have read and understand this policy and will fully cooperate with the office staff.

Patient's Signature_____ Witness_____

Date: _____

THOMAS TREY SANDS, M.D.
3100 Galleria Drive
Suite 302
Metairie, Louisiana 70001

Plastic Surgery Payment Policy

We will collect all insurance co-payments and/or deductibles prior to surgery for all procedures covered by your insurance. Patients should check the benefits with their insurance company prior to their pre operative visit with their physician, and also check with your insurance if Dr. Sands is a participating provider with your insurance plan.

The patient will be responsible for pre payment of any deductibles, co-payments for the physician as well as your hospital and or facility, at the time of your pre-operative visit. These fees are only an estimate since the insurance company may not give us their allowable fees for the surgical procedure.

We will submit all claim forms for the surgical procedures but the patient is responsible for their total bill.

Deductible not met: _____

Estimated Physician's Co-Pay: _____

Cosmetic Procedures: _____

Total: _____

All fees are due at the time of your preoperative visit on _____

I have read the above information, and understand the policy.

Patient's Name: _____

Patient's Signature: _____

Witness: _____

Date: _____

PLASTIC SURGERY

THOMAS TREY SANDS, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY

Telephone #: 504-888-4297 Fax #: 504-456-2502

RELEASE OF MEDICAL RECORDS

To: _____

_____

_____

I, _____, authorize the release of my medical records regarding any or all treatments and/or consultations, operative reports, pathology reports for _____

_____

To Thomas Trey Sands, M.D.; 3100 Galleria Drive, Suite 302, Metairie, Louisiana, 70001.

SIGNATURE: _____

PATIENT'S NAME: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

DATE OF BIRTH OF PATIENT: _____

DATE: _____

PLASTIC T SURGERY

THOMAS TREY SANDS, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY

I hereby grant Thomas Sands,M.D.permission to for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination testing, credentialing and/or certifing purposes by The American Board of Plastic Surgery, INC.

Patient's Name: _____

Patient's Signature:_____

Witness Signature:_____

Date:_____

Thomas T. Sands,M.D.

NOTICE OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES*

Thomas T. Sands, MD
3100 Galleria Drive
Suite 302,
Metairie, Louisiana 70001

I hereby acknowledge that I have received the Notic e of Privacy Practices from your office, the practice of Thomas Sands,M.D..

Patient signature:

_____ _____
Date

Printed name of patient:

_____