

South Shore Cosmetic Surgeons, LLC

Patients Name

Last

First

Middle

Address:

Street & Apt #

City

State

Zip Code

Home Phone #: _____ **Cell Phone #:** _____ **Other Phone #:** _____

Referred By: _____ **E-Mail:** _____

Age _____ **Date of Birth:** _____ **Sex Assigned at Birth:** ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married to: _____ ☐ Other: _____

Any restrictions for contacting you? ☐ Yes ☐ No **Contact Restrictions:** _____

Patient's Employer _____ **Occupation** _____

Address:

Street & Apt #

City

State

Zip Code

Work Phone: _____ **Ext:** _____ **Is it okay to contact you at work?** ☐ Yes ☐ No

Primary Health Insurance Company _____

Insured Name: _____ **Insured Date of Birth:** _____

Policy/ ID #: _____ **Group #:** _____

Referral Required? ☐ Yes ☐ No **Copay?** ☐ Yes ☐ No **If yes, how much? \$** _____

Secondary Health Insurance Company _____

Insured Name: _____ **Insured Date of Birth:** _____

Policy/ ID #: _____ **Group #:** _____

Referral Required? ☐ Yes ☐ No **Copay?** ☐ Yes ☐ No **If yes, how much? \$** _____

Emergency Contact _____ **Relationship to Patient:** _____

Home Phone #: _____ **Cell Phone #:** _____ **Other Phone #:** _____

I authorize South Shore Cosmetic Surgeons, LLC to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between South Shore Cosmetic Surgeons, LLC and myself. I authorize the release of any medical information necessary to process claims and payment from my insurance company to be made directly to South Shore Cosmetic Surgeons, LLC. Office visits for self-paying patients are to be paid the day the service is rendered to me.

** Medicare patients are responsible for the difference between Medicare's reimbursement and Medicare's approved fee (which is about 20% of the fee), as well as non-approved fees. **

Signature _____ **Date:** _____
(Parent/Guardian signature, if patient is a minor)

Name of Signee _____ **Date:** _____

South Shore Cosmetic Surgeons, LLC - Health Questionnaire

Name: _____ Referred By: _____

Primary Physician & Location: _____

Reason(s) for seeing Doctor today: _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

List all hospitalizations, operations (including plastic surgery) and serious injuries within the last 10 years:

<u>Year</u>	<u>Hospitalization; Operation/Injury</u>	<u>Hospital & Location</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

ILLNESS & MEDICAL PROBLEMS

	Yes	No		Yes	No		Yes	No
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>
Ear Trouble	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bowl Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Constant Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Nose Blockage	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Convulsion/ Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in Neck	<input type="checkbox"/>	<input type="checkbox"/>	Bleed Easily	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Ankles Swell	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY

	Yes	No		Yes	No	Family History of Cancer		
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Year	Type of Cancer	Relationship
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Trouble with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
(Sickle Cell Anemia, etc.)								

WOMEN ONLY

	Yes	No		Yes	No	Age at 1 st Pregnancy? _____
Tender Breasts	<input type="checkbox"/>	<input type="checkbox"/>	Fibrocystic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Year _____
Discharge from Nipples	<input type="checkbox"/>	<input type="checkbox"/>	Previous Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	Other Problems: _____
Lumps in Breast	<input type="checkbox"/>	<input type="checkbox"/>	Change in Breast Size	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	Did/do you breast feed	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Pharmacy Record

Patient Name: _____ Date of Birth: _____

Allergies & Reaction: _____

_____ NONE ☐

Pharmacy Name/Address: _____

Please list ALL medications you are currently taking: _____

DATE:

RX SENT:

STAFF INITIALS:

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South Shore Cosmetic Surgeons, LLC
36 Lincoln Ave.
Rockville Centre, NY 11570

ACKNOWLEDGEMENT STATEMENT

I understand that the services I receive from South Shore Cosmetic Surgeons may not be covered under my insurance plan. I understand that my insurance company determines the medical necessity of the services that I request and receive. I am also responsible for the deductibles, co-pays, co-insurance, non-covered services, and items considered not “medically necessary” by my insurance company. I understand that I must inform this office of any change in my insurance coverage before services are rendered to me. Failure to inform the office will result in me being held responsible for all fees for the services rendered. I understand that if my plan required a referral, it is my responsibility to contact South Shore Cosmetic Surgeons at least 48 hours prior to the specialist appointment for any office visits.

If you do not have any medical health insurance you will be held responsible for 100% of the fee for the services rendered to you.

Payment is due in its entirety at the time of your visit.

Signature of Patient or Legal Guardian

Date

South Shore Cosmetic Surgeons, LLC
36 Lincoln Ave.
Rockville Centre, NY 11570

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, South Shore Cosmetic Surgeons, LLC may use and disclose protected and healthcare information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals.

Please refer to the South Shore Cosmetic Surgeons Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent and my signature indicates I have reviewed it or I have declined to review it prior to signing.

South Shore Cosmetic Surgeons reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to South Shore Cosmetic Surgeons, 36 Lincoln Ave., Rockville Centre, NY 11570.

With my consent, South Shore Cosmetic Surgeons may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With my consent, South Shore Cosmetic Surgeons may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment cards, patient statements, or forms.

I have the right to request that South Shore Cosmetic Surgeons restrict how it uses or discloses my PHI to carry TPO. However, the practice is not required to agree to my requested restrictions, but if it does, in writing, it is bound by this agreement.

By signing this form, I am consenting to South Shore Cosmetic Surgeons use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, South Shore Cosmetic Surgeons may decline to provide treatment to me.

If I were to sign a Photo Release Consent (which I'd receive at a later date), I will agree to allow South Shore Cosmetic Surgeons to use my pre and post treatment photographs within its practice to educate future patients as long as I am not identified by face or name. If I decide I do not want my photographs to be used, I will not sign a Photo Release Consent.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Date

South Shore Cosmetic Surgeons, LLC
36 Lincoln Ave.
Rockville Centre, NY 11570

ASSIGNMENT OF BENEFITS

I authorize Dr. Hassan and/or Dr. Waheed to submit to my insurance company on my behalf, and that my insurance company pay benefits directly to Dr. Hassan and/or Dr. Waheed. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to Dr. Hassan and/or Dr. Waheed.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/ Guardian: _____

Date: _____

Regardless of my insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that I am responsible for any copay, co-insurance, and/or deductible per my insurance plan as processed by my insurance company. I understand my contract is between South Shore Cosmetic Surgeons, LLC and myself. I also understand South Shore Cosmetic Surgeons may not participate in my insurance plan and payment might be directly sent to me, the insured. In this case, I also understand it is my responsibility to forward this payment to South Shore Cosmetic Surgeons, LLC.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/ Guardian: _____

Date: _____