National Center for Plastic Surgery
7601 Lewinsville Rd Suite 400
McLean, VA 22102
(703) 287-8277

New Patient Information Form

Full Name:		Nickname (If Any):
Address:	City/State/Zip:	
Date of Birth:	Marital Status:	Gender:
Home Phone:	Work Phone:	Cell Phone (Required):
May we leave voice messages or send text reminders to phone numbers provided? YES NO		
Email (Required):	Other:	
Employer:	Address:	
Occupation:	Full/Part/Student/Retired Other:	
Emergency Contact (**EC**):	Relationship to Patient:	
EC Primary Phone:	**EC** Secondary Phone:	
Person Financially Responsible (Guarantor) for Treatment if Not Self:		
Address of Guarantor:	City/State/Zip of Guarantor:	
Guarantor Home Phone:	Guarantor Work Phone:	Guarantor Cell Phone:
How did you hear about us?		
Payment Method (Circle One): Cash, Credit Card, Insurance (**If Insurance**, *Complete Below*)		
Primary Subscriber:	Subscriber Date of Birth:	
Insurance:	Policy No:	Group No:
Secondary Insurance (If Any):	Secondary Policy No:	Secondary Group No:
If you authorize release of your medical information to anyone besides your insurance carrier, please provide the name:		
I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.		
I am aware of my HIPAA Rights (you can request a copy of your privacy rights at the front desk).		
Patient, Parent, or Guardian Signature:		Date:

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Health Information Form

Health Information as of _____(enter today's date)
(Please Print Legibly & Answer All Questions to the Best of Your Knowledge)

Confidential Record: Information contained here will not be released unless you have authorized us to do so.

Name:	Reason for Visit:	Age:
Height:	Weight:	Current Physician(s):
List all Surgeries (Hospitalization and the Date of Occurrence:		
List any Serious Illnesses and/or Accidents:		
List ALL Drug and/or Latex Allergies:		
List all medications (incl. name of drug, dosage, and frequency) you are presently taking or have taken within the last month:		

Do you have or have you had any of the following: (circle for each, give date occurred if 'Yes')

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Issues / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes			
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke?	No	Yes	If yes, how much?	_____ Pack(s)/Day	How long? ____ Year(s)
Do you drink alcohol?	No	Yes	If yes, how much?	_____	How often? _____
Do you have bleeding or bruising problems?	No	Yes	If yes, describe?	_____	
Do you have problems with scarring?	No	Yes	If yes, describe?	_____	
Do you have any history of problems with anesthesia?	No	Yes	If yes, describe?	_____	

The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____

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Notice of Privacy Practices
Patient Acknowledgement Form

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Signature _____ Date _____

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Financial Policies

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, or your financial responsibility. The patient or responsible party is responsible for seeing that the entire bill is paid in full. Responsible parties will be responsible for any collection fees, interest, and other expenses necessary to collect on any account, including court costs, should legal action be necessary to collect.

We will ask to see your insurance card (if you are a medical patient) of your first visit, and will scan your card into our system as needed to keep our information current. We will ask for this information at every visit, in order to ensure that no change in benefits or carrier as occurred. Please notify us if your insurance carrier of policy has changed. Billing of insurance is a courtesy we provide for patients and is not required by law.

PLEASE READ AND INITIAL EACH LINE BELOW ACKNOWLEDGING YOU HAVE READ ALL POLICIES.

_____ **COPAYMENTS**: Your insurance REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.

_____ **DEDUCTIBLES AND CO-INSURANCE**: We may collect your deductable and co-insurance at time of service. National Center for Plastic Surgery (NCPS) will bill your insurance company. Patient Responsibility portions of your bill are to be paid within 90 days.

_____ **REFERRALS**: If your insurance plans require a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and to have it with you at the time of your appointment. If you do not have your referral, you may be required to reschedule.

_____ **RETURNED CHECK FEES**: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $40.00 fee per returned check.

_____ **FORMS/PAPERWORK**: There is a $40.00 pre-payment per form fee for the completion of paperwork or forms relating to disability, FMLA, etc. This fee is collected prior to completion of the paperwork, and for each time the paperwork is required. Allow seven business days for completion of forms. Any formed needed within 48 hours from the time it was given to our staff will need to pre-pay an additional $20.00 rush fee.

_____ **NO SHOW FEE**: You will be charged $75.00 if you fail to cancel an appointment with our esthetician within 24 hours and do not show for your appointment.

_____ **SURGERY CANCELLATION FEE**: Any surgeries cancelled within 7 business days of the date of surgery will incur a cancellation fee of $500.00.

Signature: _____ Date: _____