Faerber Surgical Arts

CONSULTATION AND MEDICAL QUESTIONNAIRE

NAME: ______________________________ **DATE:** ______________________

ADDRESS: ______________________________ ______________________________

APT. CITY STATE ZIP

SOCIAL SECURITY #: ______________________ **BIRTHDATE:** ______________________

HOME #: ( ) ______________________ **WORK #:** ( ) ______________________

CELLULAR #: ( ) ______________________ **E-MAIL:** ______________________

MAY WE AUTHORIZE COMMUNICATION BY E-MAIL OR CELLULAR PHONE? ❑ **YES** ❑ **NO**

❑ **MALE** ❑ **FEMALE** **CHECK ONE:** ❑ **MINOR** ❑ **SINGLE** ❑ **MARRIED** ❑ **DIVORCED** ❑ **WIDOWED**

STUDENT: ❑**FULL TIME** ❑ **PART TIME** **SCHOOL:** ______________________

YOUR DENTIST: ______________________ **YOUR PHYSICIAN:** ______________________

REFERRED BY: ______________________ **REASON FOR TODAY'S VISIT:** ______________________

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

❑**SELF** ❑**SPOUSE** ❑**MOTHER** ❑ **FATHER** ❑ **STEP-PARENT** ❑**OTHER** ______________________

NAME OF RESPONSIBLE PARTY: ______________________________

RESPONSIBLE PARTY'S ADDRESS: ______________________________

CITY STATE ZIP

SOCIAL SECURITY #: ______________________ **BIRTHDATE:** ______________________

HOME #: ( ) ______________________ **WORK #:** ( ) ______________________

NAME OF EMPLOYER: ______________________ **EMPLOYER'S ADDRESS:** ______________________

EMPLOYER'S ADDRESS: ______________________________

SPOUSE'S NAME: ______________________ **SPOUSE'S BIRTHDATE:** ______________________

SPOUSE'S EMPLOYER: ______________________ **OCCUPATION:** ______________________

NAME OF BANK: ______________________________

INSURANCE INFORMATION

DENTAL: ______________________

PHONE #: ______________________

GROUP/ID #: ______________________

INSURED: ______________________

SS #: ______________________

DATE OF BIRTH: ______________________

MEDICAL: ______________________

PHONE #: ______________________

GROUP/ID #: ______________________

INSURED: ______________________

SS #: ______________________

DATE OF BIRTH: ______________________

PLEASE FILL OUT THE FOLLOWING 3 PAGES ▶

PLEASE COMPLETE THE FOLLOWING HEALTH HISTORY QUESTIONNAIRE

Indicate if you have had any of the following:

Yes No Rheumatic Fever
Yes No Damaged heart valves/MVP
Yes No Heart murmur
Yes No High blood pressure
Yes No Low blood pressure
Yes No Chest pain, angina
Yes No Heart attack(s)
Yes No Irregular heart beat
Yes No Cardiac pacemaker
Yes No Heart surgery
Yes No Bronchitis, chronic cough
Yes No Asthma
Yes No Hayfever/Sinus problems
Yes No Tuberculosis
Yes No Emphysema
Yes No Difficulty breathing/other lung problems
Yes No Do you smoke?
Yes No Blood transfusion
Yes No Blood disorder such as anemia
Yes No Bruise easily
Yes No Bleeding tendency (abnormal bleeding)
Yes No Jaundice, hepatitis or liver disease
Yes No Infectious mononucleosis
Yes No Gallbladder trouble
Yes No Fainting spells
Yes No Convulsions, epilepsy
Yes No Stroke
Yes No Thyroid trouble
Yes No Diabetes
Yes No Low blood sugar
Yes No Kidney trouble
Yes No Are you on dialysis?
Yes No Swollen ankles, arthritis, joint diseases
Yes No Stomach ulcers
Yes No Contagious diseases
Yes No Sexually transmitted diseases
Yes No Do you have any reason to be immunosuppressed?
Yes No Delay in healing
Yes No A tumor in growth
Yes No X-ray treatment/chemotherapy
Yes No Chronic fatigue/night sweats
Yes No Are you on a diet?
Yes No A history of drug abuse
Yes No A history of alcohol abuse
Yes No Contact lenses
Yes No Eye disease/glaucoma
Yes No Mental health problems
Yes No A removable dental appliance
Yes No Pain and clicking of jaws when eating
Yes No Malignant Hyperthermia
Yes No A prosthetic joint

Are you presently taking any medications? ❑ YES (Attach separate list if necessary.) ❑ NO

(Medicine) (Amount) (For how long)

___

___

Are you allergic to any medications? (Medicine) (What happens when taken?)

___

Have you ever had local anesthesia (Novocain or Xylocaine) by a dentist or doctor? ❑ YES ❑ NO

List all surgeries you have ever had:

(Operation) (Year) (Doctor) (City)

___

___

Were there any complications? ___

WOMEN: When was your last menstrual period? ___

❑ YES ❑ NO Are your periods often irregular?

❑ YES ❑ NO Are you pregnant?

❑ YES ❑ NO Have you had female/gynecological problems?

❑ YES ❑ NO Are you nursing?

Are there any other medical problems that we should know about? ___

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the above have been answered to my satisfaction. I will not hold my surgeon, or any member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

___

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

___

DATE

FAERBER SURGICAL ARTS FINANCIAL POLICY

Thank you for contacting our office. We appreciate the confidence you place in us by choosing our practice for your health care needs. We will uphold that responsibility by providing excellent service you desire and deserve. We will strive to make your time spent with us as comfortable and pleasant as possible. For your convenience, we accept the following forms of payment:

- Cash or Check
- Visa, MasterCard and Discover credit cards

INSURANCE REIMBURSABLE PROCEDURES/NON PARTICIPATING PLANS:

For procedures covered by your insurance, a percentage of the fee will be required at the time of service. If your insurance carrier covers your procedure, we will review your fee with them prior to surgery to determine their coverage and the amount you will be responsible for (if we are a participating member of that carrier). For example, if your insurance pays at 80%, we will require 20% (plus any deductible fee) at time of service. For procedures to be performed with a general anesthetic, where a predetermination is not submitted, or if the surgery date precedes the pre-determination response, you will be required to pay an additional 10% of the fee on the date of the surgery. **YOUR PORTION OF THE FEE IS DUE ON THE DAY OF YOUR SURGERY.**

We are aware that coverage varies with each individual policy. Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or **ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE COMPANY.** If your insurance pays more than the account balance, a refund will be issued to you. We will file your insurance for you on the day of your procedure. Your insurance company should reimburse our office within 45 days of the claim submission. We will follow up with your insurance company to ensure that your claim gets reimbursed. If no payment has been received from the insurance company within 45 days, regardless for the reason of delay, you are responsible for the immediate payment of the account balance. However, if you request our office's continued support in following up with your insurance carrier, we will gladly assist you, but you must reimburse our office for the balance. Any statements issued are due upon receipt. 1.5% will be added to your balance 30 days after statement. On-going interest will be charged at the rate of 18% per annum for any unpaid balance. If for any reason collection activity is required, the patient will be responsible for all reasonable attorney fees and collection costs.

If we do not have a contract with your insurance carrier, we will advise you of that. You will be responsible for any balance remaining after your insurance carrier has paid. Please remember that your insurance policy is a contract between you and your insurance carrier. We are not a party of that contract. **THE AMOUNT PAID BY YOUR INSURANCE CARRIER IS NOT PAYMENT IN FULL.** Our fee for each service has been determined through careful analysis. These fees are reasonable and reflect other area physicians' charges. You are responsible for your payment regardless of any insurance company's determination of usual and customary rates.

LABORATORY/PATHOLOGY:

Some services require specimens to be sent to an outside diagnostic laboratory. Costs for these services are **NOT** included in our fee. You will be billed separately by an outside lab.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THE FINANCIAL POLICY. This signature on file is my authorization for the release of information necessary to process my claim. I further authorize that any insurance payments be made directly to Dr. Faerber.

____ ______________________________

SIGNATURE OF FINANCIALLY RESPONSIBLE PARTY* **DATE:**

***Must be signed by the either the insured or his/her spouse.**

Faerber Surgical Arts
PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our used and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: ______________________________________
PRINTED NAME – PATIENT OR REPRESENTATIVE

Relationship to the Patient (if other than patient): ____________________

Date: _____________________________

In front of: ________________________________
PRINTED NAME – PRACTICE REPRESENTATIVE