COSMETIC PATIENT PROFILE FORM

ANNA ARSENOUS, M.D.

DATE: _____

Name: _____ (First, Last, M.I.) Male ? Female ?

SS#: _____ DATE OF BIRTH: _____ _____

(Tel: Home)

ADDRESS: _____ ____ _____ _____ _____ _____ _____

(Street) (Apt#) (City) (State) (Zip) (Tel: Cell)

EMPLOYER: _____ _____ _____

(Tel: Work) E-Mail Address

INSURANCE: _____ POLICY#: _____ :_____

PHONE#: _____

How did you hear about our office? _____

What Procedure(s) are you interested in? _____

Any Cosmetic work done before? YES ? NO ? List : _____

Are you taking any medications? YES ? NO ? List : _____

Are you allergic to any medications? YES ? NO ? List : _____

Use Vitamins or Herbal Products? YES ? NO ? List : _____

Have you ever used any diet pills? YES ? NO ? List : _____

Have you done any type of Surgery? YES ? NO ? List : _____

What type of Career are you in presently? _____

What type of Hobbies Interest you? _____

What Health complaints do you have? _____

Is there any information you feel would be of any concern to the doctor or her staff?

_____

Do you smoke tobacco? YES ☐ NO ☐ List: How Many Packs a day? _____

Do you drink coffee? YES ☐ NO ☐ List: How Many Cups a day? _____

Do you exercise regularly? YES ☐ NO 1 – 2 days a week ☐ 3 – or more days a week ☐ Health Buff ☐ ☐

What are your eating habits? A lot of junk food ☐ A lot of healthy food ☐ Moderately healthy food ☐

FEMALES: How old were you when you got your first period? _____ What was the date of your last Period? _____

Are you presently taking birth control or hormones? YES ☐ ☐ NO When was your last mammogram? _____

Have you ever had an abnormal mammography? YES ☐ NO ☐ Explain? _____

NOTE: *All patients must know that Insurance does not cover any Cosmetic work, also we do not accept insurance for cosmetic procedures. Patients must pay a $500.00 deposit to secure a date for surgery. All payments must be made the morning of or before the day of surgery.*

Cash, Credit Card and Cashiers Checks are the only acceptable forms of payment. Please make payable to Dr. Anna Arsenous.

FOR OFFICE USE ONLY: (DO NOT FILL IN):

WEIGHT: _____ HEIGHT: _____ ARMHOLE: _____ SHOULDER: _____

LENGTH OF ARM: _____ BICEPS: _____ ELBOW: _____ BUST/CHEST: _____

UNDER/ AREOLA: _____ WAIST: _____ HIPS: _____ THIGH: _____ KNEE: _____

NOTE: DECISION: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Arsenous for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance. If I receive payment from my insurance company, I will send the payment to Dr. Arsenous at the above listed address.

Name of Insured _____

Insured Member ID# _____ Group # _____

Medicare ID# _____ Medicaid ID # _____
(If applicable)

Insured Social Security Number _____ - _____ - _____

Insured Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Arsenous to release any medical or incidental information that may be necessary for either medical care of in processing applications for financial benefit.

ALL TYPES OF INSURANCE

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

Patient Name (PRINT) _____

If Minor,
Parent/Guardian (PRINT) _____

_____ _____

Patient or Parent/Guardian Signature Date

Disclosure Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by Anna Arsenous, MD, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Anna Arsenous, MD. I understand that diagnosis or treatment of me by Anna Arsenous, MD may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Anna Arsenous, MD is not required to agree to the restrictions that I may request. However, if Anna Arsenous, MD agrees to a restriction that I request, the restriction is binding on Anna Arsenous, MD. I have the right to revoke this consent, in writing, at any time, except to the extent that Anna Arsenous, MD has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Anna Arsenous, MD's Notice of Privacy Practices prior to signing this document. Anna Arsenous, MD's. Notice of Privacy Practices has been provided for me to view and copy. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Anna Arsenous, MD's medical/surgical practice. The Notice of Privacy Practices for Anna Arsenous, MD is also provided in the reception/waiting room and This Notice of Privacy Practice also describes my rights and the duties of Anna Arsenous, MD's General & Cosmetic Surgery practice with respect to my protected health information.

Anna Arsenous, MD reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing by writing or calling the office and requesting a revised copy be sent in the mail. I may also ask for a copy of the revised copy at the time of my next appointment.

_____

Name of Patient or Personal Representative (PRINT)

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

BOOKING & CANCELLATIONS FOR COSMETIC PROCEDURE POLICIES

A 50% deposit of the total fee must be made payable by cash, certified check, wire transfer or major credit cards except American Express to secure a scheduled surgery date with final payment collected at the pre-operative visit 7 days before surgery. ____

In the event that you should choose to cancel a booked surgery date, we require notification in writing no later than 2 weeks prior to your surgery date. All deposits toward surgical procedures are non-refundable ____

In the case of rescheduling a surgery with less than a 72 business hours notice, an additional fee of $1000 will be charged. ____

Unfortunately, cancellations made later than 72 hours prior to your surgery date will result in a 50% loss of the entire amount paid. ____

We therefore respectfully request your understanding and cooperation with our cancellation policy.

_____

PROCEDURE

_____

PATIENTS SIGNATURE **DATE**

_____

WITNESS SIGNATURE **DATE**