INSURANCE INFORMATION AND ASSIGNMENT

PLEASE NOTE THAT WE DO NOT PARTICIPATE IN MOST INSURERS OR HMOS NETWORKS.
IT IS YOUR RESPONSIBILITY TO DETERMINE IF WE PARTICIPATE IN YOUR PLAN.

Legal Name of Patient: _____
Name of Primary Insurance Company:_____
Address and Phone Number:_____
Policy Number (Letters and Numbers):_____ Group Number: _____
Subscriber's Name (As it shows on the policy):_____
Subscriber's DOB (MM/DD/YEAR):_____ Subscriber's SS:_____
Please select your Relationship: Self[ ] Spouse[ ] Parent[ ] Other[ ]

Name of Secondary Insurance Company:_____
Address and Phone Number:_____
Policy Number (Letters and Numbers):_____ Group Number: _____
Subscriber's Name (As it shows on the policy):_____
Subscriber's DOB (MM/DD/YEAR):_____ Subscriber's SS:_____
Please select your Relationship: Self[ ] Spouse[ ] Parent[ ] Other[ ]

Name of Tertiary Insurance Company:_____
Address and Phone Number:_____
Policy Number (Letters and Numbers):_____ Group Number: _____
Subscriber's Name (As it shows on the policy):_____
Subscriber's DOB (MM/DD/YEAR):_____ Subscriber's SS:_____
Please select your Relationship: Self[ ] Spouse[ ] Parent[ ] Other[ ]

Please circle if applicable: Motor Vehicle Accident **(MVA)** Workers' Compensation **(WC)**
Is your injury the result of an accident?____ If Yes, please best describe what occurred:____
_____
_____
Date of accident/injury:_____State in which the accident/injury occurred:_____
Do you have an Insurance Claim Number?_____
Adjuster's Name and Contact Information:_____
If MVA, provide the name and address of YOUR automobile insurance company: _____
_____
If WC, provide the name and address of YOUR employer/insurance company:_____
_____
Are you represented by an Attorney?____If Yes, name of Practice: _____
Contact Name and Phone Number:_____
Address:_____

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary insurance. Any remaining balance after receipt of explanation of benefits from your primary and/or secondary insurance carrier will be billed to you.

PATIENT INFORMATION

Patient's Legal Name:_____ Preferred Name:_____
Last Middle Initial First

Patient's Address:_____
Street City State Zip

Email:_____ Do you approve using your email? Yes__No__Initials:___

Cellphone:_____Home Phone:_____Work Phone:_____Ext:___

Do you approve the use of text messages? Yes___No___Initials___ Language: _____

Date of Birth (MM/DD/YEAR): _____Age:____SS#_____ Biological Sex: [ ]Male [ ]Female

Gender [ ]Man [ ]Woman [ ]TransMale/TransMan [ ]TransFemale/TransWoman

Identity: [ ]Genderqueer/Noncomforming [ ]Different Identity [ ]Prefer not to answer

Choose your Marital Status: [ ]Married [ ]Single [ ]Widowed [ ]Divorced [ ]Other_____

Group identity:
[ ]Alaska Native or American Indian or Indigenous or Native American
[ ]Black, African, AfroCaribbean or African American
[ ]Asian or Asian American
[ ]Hispanic, Latina/o/x or of Spanish origin
[ ]Middle Eastern or North African
[ ]Native Hawaiian or Other Pacific Islander
[ ]White
[ ]Prefer not to answer
[ ]Other/Prefer to self describe_____

Occupation:_____Employer: _____
Bussines Address: _____

Emergency Contact and Phone Number:_____Relationship:_____
Person Financially Responsible Information:_____

Primary Care Physician:_____Phone Number: _____
List Physicians and Specialists you have seen in the last year: _____
_____

How did you hear about us? _____ If applicable, name of who referred you: _____
Reason for visit: _____
_____
Have you already consulted other physicians?___ If Yes, please provide their names:_____
_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, The Plastic Surgery Center "TPSC", Premier Surgical Network "PSN", The Center for Outpatient Surgery "TCOPS" and Aesthetic Vascular Associates "AVA" also referred to as "The Practices" have my consent to use and disclose my Protected Health Information (PHI) to carry out treatment, to obtain payment from third parties and to perform healthcare operations as outlined below:

I have been given access to a copy of the 'H.I.P.A.A Notice of Privacy Practices' which are available for download in the practice's websites and have a complete description of PHI.
I have the right to review, and to the extent I desire to do so, I have reviewed the HIPAA Notice prior to signing this Consent Form.
I authorize 'The Practices' to use and disclose my PHI in the following manner:

1. Transmit my PHI through the following means in order to carry out treatment, obtain payment from third parties and perform healthcare operations which include and are not limited to appointment reminders, confirmations, relaying test results, surgery dates, etc:

A. Cell Phone Number: _____
B. Home Phone Number: _____
C. Fax Number: _____
D. Email Address: _____
E. Mailing Address: _____

2. Disclose my PHI to the following family members in order to carry out treatment, obtain payment from third parties and perform healthcare operations:

A. Name: _____ Contact Information: _____
B. Name: _____ Contact Information: _____
C. Name: _____ Contact Information: _____

3. Transmit my PHI to other health care providers as well as my health insurance carrier in the order to carry out treatment, obtain payment and perform healthcare operations.

4. I DO NOT authorize disclosure of my PHI to anyone other than myself. _____ (Initials)

By signing this form, I consent "The Practices" to use and disclose my PHI as outlined above:
I_____acknowledge that I have read and understand the above.

_____ _____
Patient's Signature Date

I may revoke my consent in writing except to the extent that 'The Practices' have already made disclosures in reliance upon my prior consent. If I do not sign this Consent, 'The Practices' may decline to provide treatment. For questions about the HIPAA Notice, please contact our offices and ask to speak with the Administrator. We reserve the right to revise our HIPAA Notice of Privacy Practices at any time.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

To be filed in patient's medical record

I have been provided with access to an electronic copy of "The Practices" Notice of Privacy, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

PATIENT'S NAME:____

PATIENT OR LEGAL GUARDIAN SIGNATURE:____

RELATIONSHIP TO PATIENT IF OTHER THAN SELF: __________________________________

DATE SIGNED:___________

I wish to place the following restrictions on disclosure of my health information:

____
____
____
____

- -

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below:

PRESENTED TO PATIENT ON:

____
Date and Time

BY THE FOLLOWING PERSON:

____
Name and Tittle

FINANCIAL POLICY AND PATIENT RESPONSABILITY

The Plastic Surgery Center ('TPSC'), The Center for Outpatient Surgery ('TCOPS'), Premier Surgical Network ('PSN'), Aesthetic Vascular Associates ('AVA') provide the highest level of care. This financial policy has been prepared to make your visit pleasant and informative, as well as to inform you of your financial responsibility to our practices. Please read carefully, insert your initials at the end of each advisory indicating you have read this information and agree to it, then sign and date at the bottom of the page.

♦ Payment for your visit is due at the time service is rendered. If you have insurance or we participate in your insurance plan, we will bill your insurance carrier as a courtesy for you, but we make no assurances about your carrier's decision to make payment. **UNLESS THE PRACTICES PARTICIPATE IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED BY THE PRACTICES, INCLUDING FOR ALL SERVICES RENDERED BY THE PRACTICES PRIOR TO THE DATE OF THIS FINANCIAL POLICY.**

♦ If you have arrived at TPSC, AVA, TCOPS, PSN for a cosmetic consultation and during your visit there is a discussion and/or exam concerning a medically necessary condition, we will bill your insurance carrier for the visit and require that a payment be assigned to us. If your insurance company makes a payment directly to you for services rendered by our Practices, you agree to immediately forward it to us upon receipt.

♦ You will receive a monthly statement if your account has any balance due, even if an insurance claim has been filed on your behalf. The date of the insurance submission and any credits to your account will be noted on the statement.

♦ **A deposit for cosmetic surgery is required at time of scheduling a procedure. This is a non-refundable deposit. All cosmetic procedures must be paid three weeks prior to surgery. Please be aware that the surgeon's fee does not include lab fees, the anesthesiology fees, pathology charges, hospital charges or ambulatory surgery center charges also known as facility fees . There will be a non-refundable surgery fee if surgery is not canceled within five days of your scheduled date. You agree to a separate cancellation fee of _____ on all credit card refunds.**

♦ While our staff makes every effort to assist you with processing your insurance claim, any incorrect or incomplete insurance information will usually result in reduced benefits and add to your financial burden. It is your responsibility to understand and know the terms and conditions of your insurance plan, any necessary referrals, pre-authorizations, pre-certification and all your insurance related requirements. **UNLESS THIS PRACTICE PARTICIPATES IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED BY THIS PRACTICE, INCLUDING FOR ALL SERVICES RENDERED BY THIS PRACTICE PRIOR TO THE DATE OF THIS FINANCIAL POLICY.**

♦ **Insurance companies DO NOT PAY for cosmetic procedures.** If you are having a cosmetic procedure at the same time as a non-cosmetic procedure, we will submit to your insurance company only for the non-cosmetic procedure.

♦ Every insurance company determines its own payment schedule in accordance with the plan selected. Please be aware you may have a deductible, co-insurance, out of network penalty, an uncovered claim, resulting in payments due from you to this Practice.

♦ In the event we do not participate in your insurance plan our fee may be above what your insurance carrier determines to be "reasonable and customary". **UNLESS THIS PRACTICE PARTICIPATES IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED BY THIS PRACTICE, INCLUDING FOR ALL SERVICES RENDERED BY THIS PRACTICE PRIOR TO THE DATE OF THIS FINANCIAL POLICY.**

♦ I understand that a finance charge of (18%) per annum (one and one-half percent (1.5%) per month) will be added to any invoice 30 days past due. I also understand that if the account is placed in the hands of an attorney for collection, I am responsible for collection costs and reasonable attorney's fees.

♦ For your convenience, we accept payments in Cash, Debit Card, Check, American Express, Visa, MasterCard, Discover, CareCredit, Cherry, Apple and Google Pay. You can make payments in person, over the phone or through our secure online payment portals.

♦ In the event we do not participate, and the insurance company sends payments directly to you, you agree to immediately endorse the check to the corresponding Practice (TPSC. PSN, TCOPS, AVA,) and send it to us with a copy (front and back) of the Explanation of Benefits provided by your insurance company.

♦ Several of our doctors are Medicare Participating Providers which means that Medicare will tell us the amount to charge for our services. Of the amount Medicare allows us to charge, Medicare will pay eighty percent (80%) and you (unless you have supplemental insurance) are obligated to pay the remaining twenty percent (20%). In addition, Medicare has a yearly deductible that you will need to pay before Medicare payments begin/commence. Your co-pay (which is twenty percent (20%) of Medicare's allowed amount) is due at the time of your appointment unless you have a supplemental insurance policy. If you have a supplemental insurance policy, we will file with that secondary insurance carrier after we receive a check or payment from Medicare. We allow sixty (60) days from the date Medicare responds or makes payment for your supplement policy to pay the outstanding balance. After the sixty (60) days expires, the outstanding balance becomes your responsibility.

~I have received a copy of this Financial Policy and Patient Responsibility, understand the terms stated herein and have voluntarily executed this agreement.~

Should you have any questions or concerns regarding this policy, please feel free to discuss this with your patient coordinator. No changes to the terms set forth in this agreement are binding upon this Practice unless written below and signed separately by both you and an authorized representative of our Practice.

Signature of Patient or Legal Representative: _____ Date: _____
If signed by a legal representative, state relationship to patient: _____

ASSIGNMENT OF BENEFITS

♦ **Assignment of Right to Reimbursement and Payment.** Pursuant to N.J.S.A 26:2S6.1(c) and the common law, I hereby assign any and all of my rights to receive payments to any and all benefits under my insurance policy to my medical provider, The Plastic Surgery Center ('TPSC'), The Center for Outpatient Surgery ('TCOPS'), Premier Surgical Network ('PSN'), Aesthetic Vascular Associates ('AVA'), relating to and/or arising out of any and all medical treatment provided TPSC, TCOPS, PSN, AVA to me, including, but not limited to, major medical, personal injury protection (PIP), and workers' compensation benefits otherwise payable to me, regardless of whether TPSC, TCOPS, PSN, AVA is a participating or non-participating provider of my health insurance carrier.

♦ **Irrevocable Assignment of All Benefits and Legal Rights.** I hereby irrevocably assign to The Plastic Surgery Center ('TPSC'), The Center for Outpatient Surgery ('TCOPS'), Premier Surgical Network ('PSN'), Aesthetic Vascular Associates ('AVA') any and all of my legal rights, benefits, and claims relating to and/or arising out of my health insurance policy/policies and the medical treatment provided by TPSC, TCOPS, PSN, AVA to me; the assignment includes, but is not limited to, any and all of my legal rights to major medical, personal injury protection (PIP), and workers compensation benefits, and includes, but is not limited to, my assignment of any and all legal rights to file and prosecute my legal rights and benefits to any and all appeals, claims, and litigation against my health insurance policy/policies relating to and/or arising out of the aforesaid. I hereby name TPSC, TCOPS, PSN, AVA as my Designated Authorized Representative and further authorize any plan administrator or fiduciary, insurer, and my attorney to release any and all plan documents, insurance policy and/or settlement information upon written request from TPSC, TCOPS, PSN, AVA in order to assert any and all of my legal rights relating to and/or arising out of my health insurance policy and the medical treatment provided to me by TPSC, TCOPS, PSN, AVA in order to prosecute any and all claims for such medical benefits, reimbursement, and any and all applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

♦ **Waiver and Release of HIPAA.** I hereby authorize my insurance carrier, the plan sponsor, and/or any employer and/or plan administrator to release all of my medical information under HIPAA to TPSC, TCOPS, PSN, AVA, relating to and/or arising out of any and all determinations of any claims for medical services provided by TPSC, TCOPS, PSN, AVAto me.

This assignment shall be binding on and incur to the benefit of TPSC, TCOPS, PSN and AVA, its successors, assigns and its legal representatives.

~A photocopy of this assignment is to be considered as valid as the original. I expressly acknowledge and agree that I have read and fully understand this Assignment of Benefits 2 of 2 and expressly acknowledge and agree that by executing this Assignment of Benefits below I agreed to its terms herein.~

Signature of Patient or Legal Representative:_____ Date: _____
If signed by a legal representative, state relationship to patient: _____

LETTER OF PROTECTION

I, the undersigned, hereby agree that this Letter of Protection constitutes my agreement to both assign to The Plastic Surgery Center **('TPSC')**, Premier Surgical Network **('PSN')**, Aesthetic Vascular Associates **('AVA')**, and to grant The Plastic Surgery Center **('TPSC')**, Premier Surgical Network **('PSN')**, Aesthetic Vascular Associates **('AVA')**, a first lien (after the payment of all attorney's fees and litigation costs) on any recovery of proceeds paid as a result of any settlement, judgment or verdict which is paid to my attorney or me as a result of the injuries by reason of an accident which occurred on_____.

I hereby authorize my attorney to discuss my case and to provide The Plastic Surgery Center **('TPSC')**, Premier Surgical Network **('PSN')**, Aesthetic Vascular Associates **('AVA')**, with any information necessary so that payment shall be made directly to them for such sums as may be due and owing for medical services rendered me. I, furthermore, authorize my attorney to withhold such sums from any proceeds paid as a result of any settlement, judgment or verdict and to immediately pay **TPSC, PSN, AVA** all outstanding sums from such proceeds.

I, fully understand that I am solely responsible to **TPSC, PSN, AVA** for all medical bills for services rendered me and this agreement does not relieve me of any personal responsibility for said charges. I further understand that this agreement is made solely for the protection of **TPSC, PSN, AVA** and such payment by me is not contingent on any settlement, judgment or verdict.

I understand that this Letter of Protection is irrevocable and shall apply to any cause of action whether or not I should engage legal counsel or substitute counsel at any future time. I further understand and agree to notify **TPSC, PSN, AVA** in writing, if I change or terminate attorney/client relations

PATIENT'S NAME:_____ DATE:_____

I, the undersigned, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above agreement and agree to withhold such sums from any proceeds paid as a result of any settlement, judgment or verdict on behalf of and to immediately pay The Plastic Surgery Center **('TPSC')**, Premier Surgical Network **('PSN')**, Aesthetic Vascular Associates **('AVA').**

I, furthermore, understand and agree to immediately notify **TPSC, PSN, AVA** in writing, should there occur a substitution of counsel, referral to another attorney or law firm, retention of cocounseling or should the attorney/client relationship be terminated or modified in any manner.

ATTORNEY SIGNATURE:_____ DATE:_____