



Plastic Surgery Specialists, P.C.

Dennis T. Monteiro, M.D., F.A.C.S.

Diana B. Bragoli, C.R.N.P

1288 Valley Forge Road, Suite 65

Phoenixville, PA 19460

PATIENT NAME: _____ **SEX:** M / F

DATE OF BIRTH: _____ **AGE:** _____ **S.S#** _____

ADDRESS: Street: _____

City: _____ **State:** _____ **Zip Code:** _____

I wish to be contacted in the following manner (check all that apply):

- ☐ **Home Phone:** (_____) _____
☐ OK to leave message with detailed information
☐ Leave message with callback number only

- ☐ **Work Phone:** (_____) _____
☐ OK to leave message with detailed information
☐ Leave message with callback number only

- ☐ **Cell Phone:** (_____) _____
☐ OK to leave message with detailed information
☐ Leave message with callback number only

- ☐ **I give permission to use
and disclose my protected
health information to the
following people:**

☐ _____
relationship _____
initials: _____

☐ _____
Relationship _____
initials: _____

☐ **EMAIL:** _____

EMPLOYER: _____

PRIMARY PHYSICIAN & PHONE #: _____

REFERRING PHYSICIAN & PHONE #: _____

EMERGENCY CONTACT: _____

How is this person related to you? _____

Emergency contact phone number: _____ **Work** **Home** **Cell**

How did you hear about our office? _____

INSURANCE INFORMATION

Please provide a copy of your insurance card and a driver's license or other government issued picture ID.

If your insurance card is in a different name or if the patient is under the age of 18 years, the following information is required:

Responsible Party

NAME: _____ SEX: M / F

ADDRESS: _____

Employer: _____

BIRTH DATE: _____ S.S.# _____

Phone Number: _____ Relationship: _____

WORKER'S COMP: ← Circle which is applicable → **AUTO ACCIDENT**

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

PHONE #: _____ ADJUSTOR: _____

DATE OF ACCIDENT: _____ CLAIM #: _____

AUTHORIZATIONS

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PROVIDER FOR SERVICES FURNISHED TO ME, AND I AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION/MEDICAL RECORDS / DOCUMENTATION TO THE INSURANCE COMPANY, THIRD PARTY PAYORS, AND ANYONE ASSISTING THEM IN OBTAINING PAYMENT, INCLUDING BILLING, CODING AND COLLECTION AGENTS, THEIR ATTORNEYS AND CONSULTANTS FOR SERVICES RENDERED TO ME AS NEEDED TO OBTAIN BENEFITS. I UNDERSTAND THAT I MAY BE SEEN BY A NURSE PRACTITIONER AND THAT I ALWAYS HAVE THE CHOICE OF SEEING A DOCTOR INSTEAD OF THE PRACTITIONER. I AUTHORIZE THE PHYSICIAN TO USE ANY PHOTOGRAPHS TAKEN DURING THE COURSE OF MY TREATMENT FOR SCIENTIFIC, EDUCATIONAL AND/OR PROMOTIONAL PURPOSES. I WILL NOT BE IDENTIFIED BY NAME, NOR WILL PHOTOGRAPHS OF MY FACE BE USED WITHOUT SEPARATE, SPECIFIC AUTHORIZATION. I FURTHER AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION, MEDICAL RECORDS AND/OR DOCUMENTATION TO OTHER PHYSICIANS, MEDICAL FACILITIES, INSURANCE COMPANIES, FOR QUALITY ASSURANCE, PEER REVIEW, CONSULTATIONS, AND DIAGNOSTIC STUDIES. IF I DO NOT PAY MY CHARGES WITHIN 90 DAYS OF INCURRING THE CHARGE, I WILL PAY AN ADDITIONAL \$30 FEE, PLUS APPLICABLE SALES TAX, FOR COLLECTION SERVICES.

SIGNATURE

DATE

HIPAA NOTICE

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. A copy of this form is available for review in our office. If you desire a copy to take with you, one will be provided. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

I understand that...

(Initial all five boxes):

_____ A referral from my Primary Care Physician may be required for any and all non-Emergency outpatient hospital/specialist services, based on my insurance plan in effect at the time of the service. I acknowledge that if I do not have a referral with me at the time of the appointment, and I choose to receive the services without the required referral, I will be held responsible for any payments incurred for these services.

_____ For your comfort and peace of mind, a chaperone is available to be present during your consultation, examination, or procedure. If you would like a chaperone, please let our staff know at any time during your visit.

_____ I understand that if I have a noncovered service for which my insurance carrier will not make payment and I agree to be financially liable for any payments incurred for these services.

_____ The patient agrees that any legal claims related to treatment provided by Plastic Surgery Specialists, PC will be brought only in the Court of Common Pleas of Chester County, PA, where Plastic Surgery Specialists, PC is located.

_____ I understand that I will be responsible for all fees incurred if this visit or any other service precedes the effective date that has been assigned to my enrollment or my dependent's enrollment or occurs after termination of coverage.

_____ I understand that I will be responsible when an insurance company will not pay a benefit or contracted claim, or if the insurance company requests money back on a previously paid claim. There can be several reasons why the claim is denied or reversed:

- 1) The service was not covered under the patient's health insurance contract.
- 2) The claim was allegedly received in an untimely manner.
- 3) The service was considered as not being medically necessary.
- 4) There is another insurance company that is primary.
- 5) The procedure or service submitted is included with another procedure or service being billed at the same time.
- 6) The patient's policy was terminated with NO COBRA continuance.
- 7) The medical condition was deemed by the insurance company as being pre-existing.
- 8) The patient's policy is new and not effective on the date services were provided.
- 9) Authorization or Precertification was not obtained prior to rendering the service.
- 10) Benefits ran out. In other words, the patient may have been limited to a certain number of visits. This can usually happen with chiropractic visits.
- 11) The patient's insurance policy is not in effect at the time of service.

SIGNATURE

DATE

MEDICAL HISTORY

WHAT IS YOUR REASON FOR SEEKING CARE WITH OUR PRACTICE? _____

WHAT ARE YOUR SYMPTOMS? _____

WHAT MAKES THIS PROBLEM WORSE? _____

IF YOU HAVE BEEN TREATED FOR THIS PROBLEM BEFORE, WHAT TYPE OF TREATMENT DID YOU RECEIVE? _____

PAST MEDICAL/FAMILY/SOCIAL HISTORY:

HEIGHT _____ WEIGHT _____

HAVE YOU HAD A COVID VACCINATION? ☐ YES ☐ NO

LIST ANY ALLERGIES: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ☐ YES ☐ NO

MEDICATION	DOSAGE	REASON FOR TAKING
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST PREVIOUS SURGERIES:

TYPE OF SURGERY	YEAR PERFORMED	REASON FOR HAVING SURGERY
_____	_____	_____
_____	_____	_____
_____	_____	_____

IS THERE ANY CHANCE THAT YOU MAY BE PREGNANT? ☐ YES ☐ NO

ALCOHOL/CAFFEINE/TOBACCO USE:

	AMOUNT OF USE	PAST USE	STOPPED USE
ALCOHOL ☐ YES ☐ NO	_____	_____	_____
TOBACCO ☐ YES ☐ NO	_____	_____	_____
CAFFEINE ☐ YES ☐ NO	_____	_____	_____

PREFERRED PHARMACY: _____