INFORMED CONSENT FOR TREATMENT

DOCTOR Feins

Patient Name: _____

I, knowing that I am experiencing a condition requiring diagnostic, medical, or surgical treatment, do hereby request a consultation with Robert S. Feins, M.D., F.A.C.S., a Board Certified Plastic Surgeon, and do voluntarily consent to examination and evaluation of my condition by Dr. Feins.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Dr. Feins.

_____ _____
Patient signature Date

OR

_____ _____
Legal guardian signature Date

Consent for Clinical Personnel: I am aware that patients at this office may be attended by an esthetician, a nurse, or other health care personnel, whom may be present during patient care as part of their duties.

Consent for Photos: I consent to the taking of photographs for medical record documentation, treatment purposes, and educational purposes only provided that my identity is not disclosed to any outside party without my prior written consent.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider involved with my current treatment. I understand that office personnel may release the fact that I am presently a patient here, without disclosing confidential information, so that I may receive phone calls.

Pre-certification/prior authorization agreement: I understand that I am responsible to comply with the rules and requirements of my insurance company reading pre-certification and prior authorization requirements.

Guarantee of account: I agree to pay Dr. Feins for all charges not covered by any third party payor.

_____ _____ _____
Patient Signature (or legal representative) Relationship to patient Date

Reason patient is unable to sign consent: ___(minor) ___(physical or mental disability) ___(other)

Robert S. Feins, M.D., P.A., F.A.C.S.
Plastic and
Reconstructive Surgery
Doctors Park
144 Tarrytown Road
Manchester, NH 03103
603·647·4430
Facsimile 603·647·4877

ROBERT Feins

Our Financial Policies

BASIC POLICY: Payment for services is due in full at the time service is provided.

For Patients with Insurance: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-Payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than an anticipated for your care. If an insurance carrier has not paid within 45 days of billing, professional fees are due and payable in full from you.

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Deductibles and Co-Pays: It is your responsibility to check your insurance for your deductible and co-pays for office visits and surgeries. If your deductible has not been met, you will be responsible for the unpaid portion. If you have a high deductible plan, the Provider Reasonable Charge or Usual and Customary Reimbursement will be collected at the time of your appointment. If your Explanation of Benefits (EOB) indicates that we overcharged you for a service, the practice will refund the difference to you for that service.

Medicare Patients: We will bill Medicare for you. We will also bill secondary insurance for you. All co-payments or deductibles are due and payable at the time service is provided.

Medicaid Patients: All Medicaid patients must provide a current, valid certificate before being seen.

Surgery Fees: All co-pays, deductibles and payments for non-covered surgical procedures are due in full prior to surgery. Prior authorization may be required by your carrier.

Non-Covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY, INC.

Cosmetic Services: If you elect to pursue cosmetic surgery, you will meet with our surgical coordinator who will have more detailed information on policies, pricing, scheduling, informed consents and forms to be completed.

Payment and HIPAA. I understand that HIPAA authorizes you to disclose my protected health information to third party payors (including health/life insurance companies, banks, credit card companies, the issuing bank and/or payment processors) for payment purposes.

Delinquent Accounts: Should your account become delinquent and be referred to an attorney or collection agency for collection, you shall pay actual attorney's fees and collection expenses. All delinquent accounts may be charged interest at the maximum rate allowed by law.

I have read, understood, and agreed to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all professional fees.

_____ _____

Signature Date

MEDICARE PATIENT REGISTRATION

DOCTOR Feins

Name: _____ ❑ Jr. ❑ Sr.

Prefer to be called: _____ Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Date of Birth: _____
Month / Day / Year

Address: _____
Street # Street Name Apt #

_____
City State Zip

Day Phone: (_____)_____ Evening Phone: (_____)_____

Primary Care Physician: _____

Primary Care Physician Address and Phone Number: _____

Who referred you? _____

Answer questions below by placing a check **in the appropriate column:**

YES	NO	
❑	❑	Have you recently joined a Medicare HMO? If yes, identify: _____
❑	❑	Do you or your spouse work in a company which has more than 20 employees and have Coverage though the insurance at that job?
❑	❑	Are you covered by a HMO/PPO which makes Medicare secondary?
❑	❑	Is this illness covered by the VA (Veteran's Administration)?
❑	❑	Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?
❑	❑	Is this illness due to an automobile accident?
❑	❑	Is this illness due to an injury at work?
❑	❑	Are you receiving Medicaid?

Please present your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

Insurance Information:

Do you have insurance? ❑ Yes ❑ No

Primary Insurance Carrier:_____

Name of Insured (Guarantor): _____ Guarantor Date of Birth: ____/____/____

Secondary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor Date of Birth: ____/____/____

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____/_____/_____

Signature as it appears on Medicare Card **Date**

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Robert S. Feins, M.D., Prof. Ass'n
Medicare Patient Registration - continued

If you have a supplemental policy and it is a MEDIGAP policy to which you're Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____/_____/_____
Signature as it appears on Medicare Card Date

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their name and phone number:

Name: _____ Relationship: _____

Phone # (day): (_____)_____ Evening #: (_____)_____

May we leave personal medical information on your answering machine at home?

❑ YES ❑ NO

May we e-mail personal medical information to you?

❑ YES ❑ NO E-mail address: _____

Patient Signature: _____ Date: _____/_____/_____

Emergency Contact Information:

In case of an EMERGENCY whom should we notify?

Relationship to Patient:

_____ Phone: _____

Preferred Pharmacy information:

Name of Pharmacy: _____

Address: _____

_____
City State Zip

Phone number: _____ Fax number: _____

HEALTH HISTORY

PLEASE PRINT

TODAY'S DATE _____

DOCTOR Feins

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Diplomate, The American Board of Plastic Surgery

_____
PATIENT'S NAME

_____ MALE / FEMALE HEIGHT: _____
AGE DATE OF BIRTH GENDER (CIRCLE ONE) WEIGHT:

_____
PRIMARY CARE PHYSICIAN NAME, ADDRESS AND TELEPHONE NUMBER

_____
REFERRING PHYSICIAN NAME, ADDRESS AND TELEPHONE NUMBER

_____
DOES YOUR INSURANCE COMPANY REQUIRE A REFERRAL? YES/NO (CIRCLE ONE)

_____
REASON FOR VISIT:

ARE YOU A FULL TIME STUDENT? ☐YES ☐NO

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES OR NO. ALL RESPONSES ARE KEPT CONFIDENTIAL.

1. **ARE YOU IN GOOD HEALTH?** Y N
2. **HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?** Y N
3. **DATE OF LAST PHYSICAL EXAM: _____** Y N
4. **ARE YOU NOW UNDER A PHYSICIAN'S CARE?** Y N
5. **HAVE YOU HAD ANY SERIOUS ILLNESSES?** Y N
   YEAR _____ REASON: _____
   YEAR _____ REASON: _____
6. **HAVE YOU EVER HAD AN MRSA OR A VRE?** Y N
7. **HAVE YOU HAD ANY PRIOR HOSPITALIZATIONS?** Y N
   YEAR _____ REASON: _____
   YEAR _____ REASON: _____
8. **HAVE YOU HAD ANY PRIOR SURGERIES?** Y N
   YEAR _____ REASON: _____
   YEAR _____ REASON: _____
   YEAR _____ REASON: _____
9. **ARE YOU A SMOKER?** Y N
   I CURRENTLY SMOKE CIGARETTES. PACKS/DAY _____ Y N
   I USED TO SMOKE CIGARETTES. PACKS/DAY _____ Y N
   QUIT DATE: _____
   OTHER TOBACCO USE: Y N
   PIPE Y N
   CIGAR Y N
   CHEW Y N
10. **DO YOU NOW HAVE OR HAVE YOU EVER HAD:** Y N
    - **RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE?** Y N
    - **CONGENITAL HEART DISEASE?** Y N
    - **CARDIOVASCULAR DISEASE? (HEART ATTACK, HEART MURMUR, CORONARY ARTERY DISEASE,ANGINA, HIGH BLOOD PRESSURE, STROKE, PALPITATIONS, HEART SURGERY, PACEMAKER)** Y N
    - **RADIATION TREATMENT FOR CANCER?** Y N
    - **SEIZURES, CONVULSIONS, EPILEPSY, FAINTING, DIZZINESS?** Y N
    - **PSYCHIATRIC TREATMENTS, NERVOUS DISORDER OR BREAKDOWN?** Y N
    - **LIVER DISEASE (JAUNDICE, HEPATITIS?)** Y N
    - **KIDNEY DISEASE?** Y N
    - **DIABETES?** Y N
    - **PANCREATITIS?** Y N
    - **THYROID DISEASE (GOITER?)** Y N
    - **ARTHRITIS** Y N
    - **STOMACH ULCERS OR COLITIS?** Y N
    - **GLAUCOMA?** Y N
    - **FREQUENT OR RECURRENT COLD OR MOUTH SORES?** Y N
    - **IMPLANTS PLACED ANYWHERE IN YOUR BODY? (BREAST, HEART VALVE, HIP, KNEE?)** Y N
    - **LUNG DISEASE (ASTHMA, EMPHYSEMA, CHRONIC COUGH, BRONCHITIS, PNEUMONIA, TUBERCULOSIS, SHORTNESS OF BREATH, CHEST PAIN, SEVERE COUGHING?** Y N
    - **HERPES OR OTHER VIRAL INFECTIONS?** Y N
    - **EYE PROBLEMS** Y N
    - **HEARING LOSS?** Y N
    - **SINUS OR NASAL PROBLEMS?** Y N
    - **DENTURES?** Y N
    - **BLEEDING PROBLEMS?** Y N
    - **NOSE BLEEDS?** Y N
    - **BLEEDING GUMS?** Y N
    - **ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM?** Y N
    - **RECURRENT INFECTIONS OF ANY KIND?** Y N
    - **BLOOD TRANSFUSION(S)?** Y N
11. **DO YOU WEAR CONTACT LENSES?** Y N
12. **DO YOU WEAR HEARING AIDS?** Y N

13. **DO YOU TAKE ASPIRIN REGULARLY? HOW OFTEN? _____** Y N

14. **PLEASE LIST ALL CURRENT MEDICATIONS (OR PROVIDE A CURRENT LIST):**

MEDICATION	DOSAGE

15. **ARE YOU ALLERGIC OR HAVE HAD A BAD REACTION TO:**

- **LOCAL ANESTHETIC (NOVOCAINE, ETC.)?**
- **PENICILLIN, AMOXICILLIN, CEPHALOSPORINS OR OTHER ANTIBIOTICS?**
- **BARBITURATES, SEDATIVES, ETC.?**
- **ASPIRIN OR IBUPROFEN?**
- **CODEINE OR OTHER PAIN KILLERS?**
- **TAPE, LATEX OR RUBBER PRODUCTS?**
- **OTHER MEDICATIONS? PLEASE LIST:**

16. **WOMEN ONLY:**

A. ARE YOU PLANNING PREGANANCY? Y N

B. COULD YOU BE PREGNANT NOW? Y N

C. NUMBER OF PREGNANCIES: _____

D. NUMBER OF DELIVERIES: _____

E. HAVE YOU EVER BREAST FED? Y N

F. DO YOU DO REGULAR BREAST EXAMS? Y N

G. DATE OF LAST MAMMOGRAM: _____

H. DATE OF LAST PAP SMEAR: _____

WE RECOMMEND REGULAR BREAST AND PELVIC EXAMS WITH YOUR DOCTOR OR GYNECOLOGIST

17. **ALCOLHOL USE**

DO YOU DRINK ALCOHOL? Y N

IF YES, HOW MANY DRINKS PER WEEK? _____

IS YOUR ALCOHOL USE A CONCERN FOR YOU OR OTHERS? Y N Y N

18. **DRUG USE**

DO YOU USE ANY RECREATIONAL DRUGS? Y N

HAVE YOU EVER USED NEEDLES TO INJECT DRUGS? Y N

19. **BODY PIERCING**

HAVE YOU PIERCED ANY PART OF YOUR BODY WITHIN THE LAST TWO WEEKS? Y N

20. **OTHER**

HAVE YOU EVER SOUGHT PROFESSIONAL CARE FOR DRUG ABUSE OR ALCOHOLISM Y N

DO YOU HAVE ANY OTHER DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK DR. FEINS SHOULD KNOW ABOUT? Y N

DO YOU HAVE OTHER CONCERNS THAT YOU WISH TO SPEAK TO DR. FEINS ABOUT PRIVATELY? Y N

I understand the importance of a truthful health history to assist Dr. Feins and his staff in providing the best care possible. I have had the opportunity to discuss my health history with my doctor. If you become a surgical candidate, this information will be shared with the surgical facility for pre-operative purposes.

I verify that the above information is true and accurate to the best of my knowledge as of today's date.

_____ _____

Signature of Patient or Parent/Guardian if patient is a minor Date

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New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or HealthCare Operations

DOCTOR Feins

I, _____, understand that as part of my health care, ROBERT S. FEINS, M.D., PROF. ASS'N., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means of which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided or have reviewed a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that ROBERT S. FEINS, M.D., PROF. ASS'N is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ROBERT S. FEINS, M.D., PROF. ASS'N reserves the right to change their notice and practices and that prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations., should ROBERT S. FEINS, M.D., PROF. ASS'N change their notice, they will send a copy of any revised notice to the address I've provided (whether by U.S. Mail or, if I agree, email.)

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of the organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline (*circle one*) the terms of this consent.

✘ _____ _____

Patient's Signature Date

Robert S. Feins, M.D., F.A.C.S.

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THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY, INC.

ROBERT Feins

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGMENT FORM

Robert S. Feins, M.D., P.A., F.A.C.S.

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I, _____, have reviewed a copy of Dr. Feins' Notice of Privacy Practices.

_____ _____

Signature of Patient Date

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