

WELCOME TO OUR PRACTICE!



Please take a moment to complete
this form so we can better assist you
with your health care needs.

EAST LAKE
PLASTIC SURGERY CENTER

PATIENT INFORMATION

Date: _____ Account # _____

Last Name _____ First Name: _____ MI: _____ SS #: _____

Sex: M F Age _____ Date of Birth _____ Marital Status: S M D W SEP

Parents' Names if Patient is a Minor: Mother: _____ Father: _____

Spouse or Partner's Name: _____

Mailing Address _____ City: _____ State: _____ Zip: _____

Phone # home: (____) _____ cell: (____) _____ E-Mail: _____

Occupation _____ Employer Name: _____ work#: (____) _____

If Student: Full-Time Part-Time Name of School: _____

Notify in Case of Emergency: _____ Relation: _____ Phone #: (____) _____

Primary Care Doctor: _____ Phone #: (____) _____

How did you here about us? CHECK ALL THAT APPLY ER Internet Yellow Pages Yellow Pages Local newspaper Other _____

Doctor _____ Name _____ Patient _____ Name (Optional) _____ Friend _____ Name (Optional) _____

CARRIER INFORMATION

Primary Insurance: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Carrier Phone #: _____ Policy #: _____ Group #: _____

Name of Policy Holder if other than Patient: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____

Secondary Insurance: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Carrier Phone #: _____ Policy #: _____ Group #: _____

Name of Policy Holder if other than Patient: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____

PERMISSION FOR TREATMENT

I hereby voluntarily consent to and authorize medical care/diagnostic treatment and /or minor surgical treatment by **ISIDOROS MORAITIS, MD** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the use and disclosure of any of my past/current medical records for treatment and healthcare operations.

Signed: _____ Print Name: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

I hereby assign all medical/diagnostic/surgical benefits payable for the services rendered, to include major medical benefits to which I am entitled, including Medicare, Private Insurance and other health plans to **ISIDOROS MORAITIS, MD, PA**. I hereby authorize said assignee to release to CMS/Insurance Carriers and it agents all information needed to determine these benefits or benefits related to services. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/ procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services.

Signed: _____ Print Name: _____ Date: _____

Office Witness: _____ Print Name: _____ Date: _____

THANK YOU FOR CHOOSING OUR PRACTICE!



Please take a moment to complete all information on this record. The information you provide is treated as confidential.

EAST LAKE
PLASTIC SURGERY CENTER

PATIENT HISTORY

Patient Name: _____

Account #: _____

Date: _____ Reason for your visit today: _____ Date of Injury, If Applicable: _____

Please list current medical conditions (Heart problems, diabetes, bleeding disorder, etc): _____

Medications currently taken on a regular basis (including over-the-counter and Herbs): _____

HAVE YOU **EVER** HAD:

<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HIGH OR LOW BLOOD PRESSURE	<input type="checkbox"/> LIVER DISEASE
<input type="checkbox"/> LUNG PROBLEMS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> KIDNEY DISEASE
<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> PAIN IN THE CHEST	<input type="checkbox"/> DIABETES/ INSULIN USE
<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> PAIN IN THE ARMS	<input type="checkbox"/> BLEEDING PROBLEMS
<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> BREAST DISEASE
<input type="checkbox"/> HEART SURGERY	<input type="checkbox"/> CONVULSIONS	<input type="checkbox"/> GLAUCOMA

ARE YOU ALLERGIC TO:

<input type="checkbox"/> FOODS _____	<input type="checkbox"/> PENICILLIN	<input type="checkbox"/> DEMEROL
<input type="checkbox"/> SHELLFISH/ IODINE	<input type="checkbox"/> OTHER ANTIBIOTICS	<input type="checkbox"/> ANY ANESTHETIC _____
<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> CODEINE	<input type="checkbox"/> NOVOCAINE/LIDOCAINE

Please list **any other allergies** not mentioned above: _____

Have you ever had a general anesthetic before? Yes No If Yes, for what? _____

Describe any problems you had with Anesthesia, if any: _____

Do you smoke? Yes No If yes, how often? _____ How many cigarettes per day? _____

Do you use any other tobacco products? Yes No If yes, how often? _____

Are you under the care of a physician at this time for any problem? Yes No If yes, please explain: _____

COSMETIC SURGERY/PROCEDURE PATIENTS ONLY:

Have you ever consulted a plastic surgeon? Yes No For the same reason as today? Yes No

Have you had previous plastic surgery? Yes No

Have you ever been treated with Accutane (Isotretinoin) or any other acne medication? Yes No

WOMEN ONLY:

IS THERE A CHANCE YOU COULD BE PREGNANT NOW? YES NO

NURSING ONLY: AGE: _____ HEIGHT: _____ WEIGHT: _____ T/P/R: _____ BP: _____



EAST LAKE
PLASTIC SURGERY CENTER

Patient Name: _____

Account #: _____

DESIGNATED RELATIVE

_____(Initial) I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with: *Please list the family members or significant others, if any, whom we may inform about your medical condition.*

Name: _____ Relation: _____ Phone #: (____) _____
Name: _____ Relation: _____ Phone #: (____) _____

PRIVACY NOTICE

_____(Initial) I have received a copy of ISIDOROS MORAITIS, M.D.'s office *privacy notice* as required by HIPAA that provides a complete description of *personal health information* uses and disclosures. I have been provided an opportunity to review it.

FINANCIAL POLICY

USUAL AND CUSTOMARY FEES: Our practice is committed to providing the best medical care for our patients. We charge what is usual and customary for our area. All patients are responsible for providing accurate and complete personal and insurance information prior to being seen by the doctor. The charges made, for your visit and care provided, depend on the nature and the complexity of your problem.

FORMS OF PAYMENT ACCEPTED: Payment may be in the form of cash, checks, Master Card and Visa. Returned checks are subject to a service charge. Elective Cosmetic Surgeries may also be paid in full with a *Cosmetic Fee Plan* or *Patient Financing Services* account.

PAYMENT FOR SERVICES (SELF-PAY/NON-INSURED): Payment in full is expected before services are rendered unless prior financial arrangements have been made.

PAYMENT FOR SERVICES (PERSONAL HEALTH INSURANCE/MEDICARE): Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by your insurance company. In all cases, we require that the guarantor, the person who is financially responsible, is *personally* liable for all balances not covered by Medicare or other insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. All charges are your responsibility from the date services are rendered. **CO-PAYMENTS:** Co-payments are due at the time of service.

PAST DUE ACCOUNTS: Any balances on your account after 90 days, including those that insurance has not paid, will be referred to a collection agency unless other financial arrangements have been made in advance. Legal fees that we pay to secure any past due balances will be added to your account. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

WORKERS COMPENSATION: If you are seeking medical care as a result of a work-related injury, we will assist you in verifying your claim for the coverage of your medical bills. If for any reason your worker's compensation is not verified, the full responsibility for payment of services rendered will be that of the individual receiving treatment.

PAYMENT FOR ELECTIVE COSMETIC SURGERY: Payment in full is expected before services are rendered. Aesthetic (Cosmetic) surgeries will not be scheduled until your financial obligation has been met. Our office requires a minimum deposit of \$500 or 10% of the total surgeon's fee, whichever is greater, in order to schedule your surgery. This deposit will be applied to your "surgeon's fee" portion of the cost. Payment may be in the form of cash, checks, Master Card and Visa. If paying by credit card, the card must be presented in person by the authorized cardholder and a charge slip must be signed. Returned checks are subject to a service charge. Payment in full of the surgeon's fee must be received two (2) weeks prior to your scheduled procedure or we reserve the right to cancel or reschedule your surgery.

CANCELLATION OF ELECTIVE COSMETIC SURGERY: Should it become necessary for you to cancel or reschedule your surgery, we must receive notice of that change at least 10 days before your surgery date. If we receive notice of cancellation by that time, your deposit will be refunded in full. If you paid for your surgery with one of our financing companies offered, we will refund your financed portion of your payment minus 7%. If you should cancel your surgery three times, your deposit of \$500 or 10% paid will not be refunded and we will require a new deposit to reschedule your surgery. Exceptions will be made for documented emergency or medical disability.

REFUNDS FOR SKIN CARE SERVICES/PRODUCTS: Refunds will be made on pre-paid services that are not rendered, after regular prices are applied to those services already received. All SkinMedica home care products are 100% refundable within 30 days of purchase with receipt.

By signing this form, I fully understand and agree to the terms of the FINANCIAL POLICY.

Signed: _____ Print: _____ Date: _____

Office Witness: _____ Print: _____ Date: _____



EAST LAKE
PLASTIC SURGERY CENTER

CONSENT FOR TAKING AND/OR PUBLISHING PHOTOGRAPHS

Patient Name: _____ Account. #: _____

I hereby grant authority to ISIDOROS MORAITIS, M.D. and/or his designated representatives to take photographs of myself/my child with the understanding that such photographs are for confidential clinical purposes of evaluation and treatment, and that all photographs remain the property of ISIDOROS MORAITIS, M.D.. I understand that the photographs are a permanent part of my medical record, and as such may be submitted to my insurance for the specific purpose of obtaining reimbursement for authorized services. I understand that the photographs may also be used for the purpose of certification of Isidoros Moraitis, M.D. by the American Board of Plastic Surgery.

Signed: _____ Print: _____ Date: _____

Office Witness: _____ Print: _____ Date: _____

IN ADDITION to use of these photographs for the purposes as previously stated, I consent to their use as specifically indicated below **(please check appropriate boxes to indicate approved choices):**

YES **NO**

My/my child's photographs may be used for the purpose of education or science, and as such may be published and republished with appropriate documentation in professional journals or medical books, or used for any other purpose which may be deemed proper in the interest of medical education, knowledge or research; provided however, that it is specifically understood that in such publication or use I shall not be identified by name.

YES **NO**

My/my child's photographs may be used for the purpose of patient/public education, and as such may be viewed by others. It is specifically understood that in such use of these photographs, I shall not be identified by name.

addendum _____

Signed: _____ Print: _____ Date: _____

Office Witness: _____ Print: _____ Date: _____