PLASTIC SURGERY

East Coast Advanced Plastic Surgery, LLC

Cyrus Loghmanee, MD
Dean Cerio, MD
Charbel Chalfoun, MD
Mazen Bedri, MD

Phone: 201-449-1000 ❖ Fax: 201-399-2433

2017 PATIENT INFORMATION

Patient Name: _____ **Date:** _____

Home/Mailing Address: _____
Street

_____
City State Zip + 4

Date of Birth: _____ **SS#:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Alternate Phone:** _____

Email address: _____

Insurance Carrier: _____ **Insurance ID#** _____

Insurance Subscriber Name *(Policy Holder)*: _____

Subscriber Date of Birth: _____ **Your Relationship to Subscriber:** _____

Subscribers Address: _____

_____
City State Zip + 4

PRIMARY PHYSICIAN: _____ PHONE: _____

Address: _____
Street

_____
City State Zip + 4

BREAST SURGEON or OB/GYN: _____ Phone: _____

Address: _____

_____
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ALLERGIES:

Medications	Type Of Reaction	Food	Type Of Reaction	Environmental	Type Of Reaction

MEDICATIONS: please include aspirin, hormone replacement, birth control, diet pills, sleep aids, all vitamins, herbs, teas, over-the-counter or alternative therapies.

MEDICATION [name of drug]	DOSAGE [how much]	FREQUENCY [how often]

HEIGHT:_____ **WEIGHT**:_____

PAST MEDICAL HISTORY: Do you have now, or have you had in the past, any of the following:

HISTORY	YES	NO
Thyroid Disorder		
High Blood Pressure		
Tuberculosis		
Asthma		
Heart Disease		
Jaundice		
Hepatitis		
Neurological Disease		
Seizure Disorders		
Gastrointestinal Disease		
Kidney Disease/ Urinary Problems		
Diabetes		
Fever Blisters		
History of Blood Clots/Bleeding Disorders		
Family History of Blood Clots/Bleeding Disorders		
Psychiatric/Emotional Disorders		
Motion Sickness		
Steroid Use		
Heavy Scars		

List Other Medical Conditions (if any): _____

_____

PAST SURGERIES/HOSPITALIZATIONS:

DATE	TYPE OF SURGERY	NAME OF HOSPITAL	DOCTOR

ANESTHESIA HISTORY:

Have you ever had a REACTION to a GENERAL anesthetic? (Being put to sleep) Yes No

Has a family member ever had a REACTION to a GENERAL anesthetic? Yes No

Have you ever had a REACTION to a LOCAL anesthetic? (Novocain, etc.) Yes No

If you answered "yes" to any of the above, please provide details_____

_____

SOCIAL HISTORY:

Tobacco (cigarettes, cigars, pipe) [list amount/day and number of years of smoking]

_____

_____

If you ever smoked but don't now, when did you quit? _____

_____

Have you been exposed to heavy second hand cigarette, cigar, or pipe smoke for an extended period of time on a regular basis in the past two years? Yes No

Recreational Drugs (type of drug and number of years of use) _____

_____

Alcohol (type and how often) _____

_____

FAMILY HISTORY: (list relationship, age, medical problem, and please specify if currently living or deceased)

MOTHER	FATHER	SISTER(S)	BROTHER(S)

PRIMARY CARE MD: (name and telephone) _____

PHARMACY: (name and telephone) _____

EMERGENCY CONTACT PERSON: (name and telephone) _____

PATIENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP OF GUARDIAN TO PATIENT: _____

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REQUEST FOR INSURANCE PLAN DOCUMENTS TO BE FURNISHED TO MY PROVIDER

Insurance Carrier:
Address:

Re: Patient:
Policy:
Treatment Dates:

Dear Director of Claims,

This letter is to notify you that our office has obtained both an authorization of payment and compliant assignment of benefits related to treatment rendered or to be rendered to the above referenced patient. Enclosed is a copy of this legally binding assignment for your records.

As you are likely aware, an assignee has certain rights to plan disclosure available under ERISA. Full disclosure of plan provisions to an assignee allows the assignee to perfect claims for benefits in compliance with the specific requirements of the employee benefit plan. Please accept this request for the following information which will assist our office in obtaining full benefits under the ERISA plan:

Complete coverage information for:

_____

_____

including any potentially applicable limitations, exclusions, fee schedule or usual and customary adjustments.

Additionally, pursuant to Title 29 of the Code of Federal Regulations, Section 2650.503-1, please accept this pre-service claim for the following information to further clarify our rights regarding the plan in question:

1. **A copy of any form required by the employee benefit plan for the purpose of identifying the authorized representative.**
2. **A copy of any anti-assignment provision outlined in the employee benefit plan.**
3. **A copy of the Summary Plan Description (SPD).**
4. **Name and address of Fiduciary of the Plan if such fiduciary is not referenced in the above documents.**

The Department of Labor has stipulated that when a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a claim, the plan should, in the absence of a contrary direction from the claimant, direct all information and notification to which the claimant is otherwise entitled to the representative authorized to act on the claimant's behalf with respect to the aspects of the claim. Please see Question B-3 at http://www.dol.gov/pwba/faqs/faq_claims_proc_reg.html. Failure to provide the requested information may affect your ability to assert pertinent policy rights and defenses in a court of law. Further, failure to provide certain information requested by a participant or **qualified assignee** within **15 days** after a request can result in a civil penalty of up to $110 per day.

Please send these documents to our billing department: Elite Billing, LLC, 639 E. Ocean Ave. Suite 308, Boynton Beach, FL 33435 or you may fax them to our secure fax line: 201-399-3672.

Thank you for your anticipated cooperation regarding this request.

Patient Name (print) Patient Signature Date

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Legal Assignment of Benefits & Designation of Authorized Representative

I, the undersigned, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to, **East Coast Advanced Plastic Surgery, L.L.C.** and all medical professionals, including physician assistants of this practice, including, but not limited to **Charbel Chalfoun, Cyrus Loghmanee, Dean Cerio, Mazen Bedri** (the "provider(s)") as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws., of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the Designated Authorized Representative(s) any and all plan documents, including Governing Plan Documents, including, but not limited to a written explanation of how level of benefit payments are determined for out-of-network providers, Summary Plan Description, 5500 Form (Plan Annual Return), Certificate for PPACA Grandfathered Health Plan, where applicable, insurance policy and/or settlement information upon written request from the Designated Authorized Representative(s) in order to claim certain medical benefits in connection for healthcare services provided to the undersigned. This, includes, but is not limited to, receiving disbursement benefit checks for claims submitted, member's rights to appeal claim denials, as well as to claim any applicable statutory penalties on behalf of the plan participant and beneficiary. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the Designated Authorized Representative(s) to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor, including, but not limited to, issuance of reimbursement checks, Explanation of Benefits and any/all correspondence related to claims reimbursement; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the Designated Authorized Representative(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the Designated Authorized Representative(s) against any such liable party or employee group health plan in my name with derivative standing but at such Designated Authorized Representative(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement.

_____	_____	_____
Signature of Insured / Guardian	**Print Name of Insured/Guardian**	**Date**

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STATEMENT OF FINANCIAL RESPONSIBILITY

Disclosures required by the Federal Truth in Lending Act: The patient or responsible party is hereby advised:

1. The full amount of the fees, costs and expenses for **cosmetic surgery** is due and payable prior to surgery.
2. The full amount of the fees, costs and expenses for **non-cosmetic surgery** will be submitted to his/hers insurance carrier for payment, if applicable.

The patient or responsible party hereby acknowledges, agrees and states:

3. I assign my insurance benefits to the provider listed above. I understand that this form is valid for five (5) years unless I cancel the authorization through written notice to the health care provider.
4. In the event that benefits are paid directly to me by my insurer, I agree to surrender any and all such payments to the provider upon receipt, along with a copy of the corresponding explanation of benefits. This shall include, but is not limited to all monies received from initial claim payment, corrected claim payments, all appeals claim payments, and any and all interest and penalties paid as a direct result of my insurers' violation of prompt pay laws.
5. I understand that I may be responsible for any balance not covered by my insurance carrier including but not limited to lack of coverage, co-payments, co-insurance, deductible, and/or non-covered items in accordance with the terms of my plan. These amounts are due and payable within 7 days of my insurance carriers' explanation of benefits statement for said claim and if not paid at that time, a finance charge of 1% per month may be imposed. If applicable by my signature of optional pre-authorized health care agreement below, the above amounts due will be charged to my credit card.
6. I realize that all medical and surgical charges incurred by me or my dependents for services rendered are my financial responsibility. Any fees necessary to collect set amount are also payable by me. I also understand that I will be responsible and agree to pay attorney's fees, which equal 1/3 of the total balance plus any processing fee that might be incurred to collect payment in full.

_____

Patients Name (Please Print) Date

_____

Signature of Member or Legal Guardian/Representative Date

Member Assignment of Benefits and Authorization for a Designated Representative to Appeal a Determination

In consideration of services rendered, including but not limited to surgery, office visits, use of facility, emergent care, etc., I assign to the provider of service and/or his/her assignee, any benefits made on my behalf to the above mentioned non-participating provider. I understand that I may be responsible for any balance not covered by my insurance carrier, including but not limited to co-payments, co-insurance, deductible, and/or non-covered items in accordance with the terms of my plan.

In the event that benefits are paid directly to me by my insurer, I agree to surrender any and all such payment(s) to the provider upon receipt. This shall include, but is not limited to, all monies as a direct result of initial claim payment, corrected claim payment, appeals claim payment (1st level, 2nd level and external appeal), and any and all interest and penalties paid as a result of prompt pay laws. In the event that my benefits are denied due to lack of coverage or termination, I understand and agree that I will be responsible for services rendered and bill incurred. I also understand that I will be responsible and agree to pay attorney's fees which is equal to 1/3 of the total balance plus any processing fees that might be incurred to collect payment in full. I authorize release of medical information to my insurer when needed to determine benefits payable. In the event of a determination unfavorable to me and/or the provider, I hereby authorize Elite Billing, LLC to appeal my insurer's determination concerning the above mentioned date(s) of service on my behalf, as my designated representative, and as part of the appeal, I hereby authorize my insurer in its decision letter, and in connection with the processing of my appeal, to communicate with my designated representative in all aspects of the appeal. I understand that these communications may contain the following: All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by Law. This authorization is valid for a period of one year.

Signature of Member or Legal Guardian/Representative: _____

Signature of Witness: _____ Designated Representative: _____

Name of Witness/Designated Representative (Please Print), Title (If on Provider's staff) _____

Billing Address:
639 E. Ocean Ave., Suite 308
Boynton Beach, FL 33435
P: 201-355-5861
F: 201-399-3672

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS / SLIDES / AND/OR VIDEO FOOTAGE

AUTHORIZATION FOR RELEASE OF PATIENT IMAGE

Name _____

Address _____
Street City State Zip Code

I consent to the taking of photos, slides or video footage by **Dr. Loghmanee / Dr. Cerio / Dr. Chalfoun / Dr. Bedri** or his designee, of me, or parts of my body in connection with the plastic surgery procedure(s) to be performed by **Dr. Loghmanee / Dr. Cerio / Dr. Chalfoun / Dr. Bedri**. I further authorize **Dr. Loghmanee / Dr. Cerio / Dr. Chalfoun / Dr. Bedri** or one of his/her associates to release to the American Society of Plastic Surgeons ("ASPS") such images.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of ASPS and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from **Dr. Loghmanee / Dr. Cerio / Dr. Chalfoun / Dr. Bedri**.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire one year from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge **Dr.Loghmanee / Dr. Cerio / Dr. Chalfoun / Dr. Bedri** ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____
Signature of Patient/Responsible Party Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received the Notice of Privacy Practices. I have thereby been advised of the uses and disclosures of my protected health information that may be made by East Coast Advanced Plastic Surgery, LLCs practice's legal duties with respect to my protected health information. I understand that I can obtain a paper copy of East Coast Advanced Plastic Surgery, LLC's current notice of Privacy Practices upon request.

_____	_____	_____/_____/_____
Name of Patient	**Signature of Patient**	**Date**