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

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**

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

INITIAL PATIENT QUESTIONNAIRE

Date: _____ **Time:** _____

We are pleased that you have chosen us for your care.
Please check *all* that apply concerning your decision to use our services:

- ☐ **Television**
- ☐ **Internet search**
- ☐ **Magazine Ad** _____
- ☐ **Other:** _____
- □ **Referred by a friend:** _____
- □ **Referred by Center for Breast Health**
- □ **Referred by physician:** _____

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

What would you like us to call you? _____ **Sex:** ☐ **Female** □ **Male**

Home Address: _____ **Date of Birth:** _____

City/State/Zip: _____ **Marital Status:** □ **Single** □ **Married** □ **Divorced** □ **Widowed**

(for insurance purposes only)

Telephone Numbers **Home** ( ) _____
Cell ( ) _____
Work ( ) _____

Email Address: _____

Occupation: _____ **Employer:** _____

Address: _____ **Zipcode:** _____

Where may we call you? ☐ **Home** ☐ **Cell** ☐ **Work** ☐ **Other** _____

Where may we leave messages for you? □ **Home** □ **Cell** □ **Work** □ **Other**

Is there a family member that we may leave messages with? _____

Would you like us to mail/email you about any of our services? □ **Yes** □ **No**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received Plastic & Reconstructive Surgery's Notice of Privacy Practices. I understand that this notice describes how medical information about me may be used and disclosed, my rights regarding the use and disclosure of this information, and how I can obtain access to this information.

SIGNATURE: _____ **DATE:** _____

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

PRIMARY CARE PHYSICIAN

Name: _____
Address: _____ **Zipcode:** _____
Office number: ( ) _____ **Fax number: ( )** _____

REFERRING PHYSICIAN (*if different than Primary Care Physician*)

Name: _____
Address: _____ **Zipcode:** _____
Office number: ( ) _____ **Fax number: ( )** _____

PRIMARY INSURANCE

Insurance Carrier: _____ **Phone #: ( )** _____
Address: _____ **Zipcode:** _____
Policy I.D. # _____ **Group #** _____
Subscriber Name: _____ **Relation to Patient:** _____

SECONDARY INSURANCE

Insurance Carrier: _____ **Phone #: ( )** _____
Address: _____ **Zipcode:** _____
Policy I.D. # _____ **Group #** _____
Subscriber Name: _____ **Relation to Patient:** _____

RESPONSIBLE PARTY INFORMATION (*if relevant*)

Name: _____ **Relationship:** _____
Address: _____ **Zipcode:** _____
Phone #: ( ) _____ **Date of birth:** _____

EMERGENCY CONTACT INFORMATION (*if different than Responsible Party*)

Name: _____ **Relationship:** _____
Address: _____ **Zipcode:** _____
Phone #: ( ) _____

PHARMACY INFORMATION

Name and Location: _____
Phone #: ( ) _____ **Fax #: ( )** _____

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

PERSONAL MEDICAL HISTORY

Height _____ ***Weight*** _____ ***Age*** _____

Purpose of today's visit: _____

Do you have children? ☐ **no** ☐ **yes (list ages)** _____ **Last Menstrual Period (date):** _____

Medical Problems: ☐ **none**
☐ **high blood pressure** ☐ **diabetes** ☐ **hypothyroidism** ☐ **history of blood clots**
☐ **heart disease** ☐ **other:** _____

Previous Surgeries: (list ALL with approximate date including C-sections): ☐**none**

_____

_____

Current Medication: (list ALL with dosage and frequency, including herbal supplements): ☐**none**

_____

_____

Drug/Food Allergies: (list ALL with reactions): ☐**none**

_____

Tobacco Use: ☐**currently** ☐**never** ☐**in the past, but quit:** _____**(*date*)** _____**years** _____**packs/day**
Alcohol Use: ☐ **never** ☐**yes (how many per week)** _____

REVIEW OF SYSTEMS

Have you recently experienced any of the following? (Please circle all applicable)

General:	Fever ☐	Fatigue ☐	Weight loss ☐	Weight Gain ☐	Night Sweats ☐	
Neurological:	Headache ☐	Dizziness ☐	Weakness ☐	Numbness ☐	Fainting ☐	Seizures ☐
Cardiac:	Palpitations ☐	Chest Pain ☐	Feet Swelling ☐			
Respiratory:	Cough ☐	Wheezing ☐	Shortness of Breath ☐			
Abdominal:	No Appetite ☐	Pain ☐	Vomiting ☐	Constipation ☐	Diarrhea ☐	Blood in Stool ☐
Urinary:	Pain ☐	Frequency ☐	Urgency ☐	Blood in Urine ☐		
GYN:	Spotting ☐	Discharge ☐	Irregular Periods ☐			
M/Skeletal:	Back Pain ☐	Muscle Pain ☐	Joint Pain ☐	Joint Swelling ☐	Stiffness ☐	
Psychiatric:	Depression ☐	Anxiety ☐	Suicidal Thoughts ☐			
Hematology:	Easy Bruising ☐	Anemia ☐	History of Bleeding ☐			
Skin:	Discoloration ☐	Rash ☐	Itching ☐			

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

FOR BREAST PATIENTS ONLY

Current bra size_____ Known BRCA mutation? ☐ no ☐ yes (*please specify*)

_____

Any current breast symptoms? ☐ no ☐ yes (list duration, side)_____

Date of last mammogram: _____ Where was it done?_____

Have you ever had a breast biopsy? ☐ no ☐ yes Where was it done? _____
Date(s): _____ Side(s): _____ Results: _____

Do you have a FAMILY history of breast cancer? ☐ no ☐ yes
If yes, pplease specify: ☐ OTHER ☐ SISTER ☐ AUNT ☐ GRANDMOTHER

Do you have a PERSONAL history (*current or previous*) of breast cancer? ☐ no ☐ yes
If yes, please specify: ◯ RIGHT ☐ LEFT ☐ BOTH

Lumpectomy? **☐ no ☐ yes (list date) _____**
Were lymph nodes taken? ☐ no ☐ yes - how many?_____

Mastectomy? **☐ no ☐ yes (list date) _____**
Were lymph nodes taken? ☐ no ☐ yes - how many?_____

Chemotherapy **☐ no ☐ yes (date completed) _____**

Radiation? **☐ no ☐ yes (date completed) _____**

I certify that all the above answers are true and correct to the best of my knowledge.

SIGNATURE: _____ DATE: _____

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

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

Patient Name: _____ **DOB**: _____

I, _____, hereby authorize East Coast Advanced Plastic Surgery LLC, their physicians, employees, agents, assistants, and all those acting under any physicians' license, to take photos (in any and all formats, including but not limited to, digital, slides, and print) and/ or videos of me, or parts of my body, prior to, during, and after my surgery (ies) or procedures that I have or may receive, for any purpose, including but not limited to, diagnostic purposes and to enhance the medical record. I agree that these photographs, and videos, and any reproduction thereof, shall become and remain the property of East Coast Advanced Plastic Surgery, LLC, and may be used as part of my medical record.

By initialing below, I further authorize the following uses and disclosures of my photographs and video:

_____ **Medical/Scientific Purposes.** I hereby consent to the use of my photographs and videos for medical, scientific, educational, and research purposes as deemed appropriate by my physician, which may include, but not limited to the publication in medical journals, textbooks, for the purpose of medical/scientific seminars and presentations. I give my consent as a voluntary contribution in the interest of public education. I understand that while I will not be identified in any publication, the photographs or videos may portray features that may make my identity recognizable.

_____ **Advertising/Promotional Purposes.** I hereby consent to the publishing, reproduction, use or reuse of my photographs, videos, and/or other audiovisual recordings and/or related information, including but not limited to my name, biographical information, and other information which may identify me to the public in any form of print or digital media including the internet, internet websites, television, newspapers, periodicals, journals, office materials, promotional materials, and other form of public media for any marketing and advertising purpose. I understand that I will **NOT** be entitled to monetary payment or any other compensation as a result of any use of any images, or videos.

I understand that I may refuse to authorize the release of photos, videos, or other audiovisual recordings and that my refusal to consent to the release of such will prevent the disclosure of the same, but **WILL NOT** affect the health care services I presently receive, or will receive.

I understand that I may revoke this authorization, in whole or in part, at any time, except to the extent action has already been taken in reliance upon this authorization. If I revoke this authorization, my revocation must be in writing signed by me or my behalf, and delivered to East Coast Advanced 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

In executing this authorization, I hereby release East Coast Advanced Plastic Surgery LLC, its physicians, employees, agents, assistants, and all those acting under any physicians' license, from any liability and/or claims of any kind or nature, including but not limited to, all rights that I may have in the photographs, and videos 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 that result from taking, printing, publication, and using of my photographs, videos, audiovisual recordings, and other information obtained in connection therewith.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo and/ or video consent forms with a date prior to the date written below.

Patient Signature (Patient or Parent/ Guardian if Patient is under 18)	Date
Witness Signature	Date

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

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

_____

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

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any payments) under my health insurance policy or benefit plan to **Dr. Charbel T. Chalfoun, Dr. Cyrus Loghmanee, Dr. Dean R. Cerio, Dr. Mazen Bedri** and **East Coast Plastic Surgery** (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service. It is specifically intended by this assignment of benefits to assign to the fullest extent permitted under the law any and all of my rights, including without limitation, the right of one or more of the Providers to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State law rules, regulations and requirements, (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator to timely produce or respond to requests (including appeals) for all information relating to any plan documents describing the rights under any insurance policy or benefit plan as required by any applicable Federal or State law, (iii) to endorse for me any checks made payable to me for benefits and claims collected toward my account, and/or (iv) to bring any appeal, lawsuit or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination of benefits under any insurance policy or benefit plan.

Should this assignment be prohibited under my policy/plan, please disclose to Provider in writing such anti-assignment provision, otherwise this assignment shall be effective notwithstanding any anti-assignment clause in any policy/plan.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including the Law Offices of Cohen and Howard) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits from any third-party payor under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and private health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPPA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: _____ Date:_____

Patient Signature: _____

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

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

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

Dear Patient,

Please be advised that the healthcare plans in which our practice is a participating provider and the facilities with which our practice is affiliated are listed on our company website at www.ecaplasticsurgery.com. This information is also available to you upon request at our offices.

If your health plan is not listed on our website or communicated to you at the time of your appointment as a benefit plan that we participate in, please note, the physicians at East Coast Advanced Plastic Surgery, LLC. do not participate in the network of your healthcare plan. As an out-of-network practice, ECAPS, LLC. has not agreed to any set rate that your healthcare plan may pay, and [we] may charge more. The estimated amount that will be billed to you is available upon request. However, If, unforeseen medical circumstances arise when services are provided, the amount that will be billed for services rendered may be higher.

Depending on your specific plan, you may have a financial responsibility for services related to your out-of-network deductible, co-pay and/or co-insurance. Additionally, you may be responsible for the portion of our charges that are not covered by your insurance and we recommend that you contact your insurance carrier for further information regarding the costs under your specific plan.

As a courtesy to our patients, we will bill your insurance company directly for reimbursement for our services. Occasionally, the insurance company will either mail the check or deposit our reimbursement for surgical fees directly to you. In these circumstances, we kindly request that you mail us a copy of the explanation of benefits (EOB) with the check from your insurance company endorsed by you, or in the case of monies being directly deposited, a check from you in the exact amount stated in the EOB made payable to East Coast Advanced Plastic Surgery. Failure to comply will force your account to become past due. This may result in the amount owed being turned over to a collection agency and may adversely affect your credit.

We thank you for your cooperation in this matter and we are happy to assist you in any way we can.

I acknowledge that the physicians at East Coast Advanced Plastic Surgery, LLC. are out-of-network providers and I elect to obtain services from Drs. Cyrus Loghmanee, Dean Cerio, Charbel Chalfoun, Mazen Bedri, and/or Angela Monterosso, PA-C. I understand it is my responsibility to remit any funds rendered to me by my insurance carrier as payment for medical services provided to me by any of the physicians at ECAPS, LLC. I hereby authorize East Coast Advanced Plastic Surgery, LLC. or their authorized representatives, to appeal and pursue all other legal rights for any and all unpaid claims on my behalf with my insurance company. I also acknowledge that I have read the above information regarding fee disclosures.

_____ _____

PATIENT NAME (please print) **DATE**

_____

PATIENT SIGNATURE