Iorio Plastic Surgery & CosMedical Center

Printed On: 7/8/2016

First Name: ______ **Middle:** ______ **Last :** ______
Address: ______ **City:** ______ **State:** ______ **Zip:** ______
Social Security: ______ **Maritial Status:** ______
Birthdate: ______ **Gender:** ______

Home Phone: ______ Can we call you at this number? Y N Can we leave a message? Y N
Work Phone: ______ Can we call you at this number? Y N Can we leave a message? Y N
Mobile Phone: ______ Can we call you at this number? Y N Can we leave a message? Y N
Email: ______ Do you want to receive emails about our events & special pricing? Y N

Emergency Contact: ______ **Home Phone:** ______
Relationship: ______ **Work Phone:** ______

Primary Care Physician: ______
Pharmacy / Address / Phone: ______
Race: ______ **Ethnicity:** ______ **Language:** ______
To whom may we thank for your referral?
Physician Referral (name): ______ Patient Referral (name): ______
Advertisement Website Lawn Sign Other: ______

Primary Insurance: ______ **ID#:** ______ **Group#:** ______
Subscriber's Name: ______ **Birthdate:** ______
Address, City, State, Zip: ______
Employer: ______ **Relationship to patient:** ______
If accident, date of accident: ______ **Type: auto work other:** ______ **City/State:** ______

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Secondary Insurance: ______ **ID#:** ______ **Group#:** ______
Subscriber's Name: ______ **Birthdate:** ______
Address, City, State, Zip: ______
Employer: ______ **Relationship to patient:** ______

Assignment of Benefits: I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Louis M. Iorio, MD LLC d/b/a Iorio Plastic Surgery & CosMedical Center and the practice's legal representative (hereinafter, "My Authorized Representative") and I appoint them as my authorized representative with the power to: 1) File medical claims with the health plan; 2) File appeal and grievances with the health plan; 3) Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff in lawsuits and actions if necessary; 4) Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan.
Accuracy: I certify that the health insurance information that I provided is accurate as of the date set above.
Authorization to Release Information: I hereby authorize My Authorized Representatives to: 1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; 2) process insurance claims generated in the course of my treatment; and 3) allow a photocopy of my signature to be used to process insurance claims.

Signature (patient or guardian): ______ **Date**: ______

Notice of Privacy Practices: I acknowledge that I have received a copy of Louis M. Iorio, MD, LLC d/b/a Iorio Plastic Surgery & Cosmedical Center's Notice of Privacy Practices and may direct my privacy questions to the Privacy Officer.

Signature (patient or guardian): ______ **Date**: ______

HEALTH HISTORY

Name ________________________________ Birthdate __________ Age____ Today's Date __________

Medication:_________________Dosage:_________ Medication:_________________Dosage:_________

Medication:_________________Dosage:_________ Medication:_________________Dosage:_________

Vitamins:____

Allergies (include foods, medications, substances) ______________________________Reaction: _____________

Height: _____________ Weight: ________________

Conditions Experienced

☐ AIDS	☐ Chicken Pox	☐ HIV Positive	☐ Rheumatic Fever
☐ Alcoholism	☐ Diabetes	☐ Kidney Disease	☐ Scarlet Fever
☐ Anemia	☐ Emphysema	☐ Liver Disease	☐ Stroke
☐ Anorexia	☐ Epilepsy	☐ Measles	☐ Suicide Attempt
☐ Appendicitis	☐ Glaucoma	☐ Migraine Headaches	☐ Thyroid Problem
☐ Arthritis	☐ Goiter	☐ Miscarriage	☐ Tonsillitis
☐ Asthma	☐ Gonorrhea	☐ Mononucleosis	☐ Transfusions
☐ Bleeding Disorders	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Breast Lump	☐ Heart Disease	☐ Mumps	☐ Typhoid Fever
☐ Bronchitis	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Bulimia	☐ Hernia	☐ Pneumonia	☐ Vaginal Infection
☐ Cancer; Type:_______	☐ Herpes	☐ Polio	☐ Other _____________
☐ Cataracts	☐ High Blood Pressure	☐ Prostate Problem	☐ Other _____________
☐ Chemical Dependency	☐ High Cholesterol	☐ Psychiatric Care	

Surgical History

Year ______ Surgery _________________ Anesthesia Complications? ___ If yes, what? ________________

Year ______ Surgery _________________ Anesthesia Complications? ___ If yes, what? ________________

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Year ______ Surgery _________________ Anesthesia Complications? ___ If yes, what? ________________

Year ______ Surgery _________________ Anesthesia Complications? ___ If yes, what? ________________

Pregnancy History

Number of pregnancies:_____________
Number of deliveries:_____________
Type of delivery: *Vaginal* *C-section*
Complications:_____________________________

Do you have regular periods? Y N
Are you pregnant or lactating? Y N
Did you hyperpigment/mask during pregnancy? Y N
Have you gone through menopause? Y N

Family History

Cancer (relationship & type of cancer) ____

Diabetes (relationship) ____

Heart Disease (relationship) ____

High Blood Pressure (relationship) ____

Health Habits

☐ Caffeine How much per day? __________ ☐ Alcohol How much per day? __________

☐ Tobacco How much per day? __________ ☐ Drugs How much per day? __________

I certify that the above information is correct to the best of my knowledge.

____ ________________

Signature ***Date***

IORIO PLASTIC SURGERY & COSMEDICAL CENTER

Financial Policy

Thank you for choosing our practice to provide you with medical care. We are committed to serving you with high quality care. Letting you know in advance of our office policy allows for a good flow of communication. If you have any questions, please do not hesitate to ask a member of our staff.

INSURANCE – We are a non-participating provider (out-of-network) for commercial insurances. We will gladly submit your insurance claims for you and assist you in any way we reasonably can to get your claims paid. Please present an up-to-date insurance card at your visit. All charges are your responsibility from the date that services are rendered. All amounts determined to be the patient's responsibility are due at the time of service. Therefore, you should be fully aware of the benefits provided by your insurance carrier.

In situations where your insurance company makes payment directly to you, **DO NOT CASH THE INSURANCE CHECK.** Instead, endorse the back of the check and write *"Payable to Dr. Iorio"* below your signature. Then kindly send the insurance check to us so that we may adjust your account. Typically these checks are sent to you with an Explanation of Benefits (EOB). The EOB explains how your carrier arrived at the amount of money issued. Please include a copy of this EOB with the check.

MEDICARE - We are a participating provider for original Medicare. We are a non-participating provider (out-of-network) for all other secondary commercial insurances. Medicare, as well as your secondary insurance (if any), will be billed for you. Patients are responsible for paying their annual deductible. Once your deductible has been met, you are responsible for 20% of the allowed amount for services not covered by your secondary insurance.

FOLLOW-UP VISITS (ALL INSURANCES) - Please be aware that most **minor** surgery includes routine follow-up care for ten (10) days. Routine follow-up care for the first ninety (90) days is covered within your initial surgery fee for **major** surgery. Any services provided beyond ten (10) or ninety (90) days will be subject to a charge.

PATIENT BILLING – You will be sent up to three statements for your financial responsibility after payment is received from your insurance company. After the third billing statement, your account will be forwarded to collections. Please let the billing office know if you are having difficulties resolving your bill.

SELF-PAY – Payment for office visits, in-office treatments, and products are due, in full, the day of your visit. Payment for cosmetic surgery, in-office or at a facility, is due two (2) weeks prior to surgery. Facility and anesthesia fees are due the day of surgery and paid directly to the facility. For procedures performed at a facility, every effort is made to maintain the predicted operating room and anesthesia hours. However results are never compromised for time. In these rare cases where the surgery outruns the determined time, you will be billed for additional operating room and anesthesia fees.

The fee for self-pay procedures includes all pre and post-care visits for one year from the procedure/treatment. Your fee does not include: laboratory fees, radiology fees, prescriptions or other testing procedures such as EKGs. Should a hospital admission or additional surgery be necessary following your initial procedure/treatment due to a complication or unrelated event, the initial fee will not cover these costs. Many insurance companies will not cover hospital or medical costs for complications associated with cosmetic surgery. It is advisable to check with your insurance carrier prior to your surgery regarding their policies related to cosmetic surgery.

I have read this document, have had the opportunity to ask questions, and agree to comply with the above outlined financial policy regarding my current and future consultations, office visits, treatments, and surgery.

____

Patient Signature (or Person Authorized to Sign for Patient)

______________________________ ______________________

Print Name **Date**