CIRILLO CENTER
PLASTIC SURGERY

Welcome Form

Plastic Surgery
CIRILLO INSTITUTE

Patient Information

Last Name _____ First _____ Middle _____

Marital Status: Single___ Married___ LTP___ Divorced___ Widowed___ Separated___

DOB _____ /_____ /_____

Gender: Female___ Male___

ETHNICITY: Hispanic____ Non-Hispanic ____ (required by insurance company in compliance with health reform)

RACE: American Indian or Alaskan Native___ Asian___ Black___ Caucasian___ Pacific Islander___ Other___

Preferred Language_____

eMail*_____

Address _____

City _____ State _____ Zip _____

Home (_____) _____ Cell (_____) _____ Other (_____) _____

Best Contact Method (Please Circle): Home Cell Other Can we leave a detailed message? Yes___ No___

Emergency Contact _____Phone (_____) _____Relationship to Patient _____

Employer_____ Occupation _____

Primary Care Physician: _____ **Phone:** _____

How did you hear about us? (Check all that apply)

Physician Referral (name) ____ Website____ Print Advertisement ____
Friend/Family Referral (name) ____ Social Media ____ Other _____

Authorization to Disclose Protected Health Information (PHI)

Name _____ Relationship to Patient _____

Phone Number Cell (_____) _____ Home (_____) _____

Primary Insurance

Health Insurance Provider Name _____

Policy Holder Name_____ Relationship to Patient _____

Policy Holder DOB _____ /_____ /_____ Phone Number Cell (____) _____ Home (____) _____

Policy Holder eMail* _____

Policy Holder Address _____

Policy Holder City _____ State _____ Zip _____

Responsible Party employed by _____

Policy Holder Occupation: _____

*By providing my email address I give you permission to send me appointment reminders, patient information, newsletters and promotional emails about specials and events. I understand that I may unsubscribe at any time, and that you will never sell or share my email with any external entity.
Check here if you do not want to receive newsletters or promotional emails. [ ]

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HIPAA Consent Form

Patient Name: _____

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Patient or Representative

Relationship to Patient (if other than patient):_____ Date: ___/___/___

In front of _____
Printed Name – Practice Representative

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Financial Policies

When preparing for surgery, we understand that financial responsible is an important and major concern for patients. We hope that the following policies will inform you about the various payment options for your surgery. In general, we provide several payment options for patients. They include:

Cash or Check: Personal check, cashier's check, or cash.
Credit Cards: Visa, Mastercard, American Express, or Discover.
Financing Plans: We will be happy to assist you with applying for a financing plan through Care Credit. For more information, visit www.carecredit.com.

Cosmetic Surgery: Your $100 cosmetic consultation fee will be applied to your surgical bill. One-third of the surgical fee is due at the time of booking. This booking fee is non-refundable and cannot be charged to your Care Credit Account. Final payment for cosmetic plastic surgery is due a full two weeks prior to the surgical date. If the full payment is not collected in a timely manner, your surgical procure may be cancelled.

Facility and Anesthesia Fees: Please keep in mind that the surgical facility and anesthesia team will have their own fees. These are collected separately by the applicable individuals. We will do our best to estimate your financial responsibility for the facility and anesthesia team. Because you are ultimately financially responsible for your surgical procedure, we suggest that you reach out to the billing manager at the facility where your services will be rendered in order to discuss final payment and responsibility.

Insurance Coverage: The benefits paid by insurance companies for surgical procedures vary greatly between companies. We will gain precertification/preauthorization for your surgical procedure from your insurance company. Additionally, we do our best to determine what your financial responsibility (in the form of co-payments or deductibles) will be. Because you are ultimately financially responsible for your surgical procedure, we suggest that you reach out to your insurance company in order to verify benefits and coverage as well.

Cancellation Policy: We understand that emergency situations may arise that force you to cancel or postpone your surgical procedure. We ask that you provide us with as much notice as possible when rescheduling or cancelling your surgical procedure. Please keep in mind that your cancellation will not only affect your surgical team, but it will affect other patients as well. We will do our best to be as accommodating as possible, but we do request your patience and courtesy when rescheduling your procedure. Your non-refundable deposit allows for the one-time rescheduling of your procedure within a one year time frame.

If you should have any questions or if you need assistance with financial matters, please do not hesitate to contact us at 610.525.0500.