LASER SURGERY CARE
NEW PATIENT INFORMATION

DATE: _____

PATIENT NAME:_____ DATE OF BIRTH: _____

ADDRESS: _____ SS#: _____

CITY/STATE: _____ZIP CODE: _____

EMAIL: _____

PHONE NUMBERS HOME: _____ CELL:_____

WORK:_____ PREFERED METHOD OF CONTACT:_____

SINGLE PARTNERED MARRIED SPOUSE/PARTNER NAME: _____

RACE: AMERICAN INDIAN/ALASKAN NATIVE ASIAN BLACK/AFRICAN AMERICAN
NATIVE HAWAIN/API WHITE DECLINED OTHER

ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO DECLINED

NAME OF EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ TELEPHONE: _____

PREFERED PHARMACY:_____ ADDRESS/PHONE:_____

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REFERRING PHYSICIAN:_____

PRIMARY CARE PHYSICIAN: _____

INSURANCE:_____ SELF PAY: _____

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AUTHORIZATION OF BILLING

I hereby authorize the practice herein to furnish information to insurance carriers concerning my medical condition. I irrevocably assign the practice all payments for medical services rendered and understand that I am financially responsible for all charges whether or not covered by insurance.

SIGNATURE: _____ DATE: _____

Laser Surgery Care Financial Policy

We appreciate that you have entrusted us with your health care. To best serve you it is your responsibility to know your insurance plan coverage benefits for both in network or out of network coverage. This includes your need for referrals, pre-certifications, pre-authorizations, deductibles, co-payments, and/or coinsurance.

The responsibility for payment of fees for service is your direct responsibility as our patient. Your health insurance plan determines the amount of your coverage based on your specific plan. Each plan is different.

While we will do our best to assist you in answering questions related to your insurance, it is your responsibility to know your plan coverages and to make payment for services rendered by us.

Payment Policy Schedule*:

Co-Payments	Full payment is due at time of service
Deductible and coinsurance	Full payment is due at time of billing
Non-covered service	Full payment is due at time of service
Non-Participating insurance plan	Full payment is due at time of billing

Other charges/fees:

Missed Appointment	The office requires at least 24 hours notice when cancelling an appointment
Office based Procedure	- $75.00 fee will be charged to your account if you cancel your procedure less than 1 business days notice
Office based Procedure w/anesthesia	- $100.00 fee will be charged to your account if you cancel your procedure less than 1 business days notice
Surgery Center Procedures	- $200.00 fee will be charged to your account if you cancel your procedure less than 1 business days notice

Additional Outside commercial laboratory fees:

We use outside commercial labs to process medical lab tests, and/or pathology that may be performed during your visit.

The lab will bill you directly and it is your responsibility to pay lab fees directly to them for their services. Your health insurance plan determines the amount of your coverage based on your specific plan. Each insurance plan is different. It is your responsibility to know your insurance plan coverage benefits for both in network or out of network coverage for lab fees. This includes your need for referrals, pre-certifications, pre-authorizations, deductibles, co-payments, and/or coinsurance.

Patient Name: _____

Signature: _____ Date: _____

SUMMARY OF NEW PRIVACY LEGISLATION

When you visit or call our offices ***Laser Surgery Care***, a record of the visit or call is made. ***Laser Surgery Care*** has always been committed to protecting the privacy of your health information. Nonetheless, new federal laws now require us to put in place more formal policies and procedures to safeguard your medical records and other records, such as billing records, that contain personal health information about you. A complete listing of these privacy laws are available for you on request and posted in the office.

These laws give you certain rights, including the right to receive this notice explaining our privacy practices and the right to ask us for an updated copy of the notice at any time. You have the right to ask to see and copy your records, the right to ask us to amend your records if they are incorrect or incomplete, and the right to ask us for a listing of certain disclosures about you that we may have made. If you think we violated your privacy, you may complain to us and/or to the Department of Health and Human Services.

In addition to these basic rights, we will honor all reasonable requests you may have about where, when and how we may contact you. Your may ask us to make changes in our normal privacy practices. Although we will consider your requests, the law does not require us to agree to every suggestion you have. We will, however, always tell you whether we can make special arrangements to meet your needs.

We routinely use the health information you give us or that we create to treat you, to bill you or your insurer, and to operate our business in ways consistent with good patient care and sound practice management. We have procedures in place to ensure that your records are seen, in whole or in part, only by those staff members who need the information they see to do their jobs. If necessary, we may release your medical records to other health care providers involved in your care. If you agree, we also may discuss some health information about you with relatives or friends who help with your care.

Sometimes we work with individuals and businesses that help us run our practice more effectively. For example, we may hire answering services, accountants or billing consultants. We may disclose personal information about you to these business associates if they need the information to do their jobs. To protect your health information, we always include a provision in our contracts with business associates requiring them to put procedures in place to safeguard your records.

We release personal health information about our patients when we are required to do so by federal, state or local laws and for a number of public policy reasons including public health reporting, law enforcement activities, judicial proceedings, workers' compensation, and certain types of records-based research. Whenever we release records for these reasons, we follow privacy safeguards appropriate to the situation.

If we need to use or disclose your records for purposed other than those described above, we will get a written authorization from you. You should know that you may revoke any authorization you give us at any time, although you must do so in writing.

RECEIPT OF PRIVACY PRACTICES NOTICE

I have read or been given a copy of the Office Privacy Practices Notice. I have had the opportunity to review these and ask questions. If I refuse to sign this notice a note is made in my chart of receipt of such Notice from the Practice.

SIGNATURE: _____ DATE: _____

LASER SURGERY CARE IN NETWORK FINANCIAL POLICY FOR OXFORD, UNITED HEALTHCARE, AETNA, AND MEDICARE

We appreciate that you have entrusted us with your health care. Healthcare benefits and coverage options have become increasingly complex, and we would like to help you better understand your responsibilities as a patient.

Laser Surgery Care is in network with your insurance carrier. We will submit a claim on your behalf as a courtesy. You should check with your insurance carrier to be knowledgeable of any deductibles, co-payments, and/or coinsurance in your policy. Laser Surgery Care will accept the allowed amount calculated by your insurance carrier, and you will receive a bill for any deductible and coinsurance expense that the insurance carrier determines is the responsibility of the patient.

I authorize Laser Surgery Care to process payment for my deductible, coinsurance, and copayments on my credit card below:

American Express MasterCard Visa

Card Number: _____

Expiration Date: _____/_____/_____

CODE ON BACK OF CARD _____

Card Holders Name: _____

Card Holder Phone Number: ( ) _____-_____

Card Holder Signature: _____

Should you have any questions we encourage you to ask. It is our goal, not only to provide the best quality of medical care, but to help you by answering any questions that you might have.

Patient Name: _____ Date:_____

Signature: _____

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ SEX: _____ AGE: _____

IF YOU WOULD PLEASE TAKE THE TIME TO ANSWER THE FOLLOWING QUESTIONS, IT WILL ASSIST US IN HELPING YOU BETTER

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Why have you come to Laser Surgery Care? _____

Are you allergic to any medication? Yes _____ No _____ If yes, what are they? _____

_____

Are you taking aspirin daily or are you on anticoagulant therapy? _____

What medications are you taking? _____

Do you smoke? Yes _____ No _____ If yes, how much and how long _____

Do you drink alcoholic beverages? Yes_____ No _____ If yes, how much and how long _____

Have you had any previous surgery? Yes_____ No _____ If yes, please describe the type of surgery, who was the surgeon, when and where was it performed_____

Have you been hospitalized for anything besides the above surgery? Yes_____ No _____ If yes, please describe the reason for the hospitalization. Where and when were you hospitalized _____

Are you pregnant? Yes_____ No _____ If yes, what is your due date? _____

If surgery is required, is there someone who will help you during the recuperative period? Yes_____ No _____

If yes, who and their relationship_____

Please check any of the following ailments that you may have had in the past of that you have presently. Please describe all positive answers more fully in the space provided.

HIGH BLOOD PRESSURE
HEART ATTACK
HEART MURMUR
ANGINA
RHEUMATIC FEVER
BRONCHITIS
PNEUMONIA
ASTHMA
FAINTING

ULCERS
EMPHYSEMA
TUBERCULOSIS
KIDNEY OR BLADDER PROBLEM
DIABETES
STROKE
SEIZURES
HERNIAS
BLEEDING FROM RECTUM

GALL BLADDER
JAUNDICE
COLITIS
DIVERTICULULOSIS
DIVERTICULITIS
CANCER
TYPE _____

Additional Information:

Laser Surgery CARE OUT OF NETWORK Payment Agreement

1. OUT OF NETWORK BENEFITS

I understand that Laser Surgery Care and its medical providers are considered OUT OF NETWORK under my insurance plan and not all of their fees will be covered by my insurance.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES PROVIDED TO ME BY LASER SURGERY CARE including amounts not paid by my insurance This includes co-payments, deductibles, coinsurance or other amounts that I am required to pay under my insurance. In some instances this can be 100% of the fees for services.

It is my personal responsibility to verify with my insurance carrier what my plan covers of OUT OF NETWORK BENEFITS, if an, before I choose to obtain service from Laser Surgery Care.

2. How we calculate your bill

Laser Surgery Care will bill your insurance. As a courtesy, we will accept the "allowed amount" determined under your insurance plan including co-payment, deductible, and coinsurance expenses provided you make prompt payment of your bill in full. We may require a deposit towards your deductible, if your insurance is subject to a deductible that has not been met.

3. What you owe

If your insurance carrier submits full or partial payment directly to you, you must IMMEDIATELY FORWARD THE PAYMENT to our office together with a copy of your explanation of benefits.

I UNDERSTAND AND AGREE TO THE ABOVE.

I authorize Laser Surgery Care to process payment for the services provided me on my credit card below.

American Express MasterCard Visa

Card Number: _____

Expiration Date: _____/_____/_____

CODE ON BACK OF CARD _____

Card Holders Name: _____

Card Holder Phone Number: ( ) _____-_____

Card Holder Signature: _____

Should you have any questions we encourage you to ask. It is our goal, not only to provide the best quality of medical care, but to help you by answering any questions that you might have.

I understand that I will be using my Out Of Network Benefits for my care at Laser Surgery Care and will be subject to deductible and coinsurance as determined by my insurance carrier.

Patient Name: _____ Date:_____

Signature: _____

LASER SURGERY CARE

PATIENT INFORMATION UPDATE

Please indicate if any of the following has changed since your last visit.

Mailing Address:_____

E-Mail Address:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Primary Care Physician:_____

Additional healthcare Providers who should receive an update regarding your visit:_____

_____

_____

Pharmacy:_____ Pharmacy Phone Number:_____

Emergency Contact:_____ Phone Number:_____

Relationship:_____