LASER SURGERY CARE

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New Patient Information

Patient Name: _____ DOB: _____ Date: _____

Name (If different on insurance): _____Gender: _____ Pronouns: he/she/_____

Address: _____ SS#: _____

City/State: _____ Zip Code: _____

Email: _____

Phone Numbers: Cell: _____ Home: _____

Work: _____ Preferred Method of Contact: _____

Single ☐ Partnered ☐ Married ☐ Spouse/Partner Name: _____

Race: American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐
Native Hawaiian/API ☐ White ☐ Declined ☐ Other ☐

Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined ☐

Name of Employer: _____ Occupation: _____

Emergency Contact: _____ Telephone: _____

Preferred Pharmacy: _____ Address/Phone: _____

****

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Insurance: _____ Self-pay: _____

****

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: _____

Patient Name: _____ DOB: _____ Date: _____

Name (If different on insurance): _____Gender: _____ Pronouns: he/she/_____

Height: _____ Weight: _____

****

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
- ☐ Gallbladder
- ☐ Jaundice
- ☐ Colitis
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Cancer
  Type _____
- ☐ Hemorrhoids
- ☐ Anal fissure
- ☐ HPV
- ☐ Prostate Issues

Additional Information:

_____

_____

_____

Laser Surgery Care Financial Policy

We appreciate that you have entrusted us with your health care. Because healthcare benefits and coverage options have become increasingly complex, we have developed this policy which details our financial requirements to help you better understand your responsibilities as a patient.

It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductibles, co-payments, and/or coinsurance. This applies to all payers regardless of whether or not our physicians participate.

The responsibility for payment of fees for service is the direct responsibility of the patient. Your health benefit plan is an arrangement between you and the insurance company. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine as medically necessary. However, we will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

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	**Missed appointments prevent others from receiving care. T**he office requires advanced notice when canceling an appointment, or the following charges will automatically be applied.
Office visit	A 100.00 fee will be charged if you cancel your visit with less than 2 business days notice
Office based Procedure w/anesthesia	A $200.00 fee will be charged to your account if you cancel your procedure with less than 3 business days notice
Surgery Center/Endoscopy Procedures	A $300.00 fee will be charged to your account if you cancel your procedure with less than 10 days notice

*subject to change at any time

If you have concerns about your ability to pay for services, we recommend that you contact us for assistance. Should you have any questions with regard to our financial policy 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 questions that you might have.

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: _____

FINANCIAL INFORMATION

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 IN NETWORK Financial Policy

If you are in network with Laser Surgery Care, we will submit a claim on your behalf. You should check with your insurance carrier to be knowledgeable of any deductibles, co-payments, and/or coinsurance for 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 your carrier determines is the responsibility of the patient.

Laser Surgery Care OUT OF NETWORK Payment Agreement

If Laser Surgery Care and its medical providers are considered *out of network* with your insurance plan, it is possible that not all of their fees will be covered by your 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 for out of network benefits before I choose to obtain service from Laser Surgery Care*. 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.

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 authorize Laser Surgery Care to key in payment for my deductible, coinsurance, co-payments, and other associated fees on my credit card.

Signature: _____ Date: _____

LASER SURGERY CARE

FINANCIAL INFORMATION

Credit Card Information

American Express / MasterCard / Visa

Card Number: _____

Expiration Date: _____/_____/_____

CVC Code: _____

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.

If your insurance company does not cover the entire cost of the services rendered, we will send you an invoice for the balance. If we do not hear back from you, the billing department will call you, send you an e-mail, and then bill the credit card on file. We can enter in the credit card information from the office for you.

Patient Name: _____ Date: _____

Signature: _____

FINANCIAL INFORMATION

PROCEDURES WITH ANESTHESIA

Most procedures are done in the office without anesthesia. If sedation is required, the procedure can often be performed in the office with an anesthesiologist. This saves patients a lot of time compared to the hospital or surgery center. Our anesthesiologist may not be in-network with your insurance plan. Many insurance plans cover the anesthesiologist if the surgeon is in-network, but not all do. Alternatively, the procedure may be able to be done at an Endoscopy Center, a Mount Sinai Surgical Center, or Hospital, where the anesthesiologists are in-network with the same plans as Dr. Terlizzi. These facilities charge a facility fee for which you may be held responsible. We can provide all the necessary information for you to check with your insurance company to decide where you would like to have your procedure take place.

Message from John Grillo, MD (anesthesiologist at Laser Surgery Care):

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

Credit Card Authorization:

1. IF YOUR INSURANCE COVERAGE IS NOT IN EFFECT on the date of service, you are personally responsible for payment of all non-covered anesthesia charges up to a maximum of $500. All such denied charges must be paid to John Grillo MD within ten (10) days of receipt of your invoice from John J. Grillo MD or any other anesthesia provider.
2. If YOU HAVE AN INSURANCE DEDUCTIBLE THAT HAS NOT BEEN MET IN FULL, you are personally responsible for all charges applied to your deductible. Payment is due within ten (10) days of receipt of the invoice.
3. ANY ANESTHESIA INSURANCE PAYMENT SENT DIRECTLY TO YOU for services rendered must be paid within ten (10) days of your invoice receipt.
4. YOU ARE RESPONSIBLE FOR YOUR INSURANCE CO-PAYS AND DEDUCTIBLES AS STATED IN YOUR INSURANCE POLICY PAYMENT.
5. Dr. Grillo does not participate in all insurance plans. If he is out of network and you do not have out of network benefits or prefer not to use them, you will be billed $500 per procedure.

In the event that I have not paid any such charges as listed above within ten (10) days of the receipt of the invoice, I hereby authorize John J. Grillo M.D. to charge my Credit card as listed below for any service provided by him, if the insurance company(s) or other third party payors have designated as my responsible payment, fail to make a payment because: 1) my insurance coverage was not in effect on the date of service, or 2) because of unmet deductible, or 3) for any amount paid directly to me by a third party payor for services provided by John J. Grillo M.D. In the event my credit card company for any reason does not accept the charges, I agree to make immediate payment to John J. Grillo M.D. for all balances owed.

Signature: _____ Date: _____