Let Us Know Your Cosmetic Interests

Date

Name First_____Middle_____Last_____

E-Mail Address: _____

☐ Check box if you would like to receive our monthly email which includes our latest promotions, health tips and the latest trends in plastic surgery.

Products or procedures of interest to you (please check all that apply).

- ☐ **Botox**
- ☐ **Dermal fillers Juvederm, Belotero**
- ☐ **Lip enhancement Restylane Silk**
- ☐ **Sculptra**
- ☐ **Wrinkles Fractional peel**
- ☐ **Skin tightening-non surgical**
- ☐ **Facial redness/rosacea**
- ☐ **Brown spots of the face/hands/chest**
- ☐ **Tattoo removal**
- ☐ **Cheek lift-Voluma**
- ☐ **Breast Augmentation/Lift**
- ☐ **Eyelid lift**
- ☐ **Facelift/ Minilift**
- ☐ **Neck lift**
- ☐ **Tummy Tuck**
- ☐ **Rhinoplasty-nose job**
- ☐ **Liposuction**
- ☐ **Spider Veins**
- ☐ **Halo-The Hybrid Laser Facial ™**
- ☐ **Other please specify_____**

Ocean Plastic Surgery, P.A.
Stephen E. Small, D.O., FACOS

INSURANCE AND BILLING POLICIES

INSURANCE: Our practice will gladly submit claims to participating insurance carriers. In order to do so, we need your cooperation. **Complete and current insurance information is required** in order for our office to submit a claim to your primary insurance plan. This information needs to be provided at EACH visit or you may be required to reschedule or make payment at the time of service. ***It is the patient's responsibility to notify our office of any changes or termination of their insurance.*** If you are using a parent's insurance, the parent must sign accepting financial responsibility if not covered.

REFERRALS/AUTHORIZATIONS: It is the patient's responsibility to make sure that a referral has been obtained for their primary care physician and to bring a copy of that referral to our office. If you do not have a referral, you will be asked to reschedule your appointment until that referral is obtained or you will be responsible for the entire cost of the visit.

CO-PAYS, CO-INSURANCES AND DEDUCTIBLES: ***Co-pays are the fixed amount that your insurance plan has stated is your responsibility to pay at each office visit.*** This amount will be collected prior to your office visit. If a coinsurance or deductible is applied to your responsibility instead, you will be billed for the additional amount once your insurance processes the claim.

MEDICARE: Our office does participate with Medicare Part B. We will bill Medicare for services provided. You may be asked to sign an ABN form prior to any procedures. You will be responsible for any deductibles or coinsurances. We will submit to a secondary major medical carrier.

SELF-PAY: ***If you do not have medical insurance coverage, payment is expected in full at the time services are rendered.***

CANCELLATION POLICY: We know that schedules change and there may come a time that you need to cancel an appointment. We ask that you give us one (1) full business day notice if you cannot make your original appointment time. If for whatever reason (1) full business days cancelllation notice was not given then a $50 fee will be charged to reschedule. This must be paid prior to rescheduling your appointment.

RETURNED CHECKS: If a check you issued as payment is returned by your bank, (for any reason), you will be charged a fee of $50.00. Any future payments to our office must be made by cash, credit or debit card.

**** PLEASE NOTE WE DO NOT PARTICIPATE WITH ANY MEDICAID PLANS****

I have read and understand the above policy regarding my financial responsibilities to the office of Dr. Stephen E. Small.
My failure to fulfill my financial obligations may cause interruptions or delays in my medical care.

_____ _____

Patient or Responsible Party Signature Date

WELCOME TO OUR PRACTICE
PLEASE TAKE A MOMENT AND REVIEW YOUR MEDICAL HISTORY

OCEAN PLASTIC SURGERY MEDICAL HISTORY

First Name_____**Middle**_____**Last Name**_____

☐ **Male** ☐ **Female** **STATUS:** ☐ **Single** ☐ **Married**

Street Address **City/State** **Zip Code**

Home Telephone Number **Business Telephone Number** **Cellular Telephone Number**

___/_____/_____ _____ ___ ___/___/____ _____

Date of Birth **Age** **Social Security Number** **E-mail address**

May we leave a detailed message on your phone regarding your care? ☐ Yes ☐ No

May we contact you with text messaging or email ☐ Yes ☐ No

Please list an emergency contact and phone number to discuss your care?

Name _____

Please list anyone else who we may discuss your care. Name(s) and phone number (s).

_____

_____

Reason for Visit_____**Referred by** _____

Motor vehicle accident ☐ Yes ☐ No **Workers Compensation** ☐ Yes ☐ No

Primary Insurance_____**Driver's License Number**_____

Subscriber of Policy **Relationship** **Date of Birth** **Social Security Number**

I understand that a fee is charged for all visits, examinations, and medical reports. Fees for cosmetic surgery are payable in full prior to surgery.

ACKNOWLEDGEMENT POLICIES: I hereby acknowledge that in consideration for treatment rendered to me and/or my child or child in my care that I am responsible and will pay for all charges and fees of Ocean Plastic Surgery, P.A., Stephen E. Small, D.O. for the services rendered. I understand that although I may have insurance to cover the cost of treatment, I remain responsible for payment. All payments are due within thirty (30) days of receipt of the bill.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS: I hereby authorize Ocean Plastic Surgery, P.A., Stephen E. Small, D.O. to release and request any information acquired in the course of my examination or treatment and further authorize payment of the surgical and/or medical benefits directly to the physicians.

AUTHORIZATION TO PHOTOGRAPH: I hereby grant authority to Ocean Plastic Surgery, P.A., Stephen E. Small, D.O. to take or have taken any photographs of the patient whose name appears above for your medical record only.This signature represents patient's signature on file for insurance purposes.

_____

Signature (patient or responsible party **Date**

WELCOME TO OUR PRACTICE
PLEASE TAKE A MOMENT AND REVIEW YOUR MEDICAL HISTORY

OCEAN PLASTIC SURGERY MEDICAL HISTORY

Medical History

Allergies **Height** **Weight**

MEDICATIONS (include hormone replacement, diet pills, all vitamins, herbs, teas, over-the-counter or alternative therapies)

Drug Name	Dose e.g.- mg/units	Frequency e.g.- daily

Medical Conditions-Check all that apply to you.

Blood thinners		A-fib/Heart disease	
Blood clots		Heart attack	
Kidney disease		Heart valve	
Stroke		Asthma	
Seizures		Copd	
Hepatitis		Diabetes	
Lip cold sores		High Blood Pressure	
Keloids		GI/stomach disease	
Pregnant		Breast feeding	
Menopause		Bra size	

Skin response to being in the sun

- ☐ Always burn, never tan Usually
- ☐ Burn, sometimes tan
- ☐ Sometimes burn, usually tan
- ☐ Tan, rarely burn
- ☐ Tan, very rarely burn
- ☐ Tan never burn

- ☐ I have taken accutane or a generic accutane within the year
- ☐ I did have shingles in the past year
- ☐ I have a rash or skin condition currently being treated

WELCOME TO OUR PRACTICE
PLEASE TAKE A MOMENT AND REVIEW YOUR MEDICAL HISTORY

OCEAN PLASTIC SURGERY MEDICAL HISTORY

Surgical History- Please select the surgeries that apply

Pacemaker		**Brain**	
Cardiac Stents		**Spleen**	
Cardiac Bypass		**Liver**	
Gall bladder		**Back**	
Appendix		**Hysterectomy**	
Stomach		**C-section**	
Small bowel		**Uterine**	
Large bowel		**Prostate**	

	Right	Left		Right	Left
Hip			**Carotid**		
Ankle			**Foot**		
Shoulder			**Breast**		
Hand			**Hernia**		
Knee			**Lung**		

Social History-Please select or complete

Substances	Amount	Duration	Quit
Tobacco	enter amount		
Alcohol	enter amount		
Recreational	enter drug		

Family History

Parents	Living	Deceased	Age	Medical History
Father				
Mother				

Please list any other details of your medical, surgical, social or family history.

Primary Care Physician _____

Pharmacy name and phone number _____

WELCOME TO OUR PRACTICE
PLEASE TAKE A MOMENT AND REVIEW YOUR MEDICAL HISTORY

OCEAN PLASTIC SURGERY MEDICAL HISTO

Review of Systems-check all that apply

Constitutional: Weakness☐ Tiredness☐ Dizziness☐ Vertigo☐ Headaches☐

Weight changes loss☐ gain☐

Eyes: Wears glasses☐ Contacts☐ Blurred Vision☐ Double Vision☐

Dry eyes☐ Watery/Itchy Eyes☐

Ear Nos and Throat: Ringing of Ears☐ Hard of Hearing☐ Ear Infections☐

Nasal congestion☐ Nasal Bleeding☐ Dentures☐ Sore Throat☐

Swollen Lymph Nodes☐ Difficulty Speaking☐ Difficulty Swallowing☐

Cardiovascular: Chest Pain☐ Chest Palpitations☐ Shortness of Breath☐

Pain while walking or climbing stairs☐

Lungs: Shortness of Breath☐ Wheezing☐ Cough☐

Gastrointestinal: Nausea☐ Vomiting☐ Pain☐ Change in bowel habits☐

Musculoskeletal: Muscle aches☐ Joint pain☐

Skin and Breast: Concerning Lumps☐ Concerning Moles☐ Rashes☐

Psychiatric: Anxiety☐ Depression☐

Endocrine: Urinary Frequency☐ Drinking excessive amounts of liquids☐

Hot and cold intolerance☐

Neurologic: Slurred speech☐ Memory Loss☐ Arm weakness R☐ L☐

Leg weakness R☐ L☐ Numbness Arm R☐ L☐ Leg R☐ L☐

By checking the following box, I acknowledge receipt of notice of privacy policy at Ocean Plastic Surgery, P.A. ☐

Click here to submit all forms SUBMIT

Reset all forms RESET

Practice Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION: PLEASE REVIEW IT CAREFULLY

This is a formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice. Stephen E. Small D.O., OCEAN PLASTIC SURGERY, P.A.

II. This practice has a legal obligation to maintain all medical records and information in the strictest of confidence as required by law. What this means to the patient is that we must safeguard patient information. This means we cannot release information to others without your written consent, including conversations, reminder calls, test results and other information that may be of a confidential nature. Patient information about health care is identified as “PHI” or protected health information.

This change in policy requires that you, the patient, identify and clarify at the time of registration or re registration with this practice who we can talk to, how we can leave information on your behalf, and the process for ongoing continuity of your medical care. You can change this information at any time with either written notification or verbal notification, followed up in writing. Changes can only impact the care or information from that point in time forward Your protected health information (PHI) is an intricate part of your medical care, and can be used or disclosed with your written consent as follows:

- For your treatment in this practice and other locations under the physicians immediate care. This may include any referral for services such as lab, x-rays, other diagnostic testing or treatment related to your condition or medical care needs. This may also include conversations with other physicians.

- For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes or operative notes. This would include eligibility verification, prior authorization and claim submission.

- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.

- Appointment reminders and health related benefit services with your consent identified on the registration form

- Disclosure to your family and friends concerning any related health care. Those names provided by you on the registration form which can be modified at any time orally, followed by written consent.

• Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician or medical entity required immediate and full information for care on your behalf.

Certain disclosures can be made without your consent, and they are as follows:

• Disclosure required by the government or law enforcement agencies. Specific areas that require release include gun shot wounds, domestic violence, and victims of abuse or neglect.

• Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking.

• Information used for health care oversight, such as a site review by an insurance program.

• Information related to organ donation.

• Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.

• Information provided to avoid harm if there is a threat to patient or other safety.

• Specific governmental functions.

• Workers compensation review.

Yours rights with respect to you protected health information.

• The right to request limits on the uses and disclosure at registration or any time during your care.

• The right to choose how we send this information to you, including an alternate address.

• The right to see and obtain copies of this information, but there may be copy and postage fees.

• The right to get a listing of who we have made disclosures to about your PHI.

• The right to correct and update your file through an amendment process if appropriate.

This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our office to see if we can resolve your concerns or you may contact the Office of Civil Rights or the New Jersey Medicare Carrier.