INFORMED CONSENT FOR TREATMENT

DOCTOR Feins

Patient Name: ____

I, knowing that I am experiencing a condition requiring diagnostic, medical, or surgical treatment, do hereby request a consultation with Robert S. Feins, M.D., F.A.C.S., a Board Certified Plastic Surgeon, and do voluntarily consent to examination and evaluation of my condition by Dr. Feins.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Dr. Feins.

____ ___________
Patient signature Date

OR

____ ___________
Legal guardian signature Date

Consent for Clinical Personnel: I am aware that patients at this office may be attended by an esthetician, a nurse, or other health care personnel, whom may be present during patient care as part of their duties.

Consent for Photos: I consent to the taking of photographs for medical record documentation, treatment purposes, and educational purposes only provided that my identity is not disclosed to any outside party without my prior written consent.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider involved with my current treatment. I understand that office personnel may release the fact that I am presently a patient here, without disclosing confidential information, so that I may receive phone calls.

Pre-certification/prior authorization agreement: I understand that I am responsible to comply with the rules and requirements of my insurance company reading pre-certification and prior authorization requirements.

Guarantee of account: I agree to pay Dr. Feins for all charges not covered by any third party payor.

____________________________ ______________ _________
Patient Signature (or legal representative) Relationship to patient Date

Reason patient is unable to sign consent: ___(minor) ___(physical or mental disability) ___(other)

Robert S. Feins, M.D., P.A., F.A.C.S.
Plastic and
Reconstructive Surgery

Doctors Park
144 Tarrytown Road
Manchester, NH 03103
603-647-4450
Facsimile 603-647-4877

OUR FINANCIAL POLICIES

ROBERT Feins

BASIC POLICY: Payment for services is due in full at the time service i

For Patients with Insurance: We bill most insurance carriers f
paperwork is provided to us. We will also bill most secondary insuran
you. Co-Payments and deductibles are due at the time of servi
agreement with your insurance carrier is a private one, we do not r
why an insurance carrier has not paid or why it paid less than an an
care. If an insurance carrier has not paid within 45 days of billing, prof
due and payable in full from you.

Robert S. Feins, M.D., P.A.

Plastic and
Cosmetic Surgery

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144 Tarrytown Road

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www.drfeins.net

Deductibles and Co-Pays: It is your responsibility to check your in
deductible and co-pays for office visits and surgeries. If your deducti
met, you will be responsible for the unpaid portion. If you have a high
the Provider Reasonable Charge or Usual and Customary Reimb
collected at the time of your appointment. If your Explanation of
indicates that we overcharged you for a service, the practice will refund
you for that service.

Medicare Patients: We will bill Medicare for you. We will also bill sec
for you. All co-payments or deductibles are due and payable at the
provided.

Medicaid Patients: All Medicaid patients must provide a current, valid
being seen.

Surgery Fees: All co-pays, deductibles and payments for non-
procedures are due in full prior to surgery. Prior authorization may be
carrier.

Non-Covered Services: Any care not paid for by your existing insura
require payment in full at the time services are provided or upon no
claim denial.

Cosmetic Services: If you elect to pursue cosmetic surgery, you will meet with our surgical coordinator who will have more detailed information on policies, pricing, scheduling, informed consents and forms to be completed.

Payment and HIPAA. I understand that HIPAA authorizes you to disclose my protected health information to third party payors (including health/life insurance companies, banks, credit card companies, the issuing bank and/or payment processors) for payment purposes.

Delinquent Accounts: Should your account become delinquent and be referred to an attorney or collection agency for collection, you shall pay actual attorney's fees and collection expenses. All delinquent accounts may be charged interest at the maximum rate allowed by law.

I have read, understood, and agreed to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all professional fees.

____ __________

EALTH

PLEASE PRINT

Fein

Plastic & Cosmetic Surgery
144 Tarrytown Road•Manchester, NH 03103
603.647.4430T•603.647.4877F•www.drfeins.net
Diplomate, The American Board of Plastic Surgery

TODAY'S DATE ______________

PATIENT'S NAME

AGE | DATE OF BIRTH | MALE / FEMALE GENDER (CIRCLE ONE) | HEIGHT: WEIGHT:

PRIMARY CARE PHYSICIAN NAME, ADDRESS AND TELEPHONE NUMBER

REFERRING PHYSICIAN NAME, ADDRESS AND TELEPHONE NUMBER

DOES YOUR INSURANCE COMPANY REQUIRE A REFERRAL? YES/NO (CIRCLE ONE)

REASON FOR VISIT:

ARE YOU A FULL TIME STUDENT? ☐YES ☐NO

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES OR NO. ALL RESPONSES ARE KEPT CONFIDENTIAL.

ARE YOU IN GOOD HEALTH?	Y	N
HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?	Y	N
DATE OF LAST PHYSICAL EXAM: ________________	Y	N
ARE YOU NOW UNDER A PHYSICIAN'S CARE?	Y	N
HAVE YOU HAD ANY SERIOUS ILLNESSES?	Y	N
YEAR ______ REASON: ______________________		
YEAR ______ REASON: ______________________		
HAVE YOU EVER HAD AN MRSA OR A VRE?	Y	N
HAVE YOU HAD ANY PRIOR HOSPITALIZATIONS?	Y	N
YEAR ______ REASON: ______________________		
YEAR ______ REASON: ______________________		
HAVE YOU HAD ANY PRIOR SURGERIES?	Y	N
YEAR ______ REASON: ______________________		
YEAR ______ REASON: ______________________		
YEAR ______ REASON: ______________________		
ARE YOU A SMOKER?	Y	N
I CURRENTLY SMOKE CIGARETTES. PACKS/DAY _____	Y	N
I USED TO SMOKE CIGARETTES. PACKS/DAY _____	Y	N
QUIT DATE: ________________________________		
OTHER TOBACCO USE:	Y	N
PIPE	Y	N
CIGAR	Y	N
CHEW	Y	N
DO YOU NOW HAVE OR HAVE YOU EVER HAD:	Y	N
• RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE?	Y	N
• CONGENITAL HEART DISEASE?	Y	N

• RADIATION TREATMENT FOR CANCER?	Y
• SEIZURES, CONVULSIONS, EPILEPSY, FAINTING, DIZZINESS?	Y
• PSYCHIATRIC TREATMENTS, NERVOUS DISORDER OR BREAKDOWN?	Y
• LIVER DISEASE (JAUNDICE, HEPATITIS?)	Y
• KIDNEY DISEASE?	Y
• DIABETES?	Y
• PANCREATITIS?	Y
• THYROID DISEASE (GOITER?)	Y
• ARTHRITIS	Y
• STOMACH ULCERS OR COLITIS?	Y
• GLAUCOMA?	Y
• FREQUENT OR RECURRENT COLD OR MOUTH SORES?	Y
• IMPLANTS PLACED ANYWHERE IN YOUR BODY? (BREAST, HEART VALVE, HIP, KNEE?)	Y
• LUNG DISEASE (ASTHMA, EMPHYSEMA, CHRONIC COUGH, BRONCHITIS, PNEUMONIA, TUBERCULOSIS, SHORTNESS OF BREATH, CHEST PAIN, SEVERE COUGHING?	Y
• HERPES OR OTHER VIRAL INFECTIONS?	Y
• EYE PROBLEMS	Y
• HEARING LOSS?	Y
• SINUS OR NASAL PROBLEMS?	Y
• DENTURES?	Y
• BLEEDING PROBLEMS?	Y
• NOSE BLEEDS?	Y
• BLEEDING GUMS?	Y
• ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM?	Y
• RECURRENT INFECTIONS OF ANY KIND?	Y
• BLOOD TRANSFUSION(S)?	Y
11. DO YOU WEAR CONTACT LENSES?	Y

CORONARY ARTERY DISEASE,ANGINA, HIGH BLOOD PRESSURE, STROKE, PALPITATIONS, HEART SURGERY, PACEMAKER)

3. DO YOU TAKE ASPIRIN REGULARLY? HOW OFTEN? ________ Y N

4. PLEASE LIST ALL CURRENT MEDICATIONS (OR PROVIDE A CURRENT LIST):

MEDICATION	DOSAGE

5. ARE YOU ALLERGIC OR HAVE HAD A BAD REACTION TO:

- LOCAL ANESTHETIC (NOVOCAINE, ETC.)?
- PENICILLIN, AMOXICILLIN, CEPHALOSPORINS OR OTHER ANTIBIOTICS?
- BARBITURATES, SEDATIVES, ETC.?
- ASPIRIN OR IBUPROFEN?
- CODEINE OR OTHER PAIN KILLERS?
- TAPE, LATEX OR RUBBER PRODUCTS?
- OTHER MEDICATIONS? PLEASE LIST:

16. WOMEN ONLY:

A. ARE YOU PLANNING PREGANANCY? Y

B. COULD YOU BE PREGNANT NOW? Y

C. NUMBER OF PREGNANCIES: ___________________

D. NUMBER OF DELIVERIES: ____________________

E. HAVE YOU EVER BREAST FED? Y

F. DO YOU DO REGULAR BREAST EXAMS? Y

G. DATE OF LAST MAMMOGRAM: ____________________

H. DATE OF LAST PAP SMEAR: _____________________

WE RECOMMEND REGULAR BREAST AND PELVIC EXAMS WITH YOUR DOCTOR OR GYNECOLOGIST

17. ALCOLHOL USE

DO YOU DRINK ALCOHOL? Y

IF YES, HOW MANY DRINKS PER WEEK? _____________ Y

IS YOUR ALCOHOL USE A CONCERN FOR YOU OR OTHERS? Y

18. DRUG USE

DO YOU USE ANY RECREATIONAL DRUGS? Y

HAVE YOU EVER USED NEEDLES TO INJECT DRUGS? Y

19. BODY PIERCING

HAVE YOU PIERCED ANY PART OF YOUR BODY WITHIN THE LAST TWO WEEKS? Y

20. OTHER

HAVE YOU EVER SOUGHT PROFESSIONAL CARE FOR DRUG ABUSE OR ALCOHOLISM Y

DO YOU HAVE ANY OTHER DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK DR. FEINS SHOULD KNOW ABOUT? Y

DO YOU HAVE OTHER CONCERNS THAT YOU WISH TO Y

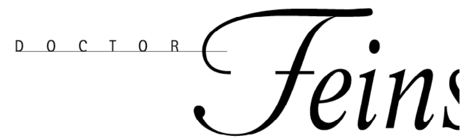
I understand the importance of a truthful health history to assist Dr. Feins and his staff in providing the best care possible. I have had the opportunity to discuss my health history with my doctor. If you become a surgical candidate, this information will be shared with the surgical facility for pre-operative purposes.

I verify that the above information is true and accurate to the best of my knowledge as of today's date.

____ ____________________

Signature of Patient or Parent/Guardian if patient is a minor Date

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or HealthCare Operations



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I, ____, understand that as part of my health care, ROBERT S. FEINS, M.D., PROF. ASS'N., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means of which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided or have reviewed a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that ROBERT S. FEINS, M.D., PROF. ASS'N is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ROBERT S. FEINS, M.D., PROF. ASS'N reserves the right to change their notice and practices and that prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations., should ROBERT S. FEINS, M.D., PROF. ASS'N change their notice, they will send a copy of any revised notice to the address I've provided (whether by U.S. Mail or, if I agree, email.)

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as part of the organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline ***(circle one)*** the terms of this consent.

✘ ____ ____________

Patient's Signature Date