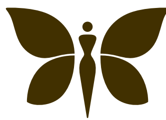


PATIENT INFORMATION: (please print)

First Name: ______________________ Middle: __________ Last: ______________________

Primary Address: ____
street apt/unit no. City State Zip

Home Phone: ______________________ May we leave a message for you at home? **Y N**
Cell Phone: ______________________ May we call you at work? **Y N**
Work Phone: ______________________ May we leave a message for you on your cell? **Y N**
E-Mail (will not be shared): ______________________ May we email you special offers/newsletters? **Y N**
Preferred Method of Contact (check one): ☐ E-mail ☐ Home ☐ Cell ☐ Work

Employer: ______________________ Occupation: ______________________
Date of Birth: __________ Age: _____ Sex: **M F** Marital Status: ________ Name of Spouse: ______________
Social Security No: ______________________ Drivers License No. & State: ______________________
Emergency Contact: ______________________ Relation: __________ Phone Number: ______________

Race (choose one): ☐ Amer Indian/AK Native ☐ Asian/Pacific Isl ☐ Black/Afri-American ☐ Hispanic ☐ White/Cauc ☐ Other ☐ Declined
Ethnicity (choose one): ☐ Hispanic/Latin ☐ Non Hispanic/Latin ☐ Declined Preferred Language: ☐ English ☐ Spanish ☐ Other

RESPONSIBLE PARTY INFORMATION:

Responsible Party: ______________________ Relationship to Patient: ______________
Responsible Party Phone: ______________________ Alternate Number: ______________
Is This Work Related or a Motor Vehicle Accident? **Y N**

INSURANCE INFORMATION: (please present insurance card to receptionist after completing below)

PRIMARY insurance company's name: ______________________ Phone #: ______________
Insurance Address: ______________________ SS# ______________
Name of policyholder/insured: __________ Date of Birth: ________ Relationship to patient: ______________
ID# ______________________ Group #: __________ Employer Name: ______________

Secondary insurance company's name: ______________________ Phone #: ______________
Insurance Address: ______________________ SS# ______________
Name of policyholder/insured: __________ Date of Birth: ________ Relationship to patient: ______________
ID# ______________________ Group #: __________ Employer Name: ______________

REFERRAL INFORMATION:

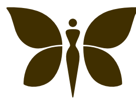
Name of Referring Physician: ______________________ Other referral form: ______________
Primary Care Physician: ____
Physician Office Address ______________________ Phone Number: ______________

Assignment of Benefits-Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Monarch Plastic Surgery, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonalbe attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I agree to be photographed by this healthcare provider for the purpose of medical record requirements, medical insurance authorization and education. I further agree that a photocopy of this agreement shall be as valid as the original.

______________________ ______________
Signature Date

______________________ ______________
Responsible Party (if minor) Date



HEALTH HISTORY

Name ______________________

Preferred Pharmacy ______________________

Pharmacy Address ______________________

Phone ______________________

Reason for visit? ______________________

Date of Onset / Injury: ______________________

Height __________ **Weight** __________

MEDICATIONS

List Medications you are currently taking, prescriptions, and over the counter medications. Also, list vitamins, dietary supplements, anti-inflammatories and aspirin:

Med	Dosage	Instructions

Do you have any known Allergies?

☐ Latex ☐ Penicillin ☐ Sulfa

Other allergies: please list

____

____

____

HEALTH HABITS:

Check which substances you use and frequency.

☐ Tobacco: Packs/Day __________

If you have quit, how long ago? __________

☐ Caffeine __________ ☐ Drugs __________

☐ Alcohol __________

ARM OR HAND CONCERNS ONLY:

Right or Left Handed? __________

Injured Hand? ☐ Right ☐ Left

CONDITIONS/SYMPTOMS: (past or current with explanation)

- ☐ Alcoholism or Chemical Dependency
- ☐ Anemia or Bleeding Disorders __________
- ☐ Breast Disease or Abnormal Mammogram __________
- ☐ Cancer __________
- ☐ Depression or Psychiatric Care
- ☐ Diabetes
- ☐ Heart Disease __________
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Kidney Disease __________
- ☐ Liver Disease __________
- ☐ Lung Disease or Asthma __________
- ☐ Nervous System Disorder __________
- ☐ Stroke
- ☐ Thyroid Disease __________
- ☐ Arthritis
- ☐ Other __________
- ☐ MRSA

HOSPITALIZATIONS/OPERATIONS/SERIOUS ILLNESS:

Year	Hospital	Reason and Outcome

FAMILY HISTORY:

Disease	Parents	Siblings	Other (Specify)
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

FOR WOMEN ONLY:

Date of last Mammogram __________ Results: __________

Are you pregnant or any chance you could be pregnant? __________

Number of pregnancies: __________ Dates of deliveries: __________

MONARCH PLASTIC SURGERY POLICIES
COPAYS, INSURANCE BILLING, FMLA/DISABILITY

Our office is committed to providing the highest quality of customer care and services. The following is a description of Monarch Plastic Surgery, hereinafter referred to as "Medical Provider", policies in place to assist our patients. All office co-pays are due at the time of service. Knowledge of insurance co-pays, coinsurance and deductibles is the responsibility of the person using the medical insurance. If your insurance requires a referral, it is the patient's responsibility to know and obtain this prior to coming in for an office visit and/or surgery. If you are unsure, you should contact your PCP or your insurance company directly. If you have Medicare or a supplemental insurance, we will be collecting the specialist office visit co-pay at the time of service. We file insurance claims **ONLY** for companies that we are contracted with. **This office is not contracted with Kansas or Missouri Medicaid/First Guard, or any other Medicaid plans.** Our office staff will not be able to answer detailed questions about your policy, as each plan is different. If we are not contracted with your insurance company, or if you are a private pay patient, all charges for examination, consultation and special procedures performed in the office, are due and payable in full at the time services are rendered. Please discuss other necessary arrangement with our billing office **BEFORE** you see the doctor. We can provide you with an itemized receipt of your charges or payments. Please be sure to request this receipt before you leave.

Payment of the doctor's fee is a personal financial obligation of the patient or the person authorizing treatment. This personal obligation is not altered because the patients charge is not covered in part or in whole, by insurance. It is your responsibility to know what is and is not covered by your insurance company. Full payment is expected within 30 days after a response from your insurance company. Any statement not receiving payment after 30 days is considered past due. Regardless of performance by your insurance company, you are responsible for payment of your account. In the event that you default, you will be responsible to pay all reasonable collection costs including but not limited to attorney fees and court costs.

We are happy to complete Disability and an FMLA form for you, however there is a fee of **$35 for EACH set of forms completed.** Please note that this fee is subject to change. This will include any records request made with the form completion requests. The fee must be paid prior to completion. We will only complete the physician section. FMLA guidelines advise that FMLA forms must be returned to employer within a minimum of 15 calendar days of receipt of the forms. However, if your employer has a different timeline set for the forms to be returned to them, please make sure that this information is indicated on the forms. Other forms, including Disability forms, needing completion, will be completed and returned within 30 days unless otherwise indicated. You may fax (913-663-4434) or mail forms to our office. Your signature below also releases our office to provide medical information to your disability/insurance company in compliance with HIPAA guidelines.

- Signature ___________________________________ Date _____________

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN

I hereby authorize the release of any medical or other information necessary to process my claims. I also authorize payment of medical claims directly to the Medical Provider, such sums as may be due and owing it for medical service(s) rendered to me or my dependents both by reason of this injury/illness or by reason of any other bills that are due the Medical Provider, and to withhold such sums from any settlement, judgment, or verdict as may be necessary as to adequately pay the Medical Provider first. I hereby further give lien on my case to the Medical Provider against any and all proceeds of any settlement, judgment or verdict which may be paid to anyone on my behalf as a result of the injury/illness for which I have been treated by the Medical Provider. This lien shall not attach to any attorney's fees. I fully understand that I am directly and fully responsible to the Medical Provider for all medical bills submitted by it for services rendered to me or my dependents, and I agree to pay the same, and that this assignment is made solely for the Medical Provider's additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover. This assignment is irrevocable unless: (1) I and the Medical Provider, in writing, terminate this assignment and (2) the Medical Provider is fully paid for all of its services relating to my injury/illness.

- Signature ___________________________________ Date ______________

MEDICARE CONSENT TO AGREEMENT

I request that payment for authorized insurance benefits be made on my behalf directly to the Medical Provider for any services. I authorize any holder of my medical information to release to the Medical Provider, any information needed to determine benefits payable for related services. I authorize my insurance to furnish the above named doctor any information regarding my claims under Title VII of the Social Security Act. I agree that photographic copy of this authorization is as valid as the original.

- Signature __________________________________ Date ________________

NOTICE OF PRIVACY ACT

I have received a copy of the Notice of Privacy Practices for Protected Health Information, effective September 23, 2013; from Monarch Plastic Surgery.

- Signature __________________________________ Date _________________