



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 reasonable 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 _____

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 _____

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)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR WOMEN ONLY:

Date of last Mammogram _____ Results: _____

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

Number of pregnancies: _____ Dates of deliveries: _____

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

ARM OR HAND CONCERNS ONLY:

Right or Left Handed? _____

Injured Hand? Right Left

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 _____