INSURANCE INFORMATION AND ASSIGNMENT

PLEASE NOTE THAT WE DO NOT PARTICIPATE IN MOST INSURERS OR HMOS NETWORKS.
IT IS YOUR RESPONSIBILITY TO DETERMINE IF WE PARTICIPATE IN YOUR PLAN.

Legal Name of Patient: _____
Name of Primary Insurance Company: _____
Address and Phone Number: _____
Policy Number (Letters and Numbers): _____ Group Number: _____
Subscriber's Name (As it shows on the policy): _____
Subscriber's DOB (MM/DD/YEAR): _____ Subscriber's SS: _____
Please select your Relationship: Self [ ] Spouse [ ] Parent [ ] Other [ ]
Name of Secondary Insurance Company: _____
Address and Phone Number: _____
Policy Number (Letters and Numbers): _____ Group Number: _____
Subscriber's Name (As it shows on the policy): _____
Subscriber's DOB (MM/DD/YEAR): _____ _____Subscriber's SS: _____
Please select your Relationship: Self [ ] Spouse [ ] Parent [ ] Other [ ]
Name of Tertiary Insurance Company: _____
Address and Phone Number: _____
Policy Number (Letters and Numbers): _____ Group Number: _____
Subscriber's Name (As it shows on the policy): _____
Subscriber's DOB (MM/DD/YEAR): _____ Subscriber's SS: _____
Please select your Relationship: Self [ ] Spouse [ ] Parent [ ] Other [ ]
Please circle if applicable: Motor Vehicle Accident (MVA) Workers' Compensation (WC)
Is your injury the result of an accident? If Yes, please best describe what occurred:_____
_____
_____
Date of accident/injury: _____State in which the accident/injury occurred: _____
Do you have an Insurance Claim Number? _____
Adjuster's Name and Contact Information: _____
If MVA, provide the name and address of YOUR automobile insurance company: _____
_____
If WC, provide the name and address of YOUR employer/insurance company: _____
_____
Are you represented by an Attorney? If Yes, name of Practice: _____
Contact Name and Phone Number:_____
Address:_____

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary insurance. Any remaining balance after receipt of explanation of benefits from your primary and/or secondary insurance carrier will be billed to you.

PATIENT INFORMATION

Patient's Legal Name: _____ Preferred Name: _____
Last Middle Initial First

Patient's Address: _____
Street City State Zip

Email: _____ Do you approve using your email? Yes___No___Initials:_____

Cellphone: _____Home Phone: _____Work Phone: _____Ext: ___

Do you approve the use of text messages? Yes _____ No ____ Initials _____ Language: _____

Date of Birth (MM/DD/YEAR): _____ Age: _____ SS# _____ Biological Sex: [ ] Male [ ] Female

Gender Identity: [ ] Man [ ] Woman [ ] Trans-Male/Transman [ ] Trans-Female/Transwoman [ ] Genderqueer/Nonconforming [ ] Different Identity [ ] Prefer not to answer

Choose your Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Other_____

Group identity:
[ ] Alaska Native or American Indian or Indigenous or Native American
[ ] Black, African, Afro-Caribbean or African American
[ ] Asian or Asian American
[ ] Hispanic, Latina/o/x or of Spanish origin
[ ] Middle Eastern or North African
[ ] Native Hawaiian or Other Pacific Islander
[ ] White
[ ] Prefer not to answer
[ ] Other/Prefer to self-describe _____

Occupation: _____Employer: _____
Business Address: _____

Emergency Contact and Phone Number: _____Relationship: _____
Person Financially Responsible Information: _____

Primary Care Physician: _____Phone Number: _____
List Physicians and Specialists you have seen in the last year: _____
_____

How did you hear about us? _____ If applicable, name of who referred you: _____
Reason for visit: _____
_____

Have you already consulted other physicians? _____ If Yes, please provide their names: _____
_____

CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, The Plastic Surgery Center, P.A., Premier Surgical Network, The Institute for Advanced Reconstruction, The Center for Hand and Upper Extremity Surgery, It Aesthetix, and Aesthetic Vascular Associates (collectively, the "Practices") have my consent to use and disclose my Protected Health Information ("PHI") to carry out treatment, to obtain payment from third parties and to perform healthcare operations as outlined below:

I have been given access to a copy of the "HIPAA Notice of Privacy Practices" which is available for download on the Practices' websites and have a complete description of PHI.

I have the right to review, and to the extent I desire to do so, I have reviewed the HIPAA Notice prior to signing this Consent Form.

I authorize the Practices to use and disclose my PHI in the following manner:

1. Transmit my PHI through the following means in order to carry out treatment, obtain payment from third parties and perform healthcare operations which include and are not limited to appointment reminders, confirmations, relaying test results, surgery dates, etc:

A. Mobile Call / Text: _____
B. Home Phone Call: _____
C. Email: _____
D. Mail: _____

2. Disclose my PHI to the following family members in order to carry out treatment, obtain payment from third parties and perform healthcare operations:

A. NONE [ ]
B. Parent: _____
C. Spouse: _____
D. Other: _____

3. Transmit my PHI to other health care providers as well as my health insurance carrier in order to carry out treatment, obtain payment and perform healthcare operations.

I understand that I may revoke my consent in writing except to the extent that the Practices have already made disclosures in reliance upon my prior consent. I further understand that if I do not sign this Consent, the Practices may decline to provide treatment.

I acknowledge that I have read and understand the above. By electronically signing this form, I consent the Practices to use and disclose my PHI as outlined above.

Note: For questions about the HIPAA Notice, please contact our offices and ask to speak with the Administrator. We reserve the right to revise our HIPAA Notice of Privacy Practices at any time.

NAME: _____ DOB: _____ RELATIONSHIP: _____

SIGNATURE: _____ DATE:_____

CONSENT FOR TREATMENT AND FINANCIAL POLICY

Thank you for choosing The Plastic Surgery Center, P.A., Premier Surgical Network, The Institute for Advanced Reconstruction, The Center for Hand and Upper Extremity Surgery, Aesthetic Vascular Associates and It Aesthetix (collectively, the “Practices") for your healthcare needs. This form describes patient and insurance responsibility for services rendered. As either the patient or the responsible party of the patient, your understanding of and compliance with our patient financial policy is important. For purposes of clarity, the term “I” is used interchangeably to mean the patient receiving medical services, the guardian of the patient, or the person financially responsible for any cost incurred by the patient.

Please read the statement below and ask the staff any questions you may have, then sign where indicated. The original will be maintained in your file and a copy will be provided to you upon request.

CONSENT FOR TREATMENT: I authorize the Practices to provide medical treatment to myself and/or my dependent. In the event that any employee is exposed to my blood and/or body fluids, I consent to laboratory testing of my blood and/or body fluids. I consent to laboratory testing of my blood for Hepatitis B and/or C and AIDS antibody and agree for the results of such test to be released to the person who has been exposed.

RELEASE OF MEDICAL INFORMATION: I authorize the Practices to release necessary medical information to my insurance company, its agents, or to any third-party payer in order for payable benefits for these services to be determined. This assignment shall be binding on and inure to the benefit of the Practices, its successors, assigns and its legal representatives.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible and agree to pay all of the fees that are not otherwise paid by or billed to my insurance or any other third-party payer, including in such instances where my insurance company denies or does not allow a prior authorization for services I opt to receive.

I understand that, if my insurance policy is not active or accepted, I must pay in full today for all services rendered. I also understand that if my insurance is accepted, I must pay all applicable insurance copayments today. Once my insurance has been billed, any balance will be my responsibility.

I understand that though the Practices will file my insurance claims, I am ultimately responsible for full payment of all charges not covered by insurance(s). Should collection proceedings or other legal action become necessary to collect an overdue account, I also understand that the Practices have the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered.

I understand that if my insurance company makes a payment directly to me for services rendered by the Practices, I agree to immediately forward it to the Practices upon receipt agree to immediately endorse the check to the corresponding to the Practices and send along with a copy (front and back) of the Explanation of Benefits provided by my insurance company.

I understand that I am responsible for my entire visit if I have no insurance and thereby considered Self-Pay. As such, I am required to pay, upon arrival, $250 for a new patient consultation or $150 for an existing patient consult.

I further understand that it is the policy of the Practices that Self-Pay fees be paid in full at least ten (10) days

prior to the scheduled services.

NO SURPRISES ACT: The Federal No Surprises Act requires healthcare providers to give self-pay patients, including those undergoing cosmetic procedures, an estimate of their personal cost for scheduled items or services.

I understand that if the amount billed for the rendered services exceeds the self-pay cost estimate I received by more than $400, I have the right to dispute the bill.

INSURANCE POLICY: I understand that I am responsible for providing the Practices with the correct insurance information no later than at the time of service or I may be considered as Self Pay and be responsible for the cost of all services rendered.

ASSIGNMENT OF BENEFITS: I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to the Practices for services provided by associated physicians and employees.

I hereby assign, pursuant to N.J.S.A 26:2S6.1(c) and the common law, any and all of my rights to receive payments to any and all benefits under my insurance policy to my medical provider, the Practices, relating to and/or arising out of any and all medical treatment provided by the Practices to me, including, but not limited to, major medical, personal injury protection (PIP), and workers' compensation benefits otherwise payable to me, regardless of whether the Practices are a participating or nonparticipating provider of my health insurance carrier.

I hereby name the Practices as my Designated Authorized Representative and further authorize any plan administrator or fiduciary, insurer, and my attorney to release any and all plan documents, insurance policy and/or settlement information upon written request from the Practices in order to assert any and all of my legal rights relating to and/or arising out of my health insurance policy and the medical treatment provided to me by the Practices in order to prosecute any and all claims for such medical benefits, reimbursement, and any and all applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

REFERRALS: I understand that some insurance policies require a "referral" from a Primary Care Physician before being seen by a physician of the Practices.

I understand that it is my responsibility to obtain such referral and that, should I fail to do so, I am required to make a $150.00 deposit at time of registration as well as be responsible for any additional charges that might result.

COSMETIC SERVICES: I understand that insurance companies DO NOT PAY for cosmetic procedures. Further, should I have a cosmetic procedure at the same time as a non-cosmetic procedure, only the non-cosmetic procedure will be submitted to my insurance company and that I am responsible for the difference.

I understand that a 10% non-refundable deposit for cosmetic surgery is required at time of scheduling a procedure and the remaining cost paid three weeks prior to surgery. Should I cancel the procedure less than 10 days prior to the scheduled date, I will forfeit this deposit.

I understand that pre-surgical testing must be completed one week prior to the scheduled procedure date, and failure to complete such testing as required may result in the rescheduling or cancellation of the surgery.

BILLING OFFICE: I understand that, in the event a physician of the Practices does not participate with my

insurance plan, I may be responsible for any charges above that determined by my insurance carrier as "reasonable and customary".

I understand that a finance charge of (18%) per annum (one and one-half percent (1.5%) per month) will be added to any invoice 30 days past due. I also understand that if the account is placed in the hands of an attorney for collection, I am responsible for collection costs and reasonable attorney's fees.

Note: Payments may be made by Cash, Debit Card, Check, American Express, Visa, MasterCard, Discover, CareCredit, Cherry, Apple and Google Pay, in person, over the phone or through a secure online payment portal. Patients who are experiencing difficulty in making payments on open accounts are asked to contact a Patient Financial Advocate at 888-915-7392, Option 2, from 8:00 AM-5:00 PM Monday-Thursday, and 8:00 AM-4:00 PM on Friday.

MISSED SURGERY APPOINTMENTS*: I understand that for the Practices to make efficient use of expensive resources such as the ambulatory surgery center, I agree to notify the Practices of a decision to cancel a scheduled surgery no less than **SEVEN (7) DAYS BEFORE** a surgery appointment time.

I understand that should I fail to show for a scheduled surgery (including cosmetic procedures) appointment without first notifying the Practices of my decision to cancel at least **SEVEN (7) DAYS IN ADVANCE** – in other words, if surgery/laser is scheduled on a Monday, I must cancel by the previous Monday – I am responsible for a "No Show" fee of $150.

Note: THESE CHARGES ARE THE RESPONSIBILITY OF THE PATIENT AND WILL NOT BE SUBMITTED TO ANY INSURANCE CARRIER.

RETURNED CHECKS: There will be a $35 fee assessed to your account for any check returned to our bank as unable to process for any reason.

PROHIBITIONS: I understand that consistent with state and federal privacy laws, and as a condition of treatment, audio or video recordings are not permitted inside any facility of the Practices. In the event I am observed recording or taking photographs with a cellphone or other device, I may be asked to immediately erase the audio, video or photographs to protect the privacy of other patients and/or associates of the Practices.

ACKNOWLEDGEMENT: I have read and understand this Consent for Treatment and Financial Policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the Practices from time to time, and that a copy of the authorization will be considered as valid as the original.

NAME: _____ DOB: _____ RELATIONSHIP: _____

SIGNATURE: _____ DATE:_____

LETTER OF PROTECTION

I, the undersigned, hereby agree that this Letter of Protection constitutes my agreement to both assign to The Plastic Surgery Center, P.A., Premier Surgical Network, The Institute for Advanced Reconstruction, The Center for Hand and Upper Extremity Surgery, and Aesthetic Vascular Associates (collectively, the "Practices") and to grant the Practices a first lien (after the payment of all attorney's fees and litigation costs) on any recovery of proceeds paid as a result of any settlement, judgment or verdict which is paid to my attorney or me as a result of the injuries by reason of an accident which occurred on: _____

I hereby authorize my attorney to discuss my case and to provide the Practices with any information necessary so that payment shall be made directly to them for such sums as may be due and owing for medical services rendered me. I, furthermore, authorize my attorney to withhold such sums from any proceeds paid as a result of any settlement, judgment or verdict and to immediately pay the Practices all outstanding sums from such proceeds.

I fully understand that I am solely responsible to the Practices for all medical bills for services rendered me and this agreement does not relieve me of any personal responsibility for said charges. I further understand that this agreement is made solely for the protection of the Practices and such payment by me is not contingent on any settlement, judgment or verdict.

I understand that this Letter of Protection is irrevocable and shall apply to any cause of action whether or not I should engage legal counsel or substitute counsel at any future time.

I further understand and agree to notify the Practices in writing, if I change or terminate attorney/client relations.

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____ **DATE:** _____

I, the undersigned, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above agreement and agree to withhold such sums from any proceeds paid as a result of any settlement, judgment or verdict on behalf of and to immediately pay the Practices.

I, furthermore, understand and agree to immediately notify the Practices in writing, should there occur a substitution of counsel, referral to another attorney or law firm, retention of co-counseling or should the attorney/client relationship be terminated or modified in any manner.

ATTORNEY SIGNATURE: _____**DATE:** _____

THE PLASTIC SURGERY CENTER, P.A. MEDIA RELEASE AND CONSENT

I hereby agree and give my consent to The Plastic Surgery Center, P.A., its physicians, licensees, employees, and staff (collectively "TPSC") for the taking, recording, use, and publication of my name, likeness, picture, audio, and/or video, and statements (collectively "My Materials"). I understand I may be identified in any use of My Materials. I also agree My Materials may be used for advertising, promotion, and publicity purposes of any nature whatsoever, and I agree My Materials may be broadcast, displayed, published, and transmitted in various forms of media, including, but not limited to, the Internet (i.e., Facebook, Instagram, TikTok, YouTube, X, etc.) and by various other means, including, but not limited to, electronic, digital, print, and in all social, traditional, and new media. I waive the right of prior approval of My Materials.

I also understand and agree this Media Release and Consent is valid and shall continue unless I revoke it in writing, but in no event shall I revoke it sooner than (10) years from the date below.

I hereby release TPSC from any and all charges, claims, and liability for damages of any kind whatsoever (including costs), known or unknown, based on the use or disclosure of My Materials. I understand TPSC alone has the right to copyright My Materials and I will receive no compensation for My Materials regardless of whether TPSC receives compensation.

I am entering this Media Release and Consent freely and voluntarily. I represent TPSC has not paid me any compensation or promised me anything of value to enter into this Media Release and Consent. Finally, I acknowledge and agree I have received a signed copy of this Media Release and Consent.

By signing below, I agree and acknowledge I have read and understand the above Media Release and Consent, and agree to all terms described herein. I am of legal age and freely sign this Release.

NAME: _____ **DOB:** _____

SIGNATURE: _____ **DATE:** _____