Burt and Will Plastic Surgery and Dermatology Registration

Date:_____

PATIENT NAME		PATIENT OCCUPATION	
STREET 1		PATIENT EMPLOYER	
STREET 2		STREET 1	
CITY		STREET 2	
STATE & ZIP		CITY	
HOME PHONE		STATE & ZIP	
CELL PHONE		EMPLOYERS PHONE	
WORK PHONE			
E-MAIL ADDRESS		**PHARMACY NAME**	
DATE OF BIRTH		CITY AND PHONE	
MARITAL STATUS		**PATIENT PRIMARY CARE DOCTOR**	
SOCIAL SECURITY NUMBER		NAME	
RACE		ADDRESS	
(White, Black, Hispanic, Asian, Indian, Native American, Eskimo, Other)		CITY, STATE, ZIP	

BILLING/ACCOUNT INFORMATION:

PRIMARY CARDHOLDER	**INSURANCE INFORMATION**
NAME	
STREET 1	PRIMARY INSURANCE COMPANY
STREET 2	
CITY	PRIMARY INSURANCE POLICY HOLDER/SUBSCRIBER NAME/DOB
STATE & ZIP	
HOME PHONE	WHAT COMPANY/ORGANIZATION/EMPLOYER
CELL PHONE	PROVIDES THIS INSURANCE COVERAGE?
WORK PHONE	
DATE OF BIRTH	WHAT IS THE EMPLOYMENT STATUS OF THE
MARITAL STATUS	POLICY HOLDER/SUBSCRIBER?
SOCIAL SECURITY NUMBER	(FULLTIME PART TIME, STUDENT, PART TIME STUDENT, RETIRED, UNEMPLOYED, SELF EMPLOYED, UNKNOWN)

CARDHOLDER'S EMPLOYER:

NAME	**SECONDARY INSURANCE COMPANY**
STREET1	SECONDARY INSURANCE COMPANY
STREET2	
CITY	SECONDARY INSURANCE POLICY HOLDER/SUBSCRIBER NAME
STATE & ZIP	
HOME PHONE	WHAT COMPANY/ORGANIZATION/EMPLOYER
CELL PHONE	PROVIDES THIS INSURANCE COVERAGE?
OCCUPATION	
	WHAT IS THE EMPLOYMENT STATUS OF THE
	POLICY HOLDER/SUBSCRIBER? (FULLTIME PART TIME, STUDENT, PART TIME STUDENT, RETIRED, UNEMPLOYED, SELF EMPLOYED, UNKNOWN)

FOR NEW PATIENTS

How were you referred to our clinic or what is your reason for choosing our clinic? (Please circle one)

Newspaper	Spa	Event
Which? _____	Insurance	Yellow Pages
Real Self	ER Visit	Website
Specialty Magazine	Physician Referral	Radio
Internet	Family/Friend : Name_____	
	May we correspond with them: Yes No	

You must provide all insurance cards at the time of registration.

Please fill out all pages in this new patient packet.

Co-payments are due at each visit.

All payments are to be made payable to: Burt & Will Plastic Surgery, SC.

Thank you for choosing Burt and Will Plastic Surgery and Dermatology

Burt and Will Plastic Surgery and Dermatology

Patient Name: _____

Occupation: _____

Social History:

Please indicate daily consumption or prior history of each of the following:

Tobacco _____

Alcohol _____

Past Medical History/Family History **Adopted?** ___ **yes** ___ **no**

Conditions/Disease	Yourself	Blood Relative	Conditions/Disease	Yourself	Blood Relative
Basal cell skin cancer	Y/N	Y/N	HIV	Y/N	Y/N
Melanoma	Y/N	Y/N	Other skin cancer	Y/N	Y/N
Squamous cell skin cancer	Y/N	Y/N	Pacemaker	Y/N	Y/N
Abnormal moles on biopsy	Y/N	Y/N	Psoriasis	Y/N	Y/N
Actinic Keratosis	Y/N	Y/N	Seizure Disorder	Y/N	Y/N
Allergies/hay fever	Y/N	Y/N	Thyroid Problems	Y/N	Y/N
Arthritis	Y/N	Y/N	High Blood Pressure	Y/N	Y/N
Asthma	Y/N	Y/N	Bleeding Disorder	Y/N	Y/N
Cancer _____	Y/N	Y/N	History of Blood Transfusions	Y/N	Y/N
Diabetes	Y/N	Y/N	Kidney Disorder	Y/N	Y/N
Eczema	Y/N	Y/N	Joint Replacement	Y/N	Y/N
Glaucoma	Y/N	Y/N	Tuberculosis (TB)	Y/N	Y/N
Hepatitis/Liver Problems	Y/N	Y/N	Other	Y/N	Y/N

Pertinent Preoperative Information:	**Circle Yes or No**	
Have you ever reacted badly to being put to sleep for surgery?	No	Yes
Has any member of your family ever reacted badly to being put to sleep for surgery?	No	Yes
Have you required large amounts of local anesthetic for medical or dental procedures?	No	Yes
Have you ever had a bad reaction to local anesthetic (Novocain, etc.)?	No	Yes
Are you allergic to adhesive tape?	No	Yes
Do you bleed unusually easily (from cuts, surgery, tooth extractions)?	No	Yes
Do you bruise easily?	No	Yes
Have you required transfusion for surgery?	No	Yes
Are you a slow or poor healer?	No	Yes
Do you form large scars or keloids?	No	Yes
Do you have any skin disease, hives, eczema or rashes?	No	Yes
Do you have frequent infections or boils?	No	Yes
Do you have shortness of breath with walking?	No	Yes
Does your religion prohibit blood transfusions?	No	Yes
Do you have, or have you had any significant emotion problems?	No	Yes
Have you ever been advised to see a psychiatrist?	No	Yes
Are you pregnant?	No	Yes
Have you had a mammogram?	No	Yes

If yes, when ? _____

Receipt of Notice of Privacy Form

I, _____, hereby acknowledge receipt of the Physician's Notice of Privacy Practices. The Notice of Privacy provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available.

In the event that Burt and Will Plastic Surgery and Dermatology or Limelight Medical Spa is unable to contact me, I give full permission to Burt and Will Plastic Surgery and Dermatology or Limelight Medical Spa to contact the individual that I have designated below for the purpose of disclosing information pertinent to my case. This would include, but not limited to information regarding tests, reports, scheduling and business information. By my signature below, I agree to hold harmless tests, reports, scheduling and business information. By my signature below, I agree to hold harmless and waive any liability against Burt & Will Plastic Surgery and Dermatology or Limelight Medical Spa for the disclosure of information to the individual(s) designated below.

NAME **PHONE**

_____ _____

_____ _____

Signature of Patient: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

Consent for Release and Use of Photographs (for medical chart use only)

I, _____, am a patient of Tripti Burt, M.D, Neena Will, M.D and/or Tushar Dabade, M.D., and have been photographed during the course of my treatment. I grant Burt & Will Plastic Surgery and Dermatology the ongoing right to use the pre and post-operative photographs of the undersigns. The undersigned acknowledges the he/she relinquishes all right, title and interest in the photographs, or any right to profit or gain directly realized through the use of photographs. This form and the effect of my consent have been fully explained to me and any questions I have are fully answered. These photos are used as a part of my medical records.

Signature : _____ Date: _____

Witness: _____ Date: _____

Financing: We offer financing for both our cosmetic spa and surgical services, which include CareCredit, ask Thalia for more details or if you have any questions.

Burt and Will Plastic Surgery and Dermatology
Financial Policy

Thank you for choosing **Burt and Will Plastic Surgery and Dermatology** as your health care provider. Please understand that payment of your bill is considered a part of your treatment. Your clear understanding of our financial policy is important to our professional relationship.

All Patients must complete our "Patient Registration and Medical form" prior to seeing the doctor.

- Co-pays are due at the time of service.
- There will be a $35.00 service charge on all returned checks.
- The charges made for your visit depend on the nature and the complexity of your problem. If you have any questions regarding the charges made for any visit, please feel free to contact our billing office.
- Any charge that becomes sixty (60) days old without satisfactory payment provision having been made will be considered delinquent and charged a $15.00 statement fee for each statement sent out . We reserve the right to turn over delinquent accounts to a debt collection agency or an attorney for collection. Costs associated with the collection efforts will be added to the balance due to Burt and Will Plastic Surgery and Laser Centre.
- We accept cash, checks, Visa, MasterCard, Discover and Care Credit.

Cosmetic Consultation Fee

- A $50.00 cosmetic consultation fee is due at the time of the initial consult.
- This fee covers the initial consult with either Dr. Burt or Dr. Will.
- If you see both Dr. Burt & Dr. Will, the fee is $50.00 for each Physician.
- This applies to consults for cosmetic procedures only.

Cosmetic Surgery Policy

- A scheduling fee of $500.00 is due at the time of the preoperative appointment or time of surgery scheduling.
- This fee is non-refundable and will be deducted from the surgery fee.
- The surgery fee is due in full two weeks prior to the date of surgery.
- A cancellation less than two weeks prior to the date of surgery will result in 50% cancellation fee.
- Cancellation the day of surgery will result in a 100% cancellation fee.

BWPS is not responsible for errors in billing made by third party vendors such as Chase Credit, Care Credit, Visa, MasterCard, and Discover.

Medicare - I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information) Regulations pertaining to Medicare assignment of benefits also apply.

Illinois Health Partners HMO - A referral from your primary care physician is required at the time of your appointment.

Covered Services - Some health plans do not cover all services. If we are aware that your plan excludes certain services you will need to pay for those services at the time they are rendered.

If you do not currently have medical insurance a fee of $250.00 will be required at the initial physician visit.

I understand the above listed financial policy and agree to abide by this agreement.

Signature _____ Date _____

Release of Information and Authorization for Assignment of Benefits

I authorize the physician(s), staff and surgical assistants directed by the physician to do any medical treatment test or care deemed necessary. I authorize Burt & Will Plastic Surgery and Dermatology to release to my insurance company or its representatives, information including the diagnosis and the records of any treatment or examination rendered to me that they may require processing my claim for benefits. I authorize and request that my insurance company pay directly to the above named practice the amount due me in my pending claim for medical treatment of services, by reason of such treatment or services rendered to me. This assignment will remain in effect until revoked by me in writing. I understand and agree that, (regardless of my insurance policy, I am responsible for the entire balance on my account, for all professional services provided to the patient (or myself). I have read all the information contained in the financial policy. I certify that, to the best of my knowledge, this information completed is correct and true. I will notify this office in case of any changes to my health or any of the attached information.

Signature _____ Date _____