Galardi|Bowen|Rosenblum
Plastic Surgery

Chart # ____________

PATIENT

PATIENT NAME: ____________ (LAST) ____________ (FIRST) ____ (INITIAL) ____ AGE ____ BIRTH DATE

PATIENT'S SEX *(CIRCLE ONE)* MALE FEMALE SOC. SEC. NO.: ____________

MARITAL STATUS: ____________ SPOUSE'S NAME: ____________ MAIDEN NAME: ____________

ADDRESS: ____________

CITY: ____________ STATE: ____ ZIP: ____________ HOME PHONE: ( ) ____________ CELL PHONE: ( ) ____________

EMAIL ADDRESS: ____________

IF PATIENT IS A CHILD: MOM'S NAME: ____________ DAD'S NAME: ____________

MY EMPLOYER IS: ____________ BUS. PHONE: ( ) ____________

EMPLOYER'S ADDRESS: ____________ CITY: ____________ STATE: ____ ZIP: ____________

RELATIONSHIP TO RESPONSIBLE PARTY: *(CIRCLE ONE)* SELF HUSBAND WIFE CHILD FATHER MOTHER STEPCHILD *OTHER (SPECIFY)* ____________

NEXT OF KIN NAME AND ADDRESS *(Other than above)*: ____________

____

RESP PARTY

RESPONSIBLE PARTY NAME: ____________
IF OTHER THAN PATIENT OR SPOUSE OF PATIENT (LAST) (FIRST) (INITIAL)

ADDRESS: ____________ CITY: ____________ STATE: ____ ZIP: ____________

SOC. SEC. NO.: ____________ HOME PHONE: ( ) ____________ CELL PHONE: ( ) ____________

EMPLOYER: ____________ BUS. PHONE: ( ) ____________

INSURANCE

FIRST INSURANCE CO.: ____________ Check if: HMO ☐ Co-Pay $ ____

POLICY NUMBER: ____________ EFFECTIVE DATE: ____________

SUBSCRIBER'S NAME: ____________ SUBSCRIBER'S DOB: ____________ SUBSCRIBER'S SOC. SEC. NO.: ____________

RELATIONSHIP OF PATIENT TO SUBSCRIBER: *(CIRCLE ONE)* SELF, SPOUSE, CHILD, OTHER: ____________

SECOND INSURANCE CO.: ____________ Check if: HMO ☐ Co-Pay $ ____

POLICY NUMBER: ____________ EFFECTIVE DATE: ____________

SUBSCRIBER'S NAME: ____________ SUBSCRIBER'S DOB: ____________ SUBSCRIBER'S SOC. SEC. NO.: ____________

RELATIONSHIP OF PATIENT TO SUBSCRIBER: *(CIRCLE ONE)* SELF, SPOUSE, CHILD, OTHER: ____________

COMMUNICATIONS

HOW WERE YOU REFERRED? ____________ PHONE NO.: ( ) ____________

WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO

IF ACCIDENT OR INJURY GIVE DATE: ____________

IF SEEN IN HOSPITAL OR EMERGENCY ROOM, PLEASE GIVE NAME OF HOSPITAL, DATE SEEN, AND DOCTOR'S NAME: ____________

____

IS THERE AN ATTORNEY INVOLVED? ☐ YES ☐ NO

IF SO, NAME OF ATTORNEY AND ADDRESS: ____________

____

- _____ I CONSENT TO RECEIVING TEXT AND/OR EMAIL MESSAGES TO THE CELL PHONE NUMBER AND/OR EMAIL LISTED ABOVE.
- _____ I WISH TO OPT OUT OF TEXT MESSAGE COMMUNICATIONS.
- _____ I WISH TO OPT OUT OF EMAIL COMMUNICATIONS.

This certifies that the above information is correct and current as of this date.
I have read, understand and agree to the Medical Insurance and Treatment Authorization and the Financial Agreement which are printed on the back of this form.
I have received a copy of the Notice of Privacy Practices for GBRPS. GBRPS reserves the right to modify the privacy practices outlined in notice.

____________ Patient / Responsible Party ____ Date

____________ Witness ____ Date

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Galardi|Bowen|Rosenblum Plastic Surgery

MEDICAL INSURANCE AND TREATMENT AUTHORIZATION

- INSURANCE ASSIGNMENT OF BENEFITS. This will authorize Galardi|Bowen|Rosenblum Plastic Surgery ("GBRPS") to bill my insurance on my behalf and to receive direct payment of any amount due to my claim under the above policy or policies. I authorize any holder of medical or other information about me (or if different, about the Patient if I am signing as the Patient's Agent) to release to the Social Security Administration and Health Care Financing Administration or its intermediaries, or TRICARE and its authorized agents or Benefit Providers, or billing agent of the physician or supplier, any information needed for this claim or a related Medicare or Medical claim. I permit a copy of this Authorization to be used in place of the original for release of medical information and records contained within this paragraph. I request payment by insurance companies, government agencies or other benefit providers for services and products provided and treatment rendered to the patient be made directly to the provider and supplier, GBRPS. I accept responsibility for compliance with all procedures and completion of all forms required by benefit providers and agree (for the Patient if I am signing as the Patient's Agent, but for myself if I am signing as the Patient or Responsible Party) to pay all GBRPS charges not paid by any benefit providers because such procedures are not followed or such forms are not completed to their satisfaction.

- NON-GBRPS CHARGES. I hereby apply for treatment by the above physician and/or their assistants. I accept full responsibility of any charges incurred for services rendered. I understand that charges billed for services and products furnished by GBRPS on a particular date may not reflect the total amount owed for treatment on that date, because such treatment might involve tests and other services provided by parties other than GBRPS. I authorize GBRPS to refer me to other parties to provide such tests and other services as GBRPS deems necessary, and agree (for the Patient if I am signing as the Patients Agent, but for myself if I am signing as the Patient or Responsible Party) to pay the provider for all charges for such tests and services. I understand that I am responsible for charges not covered by benefits due under this authorization. In the event of default on any payments due GBRPS, I agree to pay all costs of collection including 33 ⅓% attorney fees. All checks returned by your bank, for any reason, will be assigned a $20.00 fee. I understand that I am responsible for any returned check fees.

- MEDICAL QUALITY ASSURANCE AND PEER REVIEW RELEASE OF INFORMATION. I hereby authorize all GBRPS physicians to disclose their medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment. to those individuals who in GBRPS's sole determination, are required to receive such information for the purpose of medical treatment medical quality assurance and peer review.

  MEDICAL AUTHORIZATION. I hereby give permission to all doctors and hospitals to release all films or other medical records they have on me to GBRPS. And I hereby give permission to GBRPS to release any information required by my medical insurance payor for the purpose of filing my insurance claims.

- MEDICAL TREATMENT AUTHORIZATION. I hereby consent to treatment by the physicians and/or their assistants. Such treatment is to include X-rays, injections and such other office procedures as they deem necessary.

  I understand that a law was enacted in Virginia in 1989 which mandates health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). I hereby consent to such testing in the event of such exposure, and consent to the release of test results to the health care provider who may have been exposed. I also understand that I will be informed prior to my blood being tested for HIV antibodies pursuant to this provision, that the testing will be explained, and that I will be given the opportunity to ask any questions I may have.

FINANCIAL AGREEMENT

LEGAL AGREEMENT. I understand that this Agreement contains legally binding terms and provisions relating to payment for services and products provided and treatment rendered by Galardi|Bowen|Rosenblum Plastic Surgery ("GBRPS"). If I sign this Agreement as the Patient or Responsible Party, I will be directly responsible for performing all obligations and paying all liabilities arising under it. If I sign as the Patient's Agent, the Patient will be responsible for performing all such obligations and paying all such liabilities, unless I have misrepresented my authority to act on behalf of the Patient and bind the Patient to this Agreement. In that case I will be directly responsible for performing all obligations and paying all liabilities arising under this Agreement, just as if I had signed as the Responsible Party.

I understand and agree that GBRPS will file any medical insurance claims with my insurance carrier, provided I have authorized such by signing an authorization to release medical information and benefits payable to GBRPS. I understand that GBRPS cannot accept the responsibility for collecting on an insurance claim or negotiating a settlement of a disputed claim. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services. I understand and agree that if I am registrered under litigation or workers' compensation, I will not delay payment for services rendered while awaiting any settlements, judgements or insurance carrier payments.

The undersigned understands that GBRPS is not in the business of extending credit and promises to pay at the time services are rendered, unless other terms have been agreed to in writing by GBRPS. If prompt payment is not made, the undersigned understands that GBRPS may immediately take action to collect its charges. The undersigned agrees to pay all costs and expenses incurred by GBRPS in collecting its charges, including an attorney's fee of thirty-three and one third percent (33 ⅓%) of the unpaid bill.

Each person signing this Agreement certifies that he or she has read it, understands it, and has received a copy of it, and also that he or she is either (i) the Patient named at the beginning of this Agreement, (ii) the Patient's Agent duly authorized to sign this Agreement for the Patient and to bind the Patient to its terms, or (iii) the Responsible Party who, even though not the Patient, agrees to perform all obligations and pay for all liabilities arising under this Agreement.