Joshua A. Greenwald, MD
Cosmetic Surgery Associates of New York

PATIENT INFORMATION

Name: _____
First Middle Last

Age: _____ DOB: _____/_____/_____ Social Security Number: _____-____-_____
Month Day Year

Address: _____
Street

_____
City State Zip

Email: _____
Home Phone: (___)_____ Work Phone: (___)_____Cell Phone: (____)_____

Referred by: Patient _____ Physician _____ Internet _____
Primary Medical Doctor: _____ OB/GYN: _____

Employer:_____Occupation:_____
Address: _____
Street

_____
City State Zip

Phone: (____)_____ Spouse's Name (if applicable) _____

MEDICAL INSURANCE INFORMATION

Name of person holding medical insurance (if different from patient): _____
Primary Insurance Company: _____
Policy Holder's SS#: _____-_____-_____ Policy Holder DOB: _____
Insurance ID#: _____ Insurance Group#: _____
Secondary Insurance Company (if applicable): _____
Insurance ID#: _____ Insurance Group#: _____
Workers' Compensation Case # (if applicable):
If WComp, contact @ work place: _____
Name Phone

***Please bring your insurance card to your appointment, we will retain a copy to expedite processing of your benefits.**

EMERGENCY CONTACT

Name: _____ Phone Numbers: _____ Relationship: _____

FOR PATIENTS UNDER AGE 18

Father's Name: _____ Mother's Name: _____
Employer: _____ Employer: _____
Work Phone: (___)_____ Work Phone: (___)_____
Soc Sec Number: _____-_____-_____ Soc Sec Number _____-_____-_____

Joshua A. Greenwald, MD
Cosmetic Surgery Associates of New York

MEDICAL HISTORY

Name: _____ Date: _____
First Middle Last

Age: _____ Sex: Male_____ Female_____ Race: _____ Height: _____ Weight: _____

Reason for visit: _____

PAST MEDICAL HISTORY List any medical conditions for which you have been treated:

_____

_____

_____

PAST SURGICAL HISTORY List any operations, including cosmetic, you have had:

_____

_____

_____

Do you have a history of: (Please check yes/no)

	Yes	No
Asthma		
Bleeding Disorders		
Blood Clots		
Breast Disease		
Cancer		
Contact Dermatitis		
Depression		

	Yes	No
GERD/Reflux/Ulcers		
Gout		
Heart Disease		
Hepatitis		
High Blood Pressure		
Hypoglycemia		
Kidney Disease		

	Yes	No
Latex Allergy		
Liver Disease		
Nervous Disorder		
Thyroid Disease		
Tuberculosis		
Seizures		
Other:		

If yes to any of the above, please elaborate: _____

_____

Are there ANY other conditions we should know about? _____

_____

SOCIAL HISTORY:

Do you smoke cigarettes? _____ If yes, how many packs per day? _____ How many years?_____
Have you ever smoked? _____ When did you stop? _____
Alcohol Use (Please Check): ____None ____ Social ____ Daily
Exercise (Please Check): ____Never ____ > 1 x per week ____ 4-6x per week
Drug Use:_____ Tranquilizers:_____ Diet Pills:_____

FAMILY HISTORY Has any family member had any of the following:

____ Heart attack ____ Cancer ____ High Blood Pressure ____ Breast Cancer
____ Diabetes ____ Abnormal reaction to general anesthesia
If yes, please elaborate:_____

_____

Joshua A. Greenwald, MD
Cosmetic Surgery Associates of New York

Please list all **MEDICATIONS** and **dosage** recently or regularly taken (include herbal and vitamins):

_____
_____
_____

Please list any **ALLERGIES** to any **medications:** _____
_____

Please list any **NON-MEDICINE ALLERGIES** (i.e. latex, seasonal):_____
_____

WOMEN'S HEALTH

Do you have children: _____ How many: _____
Have you ever been pregnant: _____ How many times: _____
Date of Last Menstrual Period _____
Are you certain you are NOT pregnant? ____ Yes ___ No
Do you take oral contraceptive pills? ___ Yes ___ No
Date of most recent MAMMOGRAM: _____ Results: _____
Breast augmentation/reduction patients: Current bra size: _____ Desired bra size: _____

REVIEW OF SYSTEMS

Please check any of the following conditions that pertain to you:

General: ___Weight Changes ____Fatigue ___Chills ___Fevers
Head and Neck: ___Eye Pain ___Glaucoma ___Excessive Tearing ___Dry Eyes
___Inability to wear contact lenses (if applicable) ___Red Eyes
___Ear Pain ___Dizziness ___Hearing Loss ___Dentures
___Difficulty breathing through nose ___Sinus Problems
Cardiovascular: ___High blood pressure ___Chest Pain ___Shortness of Breath
___Irregular heartbeat ___ Extremity Swelling
Pulmonary: ___Asthma ___ Shortness of Breath ___ Recent Cough
Gastrointestinal: ___Ulcers ___Reflux ___Jaundice ___Change in color of stool
Genitourinary: ___Urinary tract infections ___ Kidney stones
Skin: ___New or changing lesions on the skin ___Previous skin cancer
Hematologic: ___Abnormal bleeding ___Easy bruising
Endocrine: ___Diabetes ___Thyroid abnormalities
Neurologic: ___Seizures ___Strokes ___ Sensory Loss
Psychiatric: ___Depression ___Alcoholism ___Anxiety
Mucsculoskeletal: ___Pain in extremities ___Joint Pain ___Extremity Swelling
If yes to any of above, please explain: _____
_____

Thank you for your time. Your safety is our first priority.

Cosmetic Surgery Associates of New York

OFFICE FEE POLICY

The doctors and staff of Cosmetic Surgery Associates of Westchester want your surgical experience to be as easy and comfortable as possible. Patients appreciate receiving this explanation of financial and insurance policies in advance.

Our charge for consultation is $100, payable at the time of service. During the consultation, you can discuss goals for surgery, obtain recommendations and have your questions answered.

Cosmetic surgery fees are paid in advance. If you decide to have surgery, your initial consultation fee will be credited towards final charges. There is a nonrefundable scheduling fee (deposit) of $1000 in order to reserve a time on our surgical schedule. All payments must be received three weeks prior to surgery.

In the event that you cancel your surgery for any reason other than a medical emergency, the following charges apply:

Cancellation 14 or more days before surgery – full refund minus deposit
Cancellation 7-13 days prior to surgery – Refund = 50% of total fees
Cancellation 0-6 days prior to surgery – NO Refund

Some non-cosmetic plastic surgical procedures may be covered, either totally or partially, by insurance. The exact reimbursement may be unpredictable and therefore insurance reimbursement may not be accepted as reimbursement in full. A surgical deposit may be required at the time a commitment is made to proceed with non-cosmetic surgery, along with insurance forms that have assigned benefits to Cosmetic Surgery Associates of Westchester.

After surgery, our staff will complete any relevant insurance forms. This may take several weeks as we must collect reports to accompany the forms. In this way, we hope to maximize your reimbursement. Our staff is efficient and knowledgeable about insurance matters and you can rely on their expertise.

If you require our surgical skills and feel that a financial burden would be placed upon you, please discuss this with us before surgery to see if we can work out an equitable solution.

I have read, understood and agree to the above financial policy. I understand the charges not covered by my insurance company as well as applicable co-payments and deductibles are my responsibility. I authorize Cosmetic Surgery Associates of Westchester to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

I authorize my insurance benefits to be paid directly to Cosmetic Surgery Associates of Westchester.

Signature _____ Date _____

Print Name _____

Cosmetic Surgery Associates of New York

EXPLANATION OF RESERVATION OF SURGICAL SCHEDULE TIME

We always attempt to accommodate the scheduling wishes of our patients. Therefore, in fairness to everyone, when a patient wishes to have surgery, the surgical facility requires a non-refundable deposit of $1000 to reserve operating room time. The deposit is non-transferable and non-refundable if the surgery is cancelled.

Signature _____ Date _____

Print Name _____

COMPUTER IMAGING DISCALIMER

Computer imaging may be used to better educate you about your upcoming surgery. Although an approximation of intended results is to be displayed, I realize that there are differences in artistic ability and surgical technique among physicians. I also realize that wound healing is different among different patients which may cause the surgical result to differ fro the imaged result. I recognize that the imaging result does not constitute and should not be construed to be an exact representation of postsurgical results. I understand that it is impossible to guarantee intended results. I understand that the alteration of these images is purely for the purpose of illustration, education and discussion.

I certify my understanding that there is no guarantee (expressed or implied) as to my final surgical result.

Signature _____ Date _____

Print Name _____

MEDICARE WAIVER (***MEDICARE PATIENTS ONLY***)

Medicare will only pay for services that are determined to be reasonable and necessary under section 1862(a)(1) of the medicare law. If Medicare determines that a particular service is not reasonable and necessary under Medicare program standards, Medicare will deny payment for that service. Medicare may deny payment for cosmetic procedures.

Our staff will gladly prepare the necessary forms to assist you in gaining reimbursement from Medicare and we will credit any payment received to your account.

I have been notified by my physician that he or she believes that Medicare may deny payment for services rendered. If Medicare denies payment, I agree to be personally and totally responsible for payment in full.

Signature _____ Date _____

Print Name _____

Cosmetic Surgery Associates of New York

STATEMEMENT OF FINANCIAL RESPONSIBILITY

Disclosures required by the Federal Truth in Lending Act: The patient or responsible party is hereby advised and agrees to the following: 1) the full amount of fees, costs and expenses for cosmetic surgery is due and payable prior to surgery. 2) the full amount of fees, cost and expenses for non-cosmetic surgery is due and payable within 60 days after the date of service, and if not paid at that time, a finance charge of 1% per month may be imposed (APR 12%) on the unpaid balance on the first of each month.

Our staff will gladly prepare the necessary forms to assist you in gaining reimbursement from your insurance company and we will credit any payment received to your account.

The undersigned realizes that all medical and surgical charges by my dependents or me for services rendered by the physicians of Cosmetic Surgery Associates of Westchester are my financial responsibility. Any fees necessary to collect said amount are also my responsibility.

Signature _____ Date _____

Print Name _____

ASSIGNMENT OF BENEFITS

I hereby authorize my health insurance company to pay directly to Cosmetic Surgery Associates of Westchester, PLLC (Drs. Bernard, Morello, Beran, Guzman and Greenwald) any benefits due to me for services rendered by the doctors of Cosmetic Surgery Associates of Westchester. Payment is authorized upon your receipt of this assignment and the itemized bill/insurance form rendered by the practice to me. This policy was in effect at the time these services were rendered.

Signature _____ Date _____

Print Name _____

RECORD RELEASE AUTHORIZATION

I authorize and request to release to Cosmetic Surgery Associates of Wetchester, PLLC, the following medical records in your possession.

Please place “X” where appropriate:

___Complete Records___Operative Reports___Pathology Reports

Signature _____ Date _____

Print Name _____

Cosmetic Surgery Associates of New York

NOTICE OF PRIVACY PRACTICES

You have the right to a paper copy of our notice of privacy practices. You may ask us to provide you with a copy of this notice at any time.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain the effective date.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the office or the secretary of the Department of Health and Human Services. To file a complaint, contact Mrs. Lucy Caggiano or Dr. Joshua Greenwald. All complaints must be submitted in writing. You will not be penalized in any way for filing a complaint.

OTHER USES OF MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. It is implied that you understand we are unable to "take back" any disclosures we have already made with your permission.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PAPERS
You have the right to review our Notice and ask questions about our privacy practices. You have the right to request that we restrict how information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by this agreement.

By signing this form you acknowledge that you have received and understand our Notice of Privacy Practices and/or understand that it is available for review if desired.

Signature _____ Date _____