

Chernoff and Associates, Cosmetic Surgeons
PATIENT REGISTRATION FORM

Patient Name _____ Birth Date _____ Soc Sec # _____
Last First Middle Initial
Current Address _____
Street City State Zip
Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____ E-mail _____
Patient Employer _____
Name Address
IF PATIENT IS CHILD: _____
Parent/guardian name / address

ADDITIONAL INFORMATION

Spouse Name _____ Spouse Employer _____
Referring M.D. _____ Phone _____
PERSON TO CONTACT IN CASE OF AN EMERGENCY:
NAME: _____ RELATIONSHIP: _____ PHONE: _____
Address of Relative _____
Street City State Zip

How did you hear about us? Please check the space below of which source referred you. If you do not see the source listed below, please mark "other" and let us know!

SALONS/SPAS

- Blades
- All About Me Saloon
- David and Mary
- Entourage
- Fab Hair Design
- Flirt Salon & Spa
- Frankey's
- French Pharmacie
- Jata Hair Salon
- Lush
- Luxe Design-Jason Hagemier
- Massage Envy
- Philipe's
- Reeda Todd
- Renu
- Shear Design/Sherry Harvey
- The Skin Spot Care/Julie McClain
- Villaggio/Body Works Day Spa

RADIO

- B 105.7
- z99.5 MINDY WINKLER
- Yellow Pages Book
- 107.9 TRACK
- www.yellowpages.com

MEDICAL

- Advanced Medical Spa (Dr. Guyer)
- Dr Chernoff
- Dr Schroeder
- Geist Family Practice
- Indiana Eye Clinic
- Joy of Raphael/Dr. Carolyn
- Ortho Indy
- Physician: _____
- Prather Wellness Center

Patient: _____

Employee: _____

OTHER: _____

OTHER

- American Health & Beauty Website
- www.chernoff.com website
- Business Woman Connect
- Cindy Sauer
- Columbia Club
- Pam Sanders
- Five Seasons
- Friend/Relative: _____
- IndianapolisMetro Woman
- Indianapolis Woman Magazine
- Indy Magazine
- WOW Women's Expo
- Internet
- Lilly Employee
- Money Mailer
- Nancy Irsay's Retreat
- Newspaper _____
- GOOGLE Search
- Seminar
- Television: Channel ____
- Facebook
- Twitter

All packages are to be paid in full at the time of purchase. Packages are non-refundable. Any Pre-Payment for Laser, Fillers, Botox and Surgical deposits are NON-REFUNDABLE.

To ensure patient financial confidentiality, please discuss *all* financial arrangements with the patient coordinator. I understand that I am personally responsible for all charges. I understand that the charges I am responsible for are to be paid in full at the time of service. Should collection proceedings become necessary, I understand that I will be responsible for reasonable attorney fees, court cost and all collection cost.

Signature _____

Date _____



ACKNOWLEDGMENT OF HIPAA PRIVACY PRACTICES

ON OCCASION A FAMILY MEMBER, FRIEND OR CAREGIVER MAY CONTACT CHERNOFF AND ASSOCIATES TO INQUIRE ABOUT YOUR MEDICAL INFORMATION. PLEASE LIST THOSE INDIVIDUALS TO WHOM THE INFORMATION MAY BE DISCLOSED:

NAME(S)

RELATIONSHIP

I hereby acknowledge that I have received a copy of Chernoff and Associates, Cosmetic Surgeons Notice of Privacy Practices.

Signature: _____

Printed Name: _____

Date: _____

C H E R N O F F
AND ASSOCIATES
COSMETIC SURGEONS

Consent to Use Name and/Or Picture

I hereby irrevocably consent that my name and/or picture/or portrait of me, or any part of me, and for such purposes as he desire in the connection with his research, writing, and professional activities, and may be used, exhibited and published through any medium whatsoever as part of or in connection with his research, writing, and professional activities, even though such use may be for advertising purposes or purposes of trade.

I hereby certify and represent that I am over 21 years of age.

Name

Date

Consent of Parent or Guardian

I, _____, am the parent/guardian of _____

and I hereby irrevocably consent that his/her name and/or any picture or portrait of him/her and any part of him/her and reproductions thereof, may be used for such purposes as he may desire in connection with his research, writing, and professional activities, and may be used, exhibited, and published through any medium whatsoever as part of or in connection with his research, writing, and professional activities, even though such use may be for advertising purposes or purposes of trade.

Name

Date

I wish only for my picture to be used for chart purposes only.

Name

Date

C H E R N O F F

AND ASSOCIATES
COSMETIC SURGEONS

PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

Reason for today's visit:

DOB: _____ - _____ - _____ Ht: _____ ft _____ in Wt: _____ lbs

Allergies to Medication:

Latex Allergy? Yes No

Social History:

Married Single Divorced

Widowed How Many Children? _____

Family History:

Breast Cancer Yes No

Keloids Yes No

Bleeding or Genetic Disease Yes No

Do you have a history of Adverse Reactions with anesthesia? Yes No

Medications:

Family Physician: _____

Phone Number: _____

Previous Surgeries:

Past Medical History:

Description	Yes	No	Description	Yes	No
Dentures	[]	[]	Tuberculosis	[]	[]
Contact Lenses	[]	[]	Neurological Disease	[]	[]
High Blood Pressure	[]	[]	Heart Disease	[]	[]
Seizures	[]	[]	Liver Disease	[]	[]
Diabetes	[]	[]	Lung Disease	[]	[]
Pacer/Defibrillator in use	[]	[]	Kidney Disease	[]	[]
Smoker?	[]	[]	Intestinal Disorder	[]	[]
Packs per day? _____			Thyroid Disease	[]	[]
Other: _____					

Reviewed health and history with patient _____

DOCTOR SIGNATURE

DATE

CHERNOFF

AND ASSOCIATES

COSMETIC SURGEONS

ABOUT FINANCIAL ARRANGEMENTS: Our commitment of excellence through our various services is extended to you with regard to the payment of our services. In order to achieve this goal, definite payment arrangements must be established by your second visit. All charges quoted pertain only to Dr. Chernoff's charges additional charges will also be charged to you from outside sources with all surgery cases.

COSMETIC PROCEDURES: must be paid in full before any procedure is performed.

WHEN YOU HAVE PRIVATE INSURANCE COVERAGE: As a service, we will bill your insurance carrier (for non-cosmetic procedures only); however, you are responsible for the full amount of our charges. All deductibles and co-insurance balances will be billed to you. We will file any secondary insurance provided we have that information. You must have your insurance card(s) at the time of visit or you will be responsible for sending copies to us.

We will allow 60 days for your insurance to pay, at which time, if the insurance has not paid, we will look to you for payment of the bill and provide you with any information to settle with your insurance carrier. All services are required to be paid in full within 60 days of completion of treatment.

CO-PAYMENTS: will be collected on same day of office visit.

MEDICARE COVERAGE: Medicare will be billed as well as any supplement insurance carrier; however if you only have Medicare, you will be responsible for all deductible and co-insurance balances.

NO INSURANCE: Payment in full is expected at each visit. Should you require prolonged treatment; a monthly payment arrangement can be established. At the conclusion of your treatment, all services are to be paid in full within 60 days.

WORKER'S COMPENSATION: A confirmation, by phone or other means, is required to acknowledge the services as Worker's Compensation. If by letter, that letter should include a claim mailing address and the contact person at your place of employment.

ACCIDENT CASES: Accident cases are considered self-pay and we do not become involved in litigation of the settlement of these cases except where required by Federal law (Medicare/Medicaid). You will be given a receipt for any payment made to pursue your claim in these situations.

Another option in these cases is to go through your private auto and/or health insurance. As a courtesy, an insurance form will be supplied for your submittal to insurance for reimbursement.

POLICY ON PACKAGE PURCHASES: All packages purchased are to be paid in full at the time of purchase. Packages are non-refundable. Packages are non-transferable.

SKIN CARE PRODUCT PURCHASES: All returned unopened product boxes will be credited to your account and may be used towards any services. All opened product sales are final and cannot be refunded.

RETURNED CHECKS: There will be a charge in the amount of \$30.00 for any returned check. This policy is strictly enforced, and future treatments MAY be withheld until NSF checks have cleared the bank.

By signing below, I certify that I have read and understand the above stated information. I understand, once again, that I am responsible for any amount not covered by insurance. I will also be responsible and liable for all collection of attorney fees incurred while enforcing collection of said amount.

Signed (Patient or responsible party)

Date

C H E R N O F F
AND ASSOCIATES
COSMETIC SURGEONS

We kindly ask that you give 24 hour notice if canceling or changing an appointment. In the event of less than 24 hour notice or a “no show,” there will be a charge of \$85.00

We strive to provide the best treatment in a relaxing environment, so please make child care arrangements in advance and mute all cell phones.

By signing below, I certify that I have read and understand the above stated information.
