CHERNOFF
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_____________________________

By providing my email, I agree to receive communication from Dr. Chernoff's office via email about upcoming appointments, newsletters, and events. I also agree by providing my cell phone, I agree to receive text messages reminders for upcoming appointments.

Previous Address (if less than two years at Current) _______________________________ __________________ _______ ______
Street City State Zip

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.

_____ Friend or Family Member
Name:_______________________________

_____ Medical Office
Name _______________________________

_____ Google Search
_____ Press Democrat
_____ Facebook

_____ Hair Salon
Name: ____________________________

_____ Other
____

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____________________________

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

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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

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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.

APPOINTMENT CANCELLATIONS: We reserve the right to charge up to a $250 charge for cancelled appointments with less than 48-hours notice.

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**

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

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____

____

I hereby acknowledge that I have received a copy of Chernoff and Associates, Cosmetic Surgeons Notice of Privacy Practices. HIPPA information will be provided at the time you arrive for your appointment.

Signature: ______________________________

Printed Name: ___________________________

Date: __________________________________