PATIENT REGISTRATION FORM (2-23-15v)

John R. Burroughs, MD, PC

(Print clearly & press firmly in black ink)

Today's Date_____

Patient Name_____
Last First MI Nickname

Date of Birth_____ SSN_____ Gender (circle) F M

Address _____
Street Apt/Ste City State Zip

E-MAIL _____

Primary Phone ( )_____ May we leave a message? (circle) YES / NO

Secondary Phone ( )_____ May we leave a message? (circle) YES / NO

Work Phone ( )_____ OK to call work? (circle) YES / NO

Employer_____ How Did You Hear About Us: _____

Date of last eye examination & your Eye Doctor_____

Primary Care Physician_____ Referring Physician_____

Other Physicians (e.g., Dermatologist, Cardiologist): _____

Is this work-related? (circle) YES NO Related to an auto accident? (circle) YES NO *If YES on EITHER, please complete Auto/WC Form*

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Medical Insurance_____ Policy #/ID_____ Group # _____

Name of Policy Holder_____ SSN Date of Birth_____ Gender (circle) F M

Relationship to Patient_____ Employer_____ Employer Phone ( )_____

Secondary Insurance_____ Policy #/ID_____ Group # _____

Name of Policy Holder_____ SSN Date of Birth_____ Gender (circle) F M

Relationship to Patient_____ Employer_____ Employer Phone ( )_____

If you are a Medicare beneficiary, please circle any of the following that apply to you:

(circle) Working-Aged ESRD Auto/Med/No Fault Liability Workers Comp Federal Black Lung Veterans Affairs Disability Other Liability

If you do not have insurance, have you applied for government assistance? (circle) YES NO If yes, provide social worker's information.

Social Worker's Name_____ Phone ( )_____

If patient is a minor, name of Custodial Parent _____

Custodial Parent's Primary Phone( )_____ Secondary Phone( )_____

Custodial Parent's SSN_____ Date of Birth_____

Check or Circle Boxes:

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Declined/Undetermined

Race: ☐ 01 Black, African American ☐ 03 White ☐ 09 Native Hawaiian, Other Pacific Islander

☐ 02 Asian ☐ 08 American Indian, Alaska Native ☐ 99 Declined/Undetermined

Preferred Language: ☐ EN-English ☐ FR French ☐ VI-Vietnamese Δ Other_____

☐ ES-Spanish ☐ ZH-Chinese ☐ KO-Korean

Emergency Contact – Close friend or relative not living with you that we can contact in an emergency:

Name_____ Relationship_____ Phone( )_____
Last First

Name of person we may speak with other than yourself regarding your medical care?_____

Primary Phone( )_____ Secondary Phone( )_____ Relationship_____

INFORMATION AND FINANCIAL POLICY (2-23-15v) John R. Burroughs, MD, PC

(Print clearly & press firmly in black ink)

Patient Name_____
Last First MI Date of Birth

Thank you for choosing our practice to help with your surgical needs. The following policies have been developed to be fair to everyone including you, other patients waiting for surgery, surgery facilities, anesthesiology staff, our office staff, and your surgeon. We are committed to providing you with the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we will need your assistance and understanding of our financial policies. Please carefully review this information and sign/initial where indicated and put "N/A" otherwise.

ASSIGNMENT: I request that payment of authorized insurance, Medicare, and Medicaid benefits be made payable to John R Burroughs, MD, PC on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office. _____***(Initial) I have read and agree to the above statement.***

CO-PAY/COINSURANCE/DEDUCTIBLE: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility. _____***(Initial) I have read and agree to the above statement.***

WAIVER OF SERVICES: It is my responsibility to ensure that I have an insurance referral for services to be obtained at John R. Burroughs, MD, PC. If this not obtained, I will be financially liable for these services.

_____***(Initial) I have read and agree to the above statement.***

INSURANCE-COVERED SURGERY SCHEDULING: Scheduling of surgery requires my co-pay, deductible be paid prior to surgery if they have not been met. I may cancel my scheduled surgery up to 2 weeks before the scheduled date without penalty, but if I cancel for non-medical, non-emergent reasons less than 2 weeks before the surgery there is a $125 fee, and less than 72 hours a $250 fee. If I need to reschedule surgery then there is a $250 administration fee as it takes considerable staff resources to submit materials, obtain authorization, and schedule. These administrative fee are not covered by insurance. _____***(Initial) I have read and agree to the above statement.***

INSURANCE SURGERY REVISION FEES: Very rarely, after compete healing from surgery for which insurance has paid if Dr. Burroughs and I both agree that some revision surgery could enhance my result cosmetically then there will be a $500 office facility fee to cover costs of suture, supplies, and office time. If I wish to have cosmetic revision at a surgery facility then additional facility/anesthesia fees will apply. If revision surgery is needed that is medically necessary (not cosmetic) then my insurance will be billed for these services.

_____***(Initial) I have read and agree to the above statement.***

COSMETIC CONSULTATION: I understand the cosmetic surgical consultation charge is $100.00. This fee will be applied towards any procedure or surgery if done within 3 months. _____***(Initial) I have read and agree to the above statement.***

COSMETIC SURGERY SCHEDULING: There is a $500 scheduling fee. This fee is fully refundable if surgery is cancelled greater than 4 weeks out. Between 2 weeks and 4 weeks there is a 50% refund, and less than 2 weeks there is no refund unless there has been a medical or other emergency. The full cosmetic fees are due 2 weeks before surgery or at the preop appointment.

_____***(Initial) I have read and agree to the above statement.***

COSMETIC REVISIONAL SURGERY FEES: Very rarely, after complete healing from surgery if Dr. Burroughs and I both agree that some cosmetic revision surgery is necessary then there will be a $500 office facility fee to cover costs of suture, supplies, and office time *If I wish to have cosmetic revision at a surgery facility then additional facility/anesthesia fees will apply. If revision surgery is needed that is medically necessary (not cosmetic) then my insurance will be billed for these services.* _____***(Initial) I have read and agree to the above statement.***

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed and for benefit determination for my myself or dependents. I authorize John R Burroughs, MD, PC to release information concerning my diagnosis and treatment to my physician(s), providers after each visit.

_____***(Initial) I have read and agree to the above statement.***

REQUESTS FOR INFORMATION: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid.

_____***(Initial) I have read and agree to the above statement.***

SELF-PAY: Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided. _____***(Initial) I have read and agree to the above statement.***

WORKERS' COMPENSATION: I will provide approval/authorization by the Workers' Compensation carrier at the initial visit. If the claim is deferred, the private medical insurance will be billed. I understand if the claim is denied, I will be responsible for payment in full. If the claim is in litigation, a verification of this from an attorney and/or the Workers' Compensation carrier will be provided to this office.

_____***(Initial) I have read and agree to the above statement.***

RETURNED CHECKS/NO SHOW POLICY: I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification. I understand and agree to pay a $75.00 charge for appointments that I do not honor or do not cancel within 48 hours prior to the scheduled appointment.

_____ ***(Initial) I have read and agree to the above statement.***

PHOTOGRAPHY/RESEARCH: I consent to medical photography/video for insurance, research, and education purposes. Dr. Burroughs may use these for: insurance authorization; seminars; medical articles; digital/printed materials for the office; website; newsletters to current/prospective patients; letters to my doctors; and digital images to be uploaded to the broader internet to be viewed by the public. These images **WILL** be cropped (e.g., **NOT** whole face) so as to be largely non-identifiable to others unless I consent otherwise. These will remain the property of John R. Burroughs, MD, PC. I can request a separate detailed release/permission form to exclude any of the above by asking. Dr. Burroughs is a surgical professor and published physician and conducts clinical research studies, which mostly involve non-identifying, general data collection. I hereby grant permission to use my treatment data for these studies. I understand that Dr. Burroughs' research attempts to the full extent possible adhere to the World Medical Association's Declaration of Helsinki-Ethical Principles of Medical Research Involving Human Subjects (www.wma.net).

_____ ***(Initial) I have read and agree to the above statement.***

PAPERWORK (e.g., FMLA) FEE: There is a $20 fee per incident to fill out paperwork for FMLA, work-related, or other non health insurance forms.

PRIVACY POLICY: I have been made aware of the privacy policy of John R Burroughs, MD, PC and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

_____

Written Name & Signature **Date**

I have read and agree to the above information and I, the undersigned/patient, am ultimately responsible for the fees. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages. Your attending physician has an ownership interest in one or more Ambulatory Surgery Centers. Please contact office personnel if you have any questions.

PRINT NAME_____ Age:_____ DATE _____

Occupation/Hobbies:_____ Circle : Married Single Divorced Widow

Religious Affiliation:_____

Smoking: Yes (years)_____ No____Former (Y/N) Alcohol: None or How much/often_____

Any Family History of eyelid or anesthesia conditions: YES state condition & relative NO

Your (PERSONAL) Medical History:

Diabetes	Yes	No
Thyroid disease	Yes	No
Arthritis	Yes	No
High blood pressure	Yes	No
Heart problems	Yes	No
Heart pacemaker	Yes	No
Heart attack	Yes	No
Heart murmur/valves	Yes	No
Stroke	Yes	No
Blood clots	Yes	No
Bleeding disorder	Yes	No
Anemia	Yes	No
AIDS/HIV	Yes	No
Asthma	Yes	No
Liver disease/Hepatitis	Yes	No
Stomach Ulcers/Reflux	Yes	No
Keloid/Severe scarring	Yes	No
Pulmonary hypertension	Yes	No
Uncontrolled seizures	Yes	No

Others: _____

Major Hospitalizations/Surgeries:

Medication Allergies:

LIST ALL MEDICATIONS (prescribed/over the counter) SUPPLEMENTS VITAMINS & HERBALS (e.g., Fish Oil, COQ10 etc):

Have you had within the past year:

(Please write to side for comments)

Blurred vision	Yes	No
Double vision	Yes	No
Joint pain/swelling	Yes	No
Muscle pain/weakness	Yes	No
Loss of skin sensation	Yes	No
Headaches	Yes	No
Nosebleeds	Yes	No
Sinus Trouble	Yes	No
Chest pain	Yes	No
High blood pressure	Yes	No
Chronic cough	Yes	No
Shortness of breath	Yes	No
Stomach pain	Yes	No
Heartburn	Yes	No
Change in skin	Yes	No
Changes in weight	Yes	No
Skin, other infections	Yes	No
Enlarged glands	Yes	No
Anxiety	Yes	No
Sadness/Depression	Yes	No

****Please SIGN & Date****

Patient/Guardian **John R. Burroughs, MD**

2-23-15v