

BOSS & RABINOWITZ PLASTIC SURGERY GROUP

PLASTIC, COSMETIC AND RECONSTRUCTIVE SURGERY

HAND AND MICROSURGERY

DIPLOMAT, AMERICAN BOARD OF PLASTIC SURGERY

PATIENT INFORMATION

TODAY'S DATE: _____

NAME _____ DATE OF BIRTH _____ AGE: _____

ADDRESS _____

(STREET ADDRESS APT CITY, STATE ZIP)

HOME PH# () _____ CELL # () _____ SS# _____

E-MAIL: _____ MARRIED SINGLE MALE FEMALE

EMPLOYER NAME _____ BUSINESS PHONE # () _____

EMPLOYER ADDRESS _____

SPOUSE (OR PARENT/GUARDIAN INFORMATION FOR MINOR CHILD/18+ BUT STILL INSURED BY PARENT)

NAME _____ DATE OF BIRTH _____ SS# _____

CELL PHONE # () _____ BUSINESS PHONE # () _____

EMPLOYER NAME _____ EMPLOYER ADDRESS _____

OTHER RESPONSIBLE PARTY: (IF PATIENT IS A MINOR, OR 18 YEARS OR OLDER AND STILL INSURED BY A PARENT'S INSURANCE POLICY, PARENT/GUARDIAN INFORMATION FOR BOTH PARENTS IS REQUIRED. PLEASE LIST INFORMATION NOT ALREADY PROVIDED FOR OTHER PARENT/GUARDIAN). IF NOT A PARENT, PLEASE CITE RELATIONSHIP TO PATIENT.

NAME _____ RELATIONSHIP TO PATIENT: _____

ADDRESS _____

HOME PH# () _____ CELL # () _____ SS# _____

EMPLOYER NAME _____ BUSINESS PHONE # () _____

EMPLOYER ADDRESS _____

EMERGENCY CONTACT: (PLEASE ALSO INDICATE EMERGENCY CONTACT ON CONSENT FORM)

NAME _____ ADDRESS _____

HOME PH# () _____ CELL # () _____ BUSINESS PHONE # () _____

RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION: (PLEASE PROVIDE RECEPTIONIST WITH A COPY OF YOUR CARD)

PRIMARY INSURANCE COMPANY _____ POLICY ID # _____

NAME OF POLICYHOLDER _____ DATE OF BIRTH _____

SECONDARY INSURANCE COMPANY _____ POLICY ID# _____

NAME OF POLICYHOLDER _____ DATE OF BIRTH _____

ACCIDENT CASES:

DATE OF ACCIDENT _____ TYPE OF ACCIDENT: (PLEASE CHECK ONE) WORK HOME AUTO OTHER

IF OTHER PLEASE EXPLAIN _____

IF WORK RELATED:

EMPLOYER NAME _____ EMPLOYER PHONE# _____

EMPLOYER ADDRESS _____

CONTACT PERSON/SUPERVISOR _____

WORKER'S COMP INSURANCE CARRIER _____ CLAIM #: _____

WORKER'S COMP ADJUSTOR'S NAME/PHONE# _____

IF AUTOMOBILE ACCIDENT:

AUTOMOBILE INSURANCE CARRIER: _____

POLICY # _____ NAME OF POLICY HOLDER _____

CLAIM # _____ ADJUSTOR NAME/PHONE # _____

PERSONAL INFORMATION:

WHO REFERRED YOU TO OUR OFFICE? _____

PLEASE NOTE ANY FAMILY MEMBERS TREATED AT OUR OFFICE _____

NAME OF PRIMARY PHYSICIAN _____ OFFICE PHONE () _____

NAME OF YOUR PHARMACY: _____ PHONE# () _____

OFFICE POLICIES: PLEASE READ CAREFULLY

- PAYMENT FOR OFFICE VISITS/CONSULTATION IS EXPECTED AT THE TIME OF SERVICE
- POST-OPERATIVE OFFICE VISITS (FOR NON-COSMETIC SURGERY AND EMERGENCY PROCEDURES) ARE NOT ALWAYS INCLUDED AS PART OF THE SURGERY FEE. SURGERY PACKAGE GUIDELINES VARY BASED ON THE PROCEDURE PERFORMED.
- POST-OPERATIVE COSMETIC SURGERY OFFICE VISITS ARE INCLUDED AS PART OF THE SURGICAL FEE.

I ACCEPT FULL PAYMENT RESPONSIBILITY FOR SERVICES RENDERED THAT ARE NOT PAID IN FULL BY MY INSURANCE CARRIER.

IF PATIENT IS 18 YEARS OR OLDER AND STILL INSURED BY PARENT'S INSURANCE POLICY, BOTH PATIENT AND PARENT MUST SIGN.

 SIGNATURE OF PATIENT OR GUARDIAN DATE

 SIGNATURE OF PATIENT OR GUARDIAN DATE

ASSIGNMENT OF BENEFITS FORM

I IRREVOCABLY ASSIGN TO DRS. BOSS AND RABINOWITZ ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT OF SERVICES RENDERED TO ME BY DRS. BOSS AND RABINOWITZ. I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO CLAIMS BY DRS. BOSS AND RABINOWITZ BE RELEASED TO DRS. BOSS AND RABINOWITZ. I IRREVOCABLY AUTHORIZE DRS. BOSS AND RABINOWITZ TO FILE INSURANCE CLAIMS/APPEALS ON MY BEHALF FOR SERVICES RENDERED TO ME. I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO DRS. BOSS AND RABINOWITZ. I IRREVOCABLY AUTHORIZE DRS. BOSS AND RABINOWITZ TO ACT ON MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES. I ACCEPT FINANCIAL LIABILITY FOR ANY PORTION OF MY CLAIM THAT IS NOT PAID BY MY INSURANCE COMPANY. THIS STATEMENT IS APPLICABLE TO ALL PAST, PRESENT, AND FUTURE CLAIMS.

PATIENT SIGNATURE _____ DATE _____

GUARANTOR SIGNATURE _____ DATE _____

INSURANCE BENEFICIARIES

I HAVE BEEN INFORMED THAT DRS. BOSS AND RABINOWITZ DO NOT PARTICIPATE WITH MY INSURANCE PLAN. IF I HAVE NO OUT-OF-NETWORK COVERAGE FOR NON-EMERGENT SERVICES, I AM AWARE THAT MY INSURANCE CARRIER WILL NOT PAY FOR SERVICES RENDERED. IF I HAVE OUT-OF-NETWORK COVERAGE FOR NON-EMERGENT SERVICES, I AM AWARE THAT MY INSURANCE CARRIER MAY PAY BENEFITS AT A REDUCED RATE.

PATIENT SIGNATURE _____ DATE _____

GUARANTOR SIGNATURE _____ DATE _____

UNINSURED PATIENTS

I ACCEPT FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO ME BY DRS. BOSS AND RABINOWITZ.

PATIENT SIGNATURE _____ DATE _____

GUARANTOR SIGNATURE _____ DATE _____

DRS. BOSS AND RABINOWITZ RESERVE THE RIGHT TO CHARGE INTEREST FOR OVERDUE PAYMENT.

BOSS & RABINOWITZ PLASTIC SURGERY GROUP, LLC

*Plastic, Cosmetic and Reconstructive Surgery
Hand and Microsurgery
Diplomate, American Board of Plastic Surgery
Certification of Added Qualification in Hand Surgery*

PLEASE COMPLETE BOTH SECTIONS AND SIGN THIS FORM

Federal law does not allow us to share information about your medical services (including treatment, payment, insurance details, appointment scheduling, etc.), without your written approval. Please provide us with names and phone numbers of people with whom we are at liberty to share your information. Please include, your spouse, family members, emergency contact, attorney (if applicable), or other authorized representative (s). Thank you.

NAME: _____ RELATIONSHIP: _____

PHONE: _____

NAME: _____ RELATIONSHIP: _____

PHONE: _____

NAME: _____ RELATIONSHIP: _____

PHONE: _____

**If an attorney's name is listed, indicate "and associates" so we can also speak to representatives from his/her office.*

PLEASE CHOOSE YES OR NO FOR EACH QUESTION

*PLEASE INDICATE THE APPROPRIATE RESPONSE REGARDING TELEPHONE CONFIRMATIONS OF FUTURE APPOINTMENTS. THIS WOULD ONLY BE APPLICABLE IF YOU DO NOT ANSWER THE HOME TELEPHONE NUMBER. ONLY THE APPOINTMENT TIME, DATE AND DOCTOR'S NAME WOULD BE CITED. **CIRCLE YOUR PREFERENCE.** THANK YOU.*

YES NO: MAY WE LEAVE A MESSAGE ON YOUR CELL PHONE?

YES NO: MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE?

YES NO: MAY WE LEAVE A MESSAGE WITH WHOMEVER ANSWERS THE PHONE?

PRINT PATIENT'S NAME _____

PATIENT'S SIGNATURE _____

PARENT'S SIGNATURE (IF PATIENT IS A MINOR) _____

DATE: _____

PROSPECT PLAZA • 385 PROSPECT AVENUE • HACKENSACK, NEW JERSEY 07601 • (201) 525-0220/ (201) 488-1035
BERGEN MEDICAL CENTER • ONE WEST RIDGEWOOD AVENUE • PARAMUS, NEW JERSEY 07652 (201) 251-7700
PERILLO BUILDING • 577 CHESTNUT RIDGE ROAD • WOODCLIFF LAKE, NJ 07675 (201) 670-1122

WWW.NJCOSMETIC.COM

WWW.MYNEWJERSEYPLASTICSURGEON.COM