DOMINION
PLASTIC SURGERY

PATIENT INFORMATION - DO NOT LEAVE ANY PORTION BLANK

PLEASE PRINT the following information.

Name:

Address:

City/State/Zip:

SSN:

Birthdate:

Gender:

Language:
- ❑ English
- ❑ Spanish
- ❑ Other_____

Home Ph:

Work Ph:

Cell Ph:

Marital Status:

Race:
- ❑ Caucasian
- ❑ African Am.
- ❑ Hispanic
- ❑ Asian/Pacific Islander
- ❑ Other_____

Ethnicity:
- ❑ Hispanic or Latino
- ❑ Non-Hispanic

Email:

Height:

Weight:

Employer:

Occupation:

Employer Address:

Emergency Contact Name:

Relationship:

Emergency Contact Home Ph:

Emergency Contact Work Ph:

If patient needs a translator, provide translator name and phone.

Name:
Phone:

If patient is a minor, name of guardian:

Guardian Phone number:

Social Security Number:

Relationship:

Person financially responsible for treatment, if not self:

Address of person financially responsible:

Phone:

Pharmacy Name:
_____

Pharmacy Address:
_____

Pharmacy Phone Number:
_____

May we send you emails regarding your appointments, specials, and other information concerning your treatment?

YES **NO**

DOMINION
PLASTIC SURGERY

HEALTH INSURANCE INFORMATION
THE FOLLOWING IS MANDATORY
(If patient does not have health insurance, please skip to next set of boxes)

PRIMARY INSURANCE:	MEMBER ID:	GROUP #
SUBSCRIBER NAME:	SUBSCRIBER DOB:	SUBSCRIBER ADDRESS:
IS YOUR INSURANCE PROVIDED BY AN EMPLOYER YES NO	NAME OF EMPLOYER/ADDRESS/PHONE NUMBER:	
Secondary Insurance:	Member ID:	Group #:
Subscriber Name:	Subscriber Date of Birth:	Subscriber Address:
IS YOUR INSURANCE PROVIDED BY AN EMPLOYER YES NO	NAME OF EMPLOYER/ADDRESS/PHONE NUMBER:	

If you would like to receive information about our charity care program please indicate here: YES or NO

Please also give a brief description of your financial situation so we may better assist you:

I have truthfully entered the above information to the best of my knowledge. I also understand that I am responsible for ensuring that I obtain proper authorizations and complete necessary paperwork to process my claim as required by my health insurance carrier and this medical office. I also understand that I am responsible for my portion of deductibles, copays, coinsurance and cost share.

Patient and/or Guardian Signature_____ DATE_____

DOMINION
PLASTIC SURGERY

<u>If you do not have health, auto, or worker's compensation insurance, you must pay directly for your care.</u>

If this section is not applicable, please mark "N/A" below.

Did this injury occur at work? **YES** **NO**

What is your occupation?

How did the injury occur?

Place of business:

Supervisor's name and phone number:

If the injury was a result of an injury that occured on the job please provide the workman's compensation carrier information:

Workman Comp Insurance carrier:

Address:

Phone number:

Adjuster:

Claim number:

Did this injury involve an automobile accident? **YES** **NO**

If the injury was as a result of an automobile accident please provide the automobile insurance carrier:

Automobile Insurance Carrier:

Phone Number:

Policy Number:

Claim number:

Were your injuries as a result of a crime? **YES** **NO**

If so, please give a brief description:

Do you have an attorney representing you for the injury you are being treated for: **YES** **NO**

Attorney Name:

Attorney Address:

Attorney Phone Number:

Attorney Fax Number:

Attorney Email:

DOMINION
PLASTIC SURGERY

SELF-PAY PATIENT INFORMATION

Patients who do not have any insurance must pay out-of-pocket. These fees are due at the time of service.

Reduced fees do not apply if patient: 1., is involved in legal proceedings or is represented by an attorney; or 2., if the patient has current health insurance.

I AGREE TO NOTIFY THIS PROVIDER IF I HIRE A LAWYER.

If you would like to speak to a financial specialist, please notify someone at the front desk prior to your appointment so we can best assist you.

The office visit fees only include the office visit, and do not include costs for additional services that may be provided in the office such as minor surgical procedures and the cost of bandages.

I have truthfully entered the above information to the best of my knowledge.
I understand that if I do later obtain insurance, file a workers' compensation claim, or hire an attorney relating to my injury, I will notify this medical practice immediately and provide information necessary for this office to be reimbursed for its services.
I understand that I am responsible for all charges from office visits and surgeries.

Patient or Guardian Signature: _____ Date: _____

Patient or Guardian Printed Name: _____

DOMINION
PLASTIC SURGERY

DO NOT LEAVE ANY PORTION BLANK.

Describe the injury/illness that brings you to our office.

_____

How long has this concerned you?

_____

Have you had any previous treatment for this? If YES, how and when was this treated?

_____

Circle/List any and all MEDICAL PROBLEMS:

Diabetes	High Blood Pressure	High Cholesterol
Heart Disease/CAD	Peripheral Vasc. Disease	Asthma/COPD
Thyroid Disorder	GERD/PUD	Blood disorder
Migraines	Back Pain	Depression/Anxiety

Other:_____

_____

Have you ever been on contact isolation in the hospital (MRSA, VRE, C.Diff, etc.)? Yes No

Please list **ALL** medications taken regularly **INCLUDING** Aspirin, Motrin, birth control pills, herbs, vitamins, etc.

_____

_____

_____

List any and all HOSPITALIZATIONS and reason for hospitalization:

_____

_____

List any and all SURGERIES and dates:

_____

_____

Have you had a problem with anesthesia in the past?

_____

Are you allergic to or have you ever had a reaction to any medication or drug; local anesthetic, or general anesthetic? If so please list medication and type of reaction:

_____

_____

How many packs per day do you smoke? _____ How many years? _____
How much alcohol do you drink? _____ How often? _____
How did you hear about our office? _____

The above information is truthful and accurate to the best of my knowledge.
Patient or Guardian Signature: _____ **Date:** _____

DOMINION
PLASTIC SURGERY

DO NOT WRITE IN ANY AREA. PLEASE ONLY MARK THOSE THAT APPLY TO YOU. THANK YOU.

Eyes – Check all that apply

- ☐ Wear glasses/Contacts
- ☐ Blurred/Double Vision
- ☐ Good General Vision
- ☐ Glaucoma
- ☐ Eye Disease or Injury

Constitutional – Check all that apply

- ☐ Good general health lately
- ☐ Fatigue
- ☐ Recent weight gain
- ☐ Headaches
- ☐ Fever

ENT – Check all that apply

- ☐ Normal
- ☐ Nose bleeds
- ☐ Hearing loss
- ☐ Mouth sores
- ☐ Ringing in the ears
- ☐ Bleeding gums
- ☐ Earaches or drainage
- ☐ Bad breath
- ☐ Sinus problems
- ☐ Sore throat

Gastrointestinal – Check all that apply

- ☐ Normal
- ☐ Loss of Appetite
- ☐ Change in bowel movements
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Painful bowel movements or constipation
- ☐ Blood in stool
- ☐ Stomach pain

Hematologic – Check all that apply

- ☐ Normal
- ☐ Slow to heal after cuts
- ☐ Easily bruise or bleed
- ☐ Anemia
- ☐ Phlebitis
- ☐ Past transfusion
- ☐ Enlarged glands

Skin – Check all that apply

- ☐ Normal
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose veins

Psychiatric – Check all that apply

- ☐ Normal
- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep problems

Allergic/Immunologic – Check all that apply

- ☐ Normal
- ☐ Environmental allergy

Cardiovascular – Check all that apply

- ☐ Normal
- ☐ Heart trouble
- ☐ Chest pains
- ☐ Sudden heart beat changes
- ☐ Swelling of feet, ankles, or hands

Respiratory – Check all that apply

- ☐ Normal
- ☐ Frequent coughing
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Asthma or wheezing

Genitourinary – Check all that apply

- ☐ Normal
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Change or force of strain when urinating
- ☐ Incontinence or dribbling
- ☐ Kidney stones

Musculoskeletal – Check all that apply

- ☐ Normal
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Weakness of muscles or joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty walking

Neurological – Check all that apply

- ☐ Normal
- ☐ Frequent or recurring headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness or tingling sensations
- ☐ Tremors
- ☐ Paralysis
- ☐ Stroke

Endocrine – Check all that apply

- ☐ Normal
- ☐ Glandular or hormone problem
- ☐ Thyroid disease
- ☐ Excessive thirst or urination
- ☐ Heat or cold intolerance
- ☐ Dry Skin

DOMINION
PLASTIC SURGERY

THIS IS A MANDATORY FORM. INITIALS ARE REQUIRED TO RECEIVE SERVICES TODAY.

The Financial and Payment Policy (the "Policy") governs the patient's ("Patient", "I", or "You") rights and responsibilities concerning the Patient's financial obligations as a result of treatment with Dominion Plastic Surgery ("Dominion" or "We").

ONCE SERVICES ARE RENDERED IN COSMETIC PROCEDURES, CREDIT CARD CHARGES ARE FINAL AND NON-REFUNDABLE. Dominion makes all reasonable efforts to ensure procedures are satisfactory to you, but cannot guarantee a particular outcome. Should you have questions or concerns after Your Cosmetic Procedure, please contact Dominion immediately to discuss your concerns.

I**NSURANCE PATIENTS**: Dominion participates with some insurance plans. Please consult your insurance plan to determine if our providers participate with your insurance plan.

It is your responsibility to find out, in advance, what your particular plan covers for nonparticipating providers of your plan. If we are not participating providers in your network, then you are responsible for your bill in its entirety. We will attempt to file your insurance claim so that you may be reimbursed from your insurance company directly.

If we do not receive at least 24 hours (For a Monday appointment, please call by Friday) advance notice of your cancellation or need to reschedule, you will be charged a $75.00 fee. Insurance/Managed care does not pay for missed appointments or late cancellations. Please refer to the back of your insurance card for a contact phone number to get additional information. If we may be of assistance, please contact Dominion, however, it remains your financial responsibility for complete payment if you are seen and/or treated. Auto or Home insurance does not qualify as medical insurance. You may be able to claim these as medical benefits but you will have to file for these benefits independently. Patients without medical insurance will be expected to pay in full at the time of their visit.

Our office does not have to accept what your insurance company determines to be the "allowed amount" for a claim. As a medical provider, our relationship is with you, not your insurance company. Your insurance plan is a contract between you and your insurance carrier and may not involve this practice. Our fees may not be considered usual, customary, and reasonable (UCR) by your insurance company. However, your insurance company may not take into account the experience and highly specialized nature of the care provided to you.

TO SUBMIT CLAIMS TO MEDICARE: I request that payment of authorized Medicare/other benefits be made either to me or on my behalf to Dominion. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I further authorize any holder of Medicare information about me to release to my Medigap Insurer any information needed to determine these benefits payable for related services.

_____ Initials

DOMINION
PLASTIC SURGERY

TO SUBMIT CLAIMS TO INSURANCE: I hereby authorize Dominion, or any organization the practice designates, to apply for benefits on my behalf for covered services rendered by the practice, and request that the payments be made directly to Dominion. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original. All cost share payments are due at the time of service.

NON-PAYMENT: I understand that if my account is turned over to a collection attorney or collection agency for non-payment, I will be responsible for any additional fees as allowed by law.

MEDICAL RECORDS RELEASE: I hereby authorize Dominion to release my medical records to, and to discuss my care with, my treating physicians and all other Health Care Providers. I further authorize all of my treating physicians and other Health Care Providers to release my medical records to Dominion.

I authorize Dominion to release to the named insurance company any information necessary to expedite insurance payment: I understand that I am responsible for all charges, regardless of insurance coverage.

Workers' Compensation: The workers' compensation system requires that you and/or your employer provide Dominion with Your claim number and all necessary information for Dominion to process your claim. This will avoid any problems with your care delivery and claim processing.

I understand that if I do later obtain relevant insurance, file a workers' compensation claim, or hire an attorney relating to my injury, I will notify this medical practice immediately and provide information necessary for this office to be reimbursed for its services. If you obtain additional insurance coverage or other third party coverage or initiate legal proceedings to obtain reimbursement for your underlying injuries you are to notify Dominion immediately to allow Dominion to update its records and to assign responsibility for payment to the appropriate party. Please provide any updates to your insurance that occur within five years from your last date of service to ensure that we appropriately document your account. I understand that I am responsible for all charges from office visits and surgeries.

_____ Initials

DOMINION
PLASTIC SURGERY

Our Financial Guidelines

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful, and as such, payment is considered part of your treatment.

- Patient's cost share is due at time of service.
- We accept cash, check, Visa, Mastercard, American Express, and Discover cards.
- We offer Carecredit Healthcare Finance if approved.

INSURANCE: As a courtesy to our patients our office will file your insurance claims for you. Please keep in mind that your insurance is a contract between you and your insurance company and does NOT guarantee payment. We will prepare and mail your insurance claims, but ultimately the responsibility is that of the patient's and/or guarantor, and we cannot bill your insurance company unless you provide us with your insurance information. It is also the responsibility of the patient or guardian to assist the practice with the appeal process. The billing department will assist the patient with templates, if appropriate, and to communicate the appeal status to the patient upon request. If the patient chooses not to participate in the appeal process te balance will be the responsibility of the patient in its entirety.

COST SHARE: Many plans require that a patient pay their cost share at the time of service. If your visit is for a non-urgent reason, you may be asked to reschedule your appointment. To avoid collection issues and unnecessary billing expenses, we will collect at the time of service any percentage coinsurance or deductible not met. The amount calculated is based on your negotiated fee schedule with the carrier or our standard rates if we are out of network.

PAYMENTS AND PAYMENT PLANS: All patients are responsible for any and all charges that are not covered by your insurance plan. The Reimbursement team at Dominion Plastic Surgery will appeal claims that are denied and/or underpaid on behalf of the practice and the patient. This may require a signed authorization form signed by the patient, but we will be sure to keep the patient up to date with the process along the way. We do offer payment plans and strongly encourage prepayment discounts.

SELF PAY (UNINSURED): If you do not have health insurance, payment in full is expected at the time of service. We will assist you with payment plans if necessary. Please contact our financial billing coordinator to discuss payment options with you.

COMPLETION OF FORMS: There may also be times when you request that we complete forms of various types; examples may include medical histories for life insurance applications, disability forms, etc. There will be a $25.00 charge, payable in advance, for completion of each form. Please understand that completion of such forms requires time by our providers and staff in order to ensure that they are completed accurately. It may also take several days before the form is available for pick-up so please allow sufficient time before the form is needed.

_____ Initials

DOMINION
PLASTIC SURGERY

Cancellation/"No Show" Policy for Reconstructive Surgery: Last minute cancellations of reconstructive surgeries can create access-to-care problems as well as significant expenses for the practice. If you need to cancel your surgery, please notify our office at least two business days in advance. If you fail to show up for surgery, or if you cancel your surgery one business day or less before your reconstructive surgery appointment you may be responsible for fifty percent (50%) of the surgical fee or $500.00, whichever is greater. This may be applied against any deposit or credit you may have with the practice. This fee is not covered by insurance and must be paid in full prior to rescheduling your procedure. We understand that extenuating circumstances may cause you to cancel shortly before to your scheduled procedure. Fees in this instance may be waived subject to management approval. Patients who cancel the same procedure twice may be dismissed from the practice for treatment noncompliance.

_____ Initials

Our providers strive to provide you with the best in Reconstructive Plastic Surgery and Hand Surgery – *but their knowledge and expertise is about your medical needs, not about insurance and billing*, and they will direct you to our financial team with your billing questions. Our Billing Team and financial counselling staff are experienced and dedicated to ensuring that the charges for your medical care are billed promptly and accurately

We know this is a lot of information to read and absorb, but we want to make sure you are fully informed about what we need from you, and what you can expect from us, concerning the financial aspects of your care. As always, we are happy to answer any questions you may have, and will continue to work with you to navigate the increasingly complex maze of insurance plan rules and requirements in order to resolve your account balance timely and accurately.

DOMINION
PLASTIC SURGERY

I, the undersigned, hereby authorize payment of medical and surgical benefits directly to Dominion. I, the undersigned, have insurance with and assign directly to Dominion, all benefits, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions. I also understand that all court fees or other fees necessary to collect this account are payable by me. I WILL BE RESPONSIBLE FOR ALL REASONABLE COLLECTION FEES INCURRED.

IF A CHECK IS SENT TO ME FROM THE INSURANCE COMPANY I WILL NOTIFY THIS OFFICE IMMEDIATELY AND SIGN IT OVER TO THIS OFFICE WITHOUT DELAY.

_____Signature of Patient/Guardian/Responsible Party

_____Printed Name of Patient/Guardian/Responsible Party

_____Date

DOMINION PLASTIC SURGERY

Workers' Compensation Patients do not have to complete this form, but MUST supply Workers' Compensation information to this office

SELF PAY PATIENTS ***(Please Initial)***

_____ I UNDERSTAND THE SELF PAY FEES ARE TO BE PAID AT THE TIME OF SERVICE

INSURED PATIENTS ***(Please Initial)***

_____ I UNDERSTAND THAT THE PRACTICE IS OUT OF NETWORK WITH ALL COMMERCIAL CARRIERS AND SOME GOVERNMENT PAYERS.

_____ I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO DETERMINE MY HEALTH INSURANCE COVERAGE AND WILL PAY THE APPROPRIATE COST SHARE THAT IS DUE UNDER MY PLAN.

_____I UNDERSTAND THAT I MAY RECEIVE A CHECK FROM MY INSURANCE COMPANY. IF I RECEIVE A CHECK FOR MEDICAL SERVICES RENDERED, I UNDERSTAND THAT I MUST NOTIFY THIS OFFICE AND SIGN THE CHECK OVER TO THE DOCTOR'S OFFICE IMMEDIATELY.

_____I UNDERSTAND THAT FAILURE TO TURN OVER ANY INSURANCE PAYMENTS MADE DIRECTLY TO THE ME WILL RESULT IN ADDITIONAL FEES AND CHARGES. THESE FEES AND CHARGES MAY BE IN EXCESS OF 30% OF THE BILL AND WILL BE ADDED ON TO THE TOTAL AMOUNT DUE. I UNDERSTAND THAT THE METHOD OF COLLECTIONS FOR THESE PAYMENTS WILL BE IN THE FORM OF LEGAL ACTION IN THE FAIRFAX COUNTY COURT SYSTEM.

_____I UNDERSTAND MY COOPERATION IS REQUIRED TO ASSIST THE OFFICE WITH APPEALING AND REPROCESSING MY INSURANCE CLAIMS. I AGREE TO PROVIDE FULL COOPERATION WITH THIS PROCESS. FURTHERMORE, I AUTHORIZE THE OFFICE OF DR. VINEET MEHAN TO FILE A GRIEVANCE/APPEAL ON MY BEHALF FOR ALL SERVICES RENDERED. Failure to PIF

_____I UNDERSTAND THAT THIS OFFICE CANNOT GUARANTEE COVERAGE UNDER MY INSURANCE POLICY. IF AN INSURER FINDS THAT A PORTION OF SERVICES PROVIDED TO ME ARE NOT MEDICALLY NECESSARY ACCORDING TO MY PLAN (SUCH AS A PROCEDURE BEING DEEMED "EXPERIMENTAL" OR "INVESTIGATIONAL" BY THE INSURER), I UNDERSTAND THAT I WILL REMAIN PERSONALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO DETERMINE INSURANCE COVERAGE FOR SERVICES.

Signature of insured or responsible party _____Date_____