**Photo I.D. is required.* Please present valid identification to the front desk

PATIENT REGISTRATION INFORMATION

Patient Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____

Cell#: _____ Social Security #: _____

Email Address: _____

Would you like to be added to our email list to be notified of specials/events? Yes No

Is it acceptable to leave a message on your phone and/or email? Yes No

In Case of an Emergency, Please Provide Two Persons Whom We May Notify:

Name: _____ Relationship: _____

Phone# _____ Work/Cell#: _____

Name: _____ Relationship: _____

Phone#: _____ Work/Cell#: _____

Insurance Information – Primary Insurance

Name of Insurance Company: _____

Name of Policy Holder: _____

Relationship to Patient: _____ Date of Birth: _____

Policy#: _____ Group#: _____

Secondary Insurance

Name of Insurance Company: _____

Name of Policy Holder: _____

Relationship to Patient: _____ Date of Birth: _____

Policy#: _____ Group#: _____

Patient Signature: _____ **Date:** _____

DR. FUGO
PLASTIC SURGERY

Name: _____ Height: _____ Weight: _____

Please check if you or any family members have any of the following:

Condition	Self	Family Member	Condition	Self	Family Member
No Medical History			High blood pressure		
Anxiety			High cholesterol		
Asthma			HIV		
Bleeding disorders			Headaches		
Breast Cancer			Keloids/raised scars		
Cancer			Seizures		
Cold sores			Skin Cancer		
Depression			Sunburn		
Diabetes			Thyroid issues		
DVT/ blood clots			Ulcers		
Hepatitis			Other		

Please list all prior surgical procedures (including cosmetic procedures):

Procedure	Year	Procedure	Year

Have you ever had problems with anesthesia? Yes No _____

Please list all medications and supplements you are currently taking:

Please list any allergies to medication or food:

Allergen	Reaction	Allergen	Reaction

Do you smoke or use nicotine/tobacco products or vape? ☐ Yes ☐ No ☐ Former Smoker

If yes, how much per day? _____

If you smoked previously, when did you quit? _____

Do you live with a smoker or experience second hand smoke? ☐ Yes ☐ No ☐ Occasionally

Do you work in the healthcare industry? ☐ Yes ☐ No

Name of primary care physician _____

How did you hear about Dr. Fugo's practice _____

DR. FUGO
PLASTIC SURGERY

GENERAL CONSENT FOR TREATMENT

CONSENT TO EXAMINATION AND TREATMENT: I consent to necessary and advisable diagnostic and therapeutic procedures and care for the patient by Dr. Fugo and his assistants or designees. I acknowledge that the practice of medicine and surgery is not an exact science and that no guarantees have been made as to the result of the surgical care and medical treatment.

GUARANTY OF PAYMENT: I shall be fully responsible for the payment of the patient's plastic surgery bill, based upon Dr. Fugo Plastic Surgery's standard charges which are available to me prior to any examination or treatment being rendered. Dr. Fugo Plastic Surgery may demand full payment of the bill at any time although failure to demand immediate payments shall not release my obligation to make such payment. If insurance benefits for the patient, which have been assigned to Dr. Fugo Plastic Surgery, do not pay for any or all of the care rendered, I understand and agree that I may be fully responsible for the payment of the balance due.

ASSIGNMENTS OF INSURANCE BENEFITS: I assign, and set forth to Dr. Fugo Plastic Surgery, monies and/or benefits to which I may be entitled from the governmental agencies, insurance carries, or others who are financially liable for my medical care to cover the cost of the care and treatment rendered, but not to exceed Dr. Fugo Plastic Surgery's regular charge for this care.

MEDICARE ASSIGNMENT: I understand that the information given by me in applying for payment under title XVIII (Medicare) of the social security act is correct. I authorize release of information needed to act on this request. I request payment of the authorized benefits made in my behalf. I assign payment for the unpaid charges of physician for whom the hospital is authorized to bill. I understand I am responsible for any deductibles, copayments and co-insurance under this act.

CREDIT BALANCE: I understand that credit balances will occur in my favor, on this account may be applied by Dr. Fugo Plastic Surgery to reduce any other outstanding account for which I am responsible.

RELEASE OF INFORMATION/NOTICE OF PRIVACY: I hereby authorize Dr. Fugo Plastic Surgery to disclose all or any part of the patient record, as allowed and/or mandated by law.

I give my permission to Dr. Fugo Plastic surgery to use the patients name in the general course of treatment, for example, to identify me and, as applicable, my room number, on patient board treatment schedules.

This form has been explained to me to my satisfaction, and I understand its content.

_____

Patient/Relative/Guardian Signature | Print name | Relationship to Patient | Date

_____

Witness Signature

This signature of the patient must be obtained unless the patient is an un-emancipated minor under the age of 18 or is otherwise incompetent to sign

DR. FUGO
PLASTIC SURGERY

TO OUR PATIENTS:

IF YOUR INSURANCE PLAN REQUIRES YOU TO HAVE A REFEERAL TO SEE DR. FUGO AND YOU DO NOT HAVE ONE, WE WILL GLADLY RESCHEDULE YOUR APPOINTMENT

It is the policy of this office to provide all available information to your insurance carrier in order to facilitate appropriate reimbursement for service you receive. If pre-authorization is required by your insurer, we will obtain this prior to surgery. However, pre-authorization does NOT guarantee payment.

Despite our effort on your behalf, your insurance carrier may ultimately determine that the surgery performed was 'NOT MEDICALLY NECESSARY' and may deny payment. In this event it will be your responsibility to satisfy the charges incurred.

_____ _____

Signature Date

AUTHORIZATION FOR RELEASE OF PATIENT IMAGE

I consent to the taking of photos by Dr. Jonathan R. Fugo or his designee, of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Jonathan R Fugo. I understand that such photographs will have all personal identifiable features and characteristics masked or removed as possible without altering or masking the appearance of the specific anatomic features for which the photograph was created. Photos shall become the property of Dr. Fugo Plastic Surgery and may be retained by Dr. Fugo Plastic Surgery for the limited purpose of visual or electronic media, specifically including, but not limited to websites for the purpose of informing the medical profession or public about plastic surgery procedures.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that may make my identity recognizable to some individuals. I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it will not have any effect on any actions taken prior to my revocation.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider of health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I certify that I have read the above Authorization and Release and fully understand its term.

_____ _____

Signature Date

I have read the above Authorization and Release. I am the parent guardian, or conservator of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____

Signature Date

DR. FUGO
PLASTIC SURGERY

APPOINTMENT CANCELLATION / NO SHOW / RE-SCHEDULING POLICY

Upon booking any treatment appointment, it is required that you place a deposit toward your total treatment cost to hold your appointment.

Should you need to cancel or re-schedule your office appointment, you will need to do so 24 hours prior to your appointment time. Cancelling or re-scheduling within 24 hours of your appointment will result in a forfeiture of the deposit.

"Should I cancel my surgery without an approved medically acceptable reason, submitted in writing and acceptable to the practice, within 10 days of the scheduled surgery, this fee is forfeited. While this may appear to be a charge for services which were not provided, this fee is necessary to reserve time in the OR and in the practice, which are done when I scheduled. "

Any and all "no shows" will also result in loss of your deposit amount.

We appreciate your help & cooperation with this matter.

Thank you.

☐ I agree & understand the above policy.

Patient name (printed): _____
Patient name: (sign): _____