Allure Plastic Surgery Center **John M. Taylor, M.D.**

PATIENT INFORMATION

NAME: _____ HOME PHONE: _____

ADDRESS: _____ CELL PHONE: _____

CITY: _____ E-MAIL: _____

STATE: _____ ZIP: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: _____ DATE OF BIRTH: _____ / _____ / _____

EMPLOYER: _____ AGE: _____ GENDER: [ ] M [ ] F

EMPLOYER ADDRESS: _____

WORK PHONE: _____ OCCUPATION: _____

FAMILY PHYSICIAN: _____ REFERRED BY: _____

REASON FOR VISIT: _____

RESPONSIBLE PARTY (if patient is a minor), or SPOUSE/NEXT OF KIN INFORMATION

NAME: _____ HOME PHONE: _____

ADDRESS: _____ E-MAIL: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____ WORK PHONE: _____

RELATIONSHIP TO PATIENT: _____

The following information is required only if we are to submit claims to your insurance company for payment:

INSURED/SUBSCRIBER INFORMATION [ ] Check here if same as patient information.

NAME: _____ HOME PHONE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ / _____ / _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

_____ WORK PHONE: _____

RELATIONSHIP TO PATIENT: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME: _____

ID #: _____

GROUP #: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME: _____

ID #: _____

GROUP #: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

I hereby assign, transfer, and set over to Allure Plastic Surgery Center, LLC and John M. Taylor, MD all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance, and that a monthly finance charge equal to 0.5% of the outstanding balance or $5.00 (whichever is greater) will be assessed on any balance over 90 days delinquent. A photo copy of this authorization will be as valid as the original.

Signature of Patient/Responsible Party: _____ Date: _____

NAME: _____ DATE: _____

HEALTH QUESTIONNAIRE

HEIGHT: _____ WEIGHT: _____

PAST MEDICAL HISTORY

Do you now, or have you ever had, a history of any of the following medical problems?

NO	YES		NO	YES		NO	YES	
[ ]	[ ]	HEART DISEASE	[ ]	[ ]	EPILEPSY/SEIZURES	[ ]	[ ]	BACK OR NECK PROBLEMS
[ ]	[ ]	HEART ATTACK	[ ]	[ ]	PHLEBITIS/BLOOD CLOTS	[ ]	[ ]	ARTHRITIS
[ ]	[ ]	ANGINA OR CHEST PAIN	[ ]	[ ]	ABNORMAL BLEEDING	[ ]	[ ]	MIGRANE HEADACHES
[ ]	[ ]	PALPITATIONS	[ ]	[ ]	ANEMIA	[ ]	[ ]	ANXIETY
[ ]	[ ]	HIGH BLOOD PRESSURE	[ ]	[ ]	THYROID DISEASE	[ ]	[ ]	PSYCHIATRIC DISORDER
[ ]	[ ]	ASTHMA	[ ]	[ ]	ULCERS OR COLITIS	[ ]	[ ]	REACTION TO ANESTHESIA
[ ]	[ ]	DIFFICULTY BREATHING	[ ]	[ ]	HEPATITIS	[ ]	[ ]	OTHER, PLEASE LIST:
[ ]	[ ]	DIABETES	[ ]	[ ]	JAUNDICE	_____		
[ ]	[ ]	CANCER	[ ]	[ ]	LIVER DISEASE	_____		
[ ]	[ ]	STROKE	[ ]	[ ]	KIDNEY DISEASE	_____		

PLEASE USE THIS SPACE IF ANY OF THE ABOVE NEED FURTHER DESCRIPTION: _____

_____

List all medications you now take. Please include over-the-counter medications you have taken within the past 2 weeks (aspirin, ibuprofen, cold medicines, etc.), vitamins, herbals, and minerals OR attach list:

NAME	PURPOSE	DOSE/AMOUNT	FREQUENCY

_____

_____

_____

_____

_____

_____

ALLERGIES: (PLEASE LIST)

MEDICINES: _____

FOODS: _____

OTHER (LATEX, SEASONAL, ETC.): _____

Do you smoke? [ ] NO [ ] YES **If yes, how many packs per day?** _____

Do you drink alcohol? [ ] NEVER [ ] OCCASIONALLY [ ] REGULARLY **If so, how much per day?** _____

PAST OPERATIONS [ ] **NONE, or list any operations below (include minor operations such as tonsillectomy, etc.):**

DATE	AGE	OPERATION	PHYSICIAN/HOSPITAL

_____

_____

_____

_____

_____

_____

ALLURE PLASTIC SURGERY CENTER, LLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Allure Plastic Surgery Center, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Allure Plastic Surgery Center, LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Allure Plastic Surgery Center, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Allure Plastic Surgery Center Privacy Officer, 194 Highway 35, Red Bank, NJ 07701.

With this consent, Allure Plastic Surgery Center, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others, unless otherwise instructed by me.

With this consent, Allure Plastic Surgery Center, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential, unless otherwise instructed by me.

With this consent, Allure Plastic Surgery Center, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that
Allure Plastic Surgery Center, LLC restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to Allure Plastic Surgery Center, LLC's use and disclosure of my PHI to carry out TPO.

Allure Plastic Surgery Center, LLC restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to Allure Plastic Surgery Center, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Allure Plastic Surgery Center, LLC may decline to provide treatment to me.

_____	_____
Signature of Patient (or Legal Guardian)	Relationship to Patient
_____	_____
Print Patient's Name, or Name of Legal Guardian)	Date

ALLURE PLASTIC SURGERY CENTER FACILITY CONSENT FORM

Patient Name_____ Date: _____
(print)

CONSENT FOR TREATMENT

I, the above named and undersigned patient, give my consent for care at and by the medical, nursing allied professional staff at ALLURE PLASTIC SURGERY CENTER, which may include routine diagnostic procedures and such medical treatment as my doctor or his designees may find are needed. I acknowledge that no promises or guarantees have been made to me about the results of any examinations, treatments or procedures I may receive at the center.

RELEASE OF MEDICAL RECORDS

I authorize the ALLURE PLASTIC SURGERY CENTER to release all or any part of my medical records to (a) hospitals or medical services companies, insurance companies, workers compensation carriers, welfare funds or other organizations or agencies that may be concerned with the payment of costs related to my treatment and (b) any other organization or agency to which the center is permitted to release such information under applicable laws. I authorize the center to obtain a copie of my medical records as they pertain to my care while a patient of ALLURE PLASTIC SURGERY CENTER.

FINANCIAL ARRANGEMENTS

INSURANCE PATIENTS: I authorize and direct my insurance or payer to pay directly to ALLURE PLASTIC SURGERY CENTER any or all benefits, up to the amount of my bill, accruing to me in connection with my treatment. I agree that, in consideration of the services that were provided to me, I individually obligate myself to pay the amount promptly in accordance with the regular rates and terms of the facility. I understand, therefore that to the extent permitted under applicable laws and contractual arrangements, I am financially responsible to ALLURE PLASTIC SURGERY CENTER for any amounts not covered by insurance. Furthermore, I understand that my insurer or payer may require certain healthcare services to be authorized before they are furnished to me. I individually obligate myself to pay the account of the ALLURE PLASTIC SURGERY CENTER with respect to the services that I choose to receive not withstanding that my health insurer or payer has refused to give preauthorization for all or any portion of my services.
COSMETIC PATIENTS: I understand that I am paying for all services at the time the services are provided. I understand that my insurance company will not be billed for the services provided and that I am legally obligated to pay in full before leaving the center.

PRE-CERTIFICATION

Your insurance company will be called to pre-certify medically necessary procedures. Please make sure that we have the correct insurance information. It is important to notify us if you have different plans for the surgeon and hospital services.

☐ I understand that I am using my Out-of-Network benefits. Dr. Taylor and ALLURE PLASTIC SURGERY CENTER are not contracted with my insurance company to provide services. I understand that the reimbursement may be sent to me instead of the ALLURE PLASTIC SURGERY CENTER and that upon receipt of the insurance payment I am to forward the check and the Explanation of Benefits (EOB) to the center. An administrative fee of $100 will be incurred if the insurance check is not forwarded within 7 (seven) days. I understand that my insurance plan may still hold me responsible for a deductible and/or coinsurance. I also give permission for any billing agency contracted with ALLURE PLASTIC SURGERY CENTER to contact my insurance company on my behalf and to handle appeals.

IF YOU HAVE QUESTIONS ABOUT THE ABOVE INFORMATION, PLEASE SPEAK TO THE BILLING MANAGER.

COLLECTION EXPENSES: (Medicare excluded) Should my account with the ALLURE PLASTIC SURGERY CENTER be referred to an attorney or outside agency for collection, I will pay all reasonable collection expenses (including attorney's fees) associated with the collection effort. I acknowledge that all delinquent accounts will bear interest at the legal rate.

My signature below indicates that I have read and understand the above.

_____ _____
Patient's signature or their representative Date

_____ _____
Witness's signature Date

Patient Concerns

NAME	DATE
EMAIL	PHONE

Forehead Lines/Frown Lines?	
YES	NO

Improve Texture of Skin/Large Pores?	
YES	NO

Facial Volume Loss?	
YES	NO

Nose-to-Mouth Lines?	
YES	NO

Lips/Volume Loss	
YES	NO

Lip Lines/Lipstick Bleed Lines?	
YES	NO

Neck and Chest Discoloration?	
YES	NO

Are You Interested in Skin Care?	
YES	NO

Crow's Feet?	
YES	NO

Under Eye Circles/Lines/Bags?	
YES	NO

Thin, Short or Lightened Lashes?	
YES	NO

Brown Spots/Freckles?	
YES	NO

Broken Blood Vessels?	
YES	NO

Acne Scaring/Facial Scars?	
YES	NO

Double Chin/Neck Fullness?	
YES	NO

Red Spots/Flushing?	
YES	NO

Texture/Saggy Skin?	
YES	NO

Please add any additional concerns not listed: _____