

Patient Information as of: _____

(Please Print Legibly & Fill In or Correct All Fields)

Pt. ID. _____

Patient's Name

First

Middle

Last

Address

Street & Apt #

City

State

Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Preferred Contact: Home Phone Cell Phone E-mail Other

Age _____ Birthdate _____ SS# _____ Gender Female Male

Marital Status Single Married to: _____ Other: _____

Who is your primary physician ? _____ Phone Number: _____

Patient's Employer

_____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____

Street & Suite #

City

State

Zip

How did you hear about Dr. Nowak? (mark all that apply)

Insurance Mail Penny Saver Newspaper Yellow Pages Televisio Radio Web

Friend/Relative: _____ Doctor: _____ Other: _____

If you were referred by a specific person, may we thank them? Yes No

Emergency Contact

(Not in your household)

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Person Responsible for account: (please mark one)

Patient Gaurdian Other

Primary Health Insurance Company

Policy # _____ Group # _____ Relationship to patient: _____

Sponsors Name: _____ DOB _____ SS#: _____

Secondary Health Insurance Company

Policy #: _____ Group #: _____ Relationship to patient: _____

Sponsors Name: _____ DOB _____ SS# _____

*I understand that office visit charges are payable on the day services are rendered. I authorize «Doctor_FullName» to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between «Doctor_FullName» and myself. _____

The above information is accurate and complete to the best of my knowledge.

Signature X _____ Date _____

Patient Health Information as of: _____

(Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: The information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Physician(s): _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Rash / Allergic skin reaction	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Sinus Problems / Infections	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Stroke	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tonsillitis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Tuberculosis	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes	Ulcers	No	Yes
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

Do you use recreational drugs? No Yes If yes, describe: _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

Do you have any history of problems with anesthesia? No Yes If yes, describe: _____

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature _____ Date «Appointment_Date»

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?

We accept payment by cash, check, VISA, MasterCard, American Express and Discover.

What Is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained below:

Office Visits and Office Services		
If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visit: Co-pays, Deductible, Cost-Share, Co-insurance and other charges at the time of office visit.	*Call your insurance company ahead of time to determine deductibles and coinsurance. *File an insurance claim as a courtesy to you. *Mail you statement notices of any balances your insurance determines is your responsibility. *request authorizations or pre-certifications, if required, for any treatment needed
PPO plans with which we have a contract	<u>*If the services you receive are covered by the plan:</u> All applicable co-pays are requested at the time of the office visit. <u>*If the services you receive are not covered by the plan:</u> Payment in full is requested at the time of the visit.	*Call your insurance company ahead of time to determine co-pays, deductibles, and non-covered services for you & File an insurance claim on your behalf. *Mail you statement notices of any balances your insurance determines is your responsibility. *request authorizations or pre-certifications, if required, for any treatment needed.
HMO, which we DO NOT ACCEPT.	Payment in full for office visits and other treatment charges at the time of office visit.	*Call your insurance company ahead of time and notify you ahead of time, if you have an insurance we do not accept and will give you the choice to be seen as cash patient
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, co-pay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, co-pays, deductibles, and non-covered services & File an insurance claim on your behalf. *Mail you statement notices of any balances your insurance determines is your responsibility.
Medicare	*If you have Regular Medicare, and have not met your \$155 deductible, you are responsible for 20%. *Any services not covered by Medicare are requested at the time of the visit. <u>*If you have Regular Medicare as primary, and also have secondary insurance:</u> No payment is necessary at the time of the visit.	*File the claim on your behalf, as well as any claims to your secondary insurance. *If you don't have a secondary to Medicare we will bill you your responsibility of the office visit, once Medicare has sent us an explanation of medical benefits (EOMB), which determines the paid amount from Medicare and the patients responsibility.
Tricare: Prime or Standard	*Standard: Payment of the patient responsibility—deductible, co-pay, non-covered services—at the time of the visit. *Prime: assuring your Primary Care Physician (PCP) has requested an authorization to be seen in our office. *Payment of the patient responsibility—deductible, co-pay, non-covered services—at the time of the visit.	*Call your insurance company ahead of time to determine co-pays, deductibles, and non-covered services for you & File an insurance claim on your behalf. *Request any additional authorization from your insurance, to continue medical care and/or any treatments needed. *Mail you statement notices of any balances your insurance determines is your responsibility.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

**I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, Cost-Share and Co-insurance is my responsibility and due at the time of service.*

**I understand that if I show to my appointment without my co-payment, there is a \$10 late & administration fee to cover the invoicing cost.*

**I understand that I have any further inquires regarding my insurance coverage, payments, or balances, I need to contact my insurance for assistance.*

**I understand that if I need to make payment arrangements for any pending balance, I need to sign a Payment Plan Agreement.*

**I understand that Nowak Aesthetics will send me statement notices for any pending balances on a 30, 60, 90 day basis and a final collection notice.*

** I understand it is my responsibility to notify the office of any changes to my home/billing address or if your insurance plan changed and to provide the office with a copy of any new insurance cards. If my insurance company denies payment due to my failure in providing any of this information, I will be responsible for any unpaid claims.*

I authorize my insurance benefits be paid directly to **Eugene J. Nowak D.O.*

I authorize **Nowak Aesthetics to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

** I further agree that a photocopy of this agreement shall be as valid as the original.*

Print Patient's Name: _____

Patient's Acct #: _____

Patient's Signature: _____

Date: _____

If not signed by patient, Please indicate your relationship to patient, Print and sign below:

- Parent of minor or Legal Guardian
- Guardian or Conservator of an incomplete patient
- Personal or Legal representative of patient

Print Name : _____

Signature: _____

Date: _____

Appointment Cancellation Policy

If you must cancel your appointment, please give us at least 24 hours notice so we can schedule another person in your place. Even if you call within the same day of your appointment to cancel, it will be considered a no-show. Without a cancellation notice of 24 hours, a warning will be given for the first occurrence. A second no show will turn to a charge of \$30.00 (thirty dollars), and finally a charge of \$50.00 (fifty dollars) will be issued for any further appointments that are not kept. All balances must be paid in full prior to any further appointment.

We apologize for any inconvenience, our goal is to help standardize our schedule and to use our appointment time as efficiently as possible. By canceling your appointment in advance you will allow that appointment time to be given to a fellow patient that needs to be seen. Thank you in advance for your cooperation.

If you have any questions concerning our Policy please contact our office prior to your visit.

Thank you for choosing our office. We look forward to serving you.

SIGN _____ **DATE** «Appointment_Date»
HERE

Upon your request, copies can be provided for your records.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be with the receptionist at any time that I may need a copy of it.

Signed: _____ Date: _____.

Print Name: _____ Acct #: _____

If not signed by patient, please indicate:

Relationship:

- Parent or guardian of minor patient.
- Guardian or conservator of an incomplete patient
- Beneficiary or personal representative of deceased patient

Name: _____.

NOTIFICATION TO CONSUMERS

PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY THE PHYSICIAN ASSISTANT COMMITTEE.

(916) 561-8780

WWW.PAC.CA.GOV

Signed: _____ Date: _____.

Print Name: _____ Acct #: _____



COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____

Date: _____

General appearance or products of interest to you (please check all that apply).

<input type="checkbox"/> Eyelash length, fullness, thickness, or darkness	<input type="checkbox"/> Facial veins	<input type="checkbox"/> Neck
<input type="checkbox"/> Skin care products	<input type="checkbox"/> Leg Veins	<input type="checkbox"/> Abdominal area
<input type="checkbox"/> Skin care treatments	<input type="checkbox"/> Facial redness	<input type="checkbox"/> Hips
<input type="checkbox"/> Facial fine lines / wrinkles	<input type="checkbox"/> Liver spots/age spots	<input type="checkbox"/> Back
<input type="checkbox"/> Facial folds	<input type="checkbox"/> Birthmark / Scars	<input type="checkbox"/> Arms
<input type="checkbox"/> Thin lips	<input type="checkbox"/> Tattoo removal	<input type="checkbox"/> Legs / Thighs
<input type="checkbox"/> Skin care advice	<input type="checkbox"/> Drooping eyelids	<input type="checkbox"/> Cellulite
	<input type="checkbox"/> Facial fullness	<input type="checkbox"/> _____
	<input type="checkbox"/> Blotchy skin	

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
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«PRACTICE_NAME»

«Practice_Phone»

«Practice_Address1»; «Practice_City», «Practice_State» «Practice_PostalCode»