6335 Hospital Parkway
Suite 216
Johns Creek, GA 30097
P: 678-892-7820
F: 678-892-7824

Reason for your visit: __________________________ Who may we thank for your visit: __________________________

Date: _______________ Preferred/Nickname: ____________ _____________

First: _________________________________ Middle: ___________ Last: ______________________________________

Address: ____ Exclude me from mailings: Y N

City: _________________________________ State: _________ Zip: ________ Marital Status: Single Married Other

SSN: ___________________________ Date of Birth: ____________________________ Gender: M F

CONTACT INFORMATION

Home Phone: __________________________

Work Phone: ___________________________

Mobile Phone: __________________________

Pager: _________________________________

Other: ________________________________

Fax: __________________________________

Email address: ____

EMERGENCY CONTACT

First: _____________________ Last: __________________________

Relationship: ____

Home Phone: ____

Work Phone: ____

EMPLOYMENT

Please circle all that apply: Full Time Part Time Full Time Student Part Time Student Retired Other

Occupation: ____

Company or School: ____

Address: ____

City, State, Zip: ____

What is your primary language? ____

How did you hear about us? ____

Who is your Primary Care Physician? ____

PHARMACY INFORMATION

Name: ____

Address: ____

City: ____

Phone: ____

Fax: ____

INSURED PARTY

Name: ____

Birth date: ____

SSN: ____

Relationship to Insured: ______________________________

Gender of Insured: M F

INSURANCE INFORMATION

Carrier: ____

Address: _______________________________________

City: ____

State/Zip: ______________________________________

Phone: ____

Fax: ____

Effective Date:__________________________________

Plan Name: _____________________________________

Plan Type: ______________________________________

ID Number:______________________________________

Group Number: _________________________________

Please note we will make a copy of your driver's license or state issued ID for your record.

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FINANCIAL POLICY

- I agree to furnish Luna Plastic Surgery, PC with a copy of my current health insurance card(s). I also agree to provide an explanation of benefits and/or claim form(s) from my insurance company, when applicable.
- I authorize release of medical information necessary to process my insurance claim and I assign insurance benefits to Luna Plastic Surgery, PC for services provided to me by Dr. Patricia Yugueros.
- I understand that co-pays are due at the time of service, as required by my insurance company.
- I agree that I am responsible for the balances applied to my account that are not covered by my health insurance plan.
- In the event that my account is turned over to an attorney or collections agency to obtain payment, then I shall be responsible for the attorney's fee, court costs, and any other costs incurred in the collection agency. A copy of my signature shall have the same force and affect as the original.
- I understand that my account will be charged $40 when a check I presented for payment is returned and marked "non-sufficient funds" (NSF). Returned checks over $500 will be assessed a fee of 5% of the amount of the check.
- I understand that Luna Plastic Surgery, PC will bill my health insurance company and will refund any overpayment on my account to the appropriate party (i.e., insurance company, patient).
- I understand that Luna Plastic Surgery, PC allows 30 days for the processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim; I will be notified if they do not receive a response.
- I will notify an Insurance Specialist at the practice if I am aware of a payment delay by my insurance company. It is my understanding the Insurance Specialist at the practice will provide me with assistance in resolving the claim.
- Any co-insurance, deductible, out of pocket and co-pay amounts will be my responsibility. Any balance left after your insurance has paid must be remitted within 30 days or each month an interest charge will be applied to your account of $10.00 or 10% whichever is greater. In the event I am unable to pay my responsibility in full, I will contact the Insurance Specialist to discuss financial arrangements.
- I have read, understand, and agree to the insurance assignment and financial policies stated above. I also agree that I have had opportunity to discuss any questions or concerns regarding the above with the Insurance Specialist at the practice.
- If you plan to pay privately for your services, please be advised that it is the policy of Luna Plastic Surgery, PC to collect payment in full at the time of the service. If you are unable to make payment in full at the time of service, your appointment/surgery will be rescheduled for a more convenient time.
- Motor Vehicle Accidents (MVA)/Third Party Liability: We will require all claim detail (claim #, contact information, bill address) at the time of your appointment; otherwise, we will require payment in full for services rendered for each patient being treated for a MVA/other accident related injury. We will file claim(s) with the motor vehicle or third party insurance company you designate, provided we receive all necessary information with which to bill. If the claims are denied, or a protracted lawsuit is involved, the patient is responsible to pay the account balance in full. We will bill your private health insurance for balances left after your personal injury protection (PIP) is exhausted.
- Form Fees: Forms and letter requested by our patient will be assessed a fee as listed below. This list is not meant to be all inclusive but is merely representative of the items that may incur a charge. This fee covers our administrative expenses related to physician/staff time, photocopying, mailing, etc.
  - Disability Forms: $20 each
  - Letters of Medical Necessity $30 each
  - Medical Records 1-35 pages/$0.75 per page or more than 35 pages/$0.20 per page plus postage

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth for services rendered by Luna Plastic Surgery, PC.

____ _______________________________

Patient Signature (Guarantor) Date

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PHOTO CONSENT

I, ____ (print full name) understand that photographs will be taken periodically throughout my treatments and/or procedures. These photographs will be used to monitor progress and other factors. I understand that failure to consent to the photos will give Luna Plastic Surgery, PC the right to decline my treatment.

I consent to the taking of photographs by Dr. Patricia Yugueros, or her designee of me or parts of my body in connection with plastic surgery procedure(s) to be performed by Dr. Yugueros.

____ ____
Patient Signature Date Witness Signature Date

Consent of Use of Photos

I grant Dr. Patricia Yugueros the right to use photographs of me in the following areas:

(Please initial each line you agree to)

____ All
____ Website for Consumers
____ Newsletter to be sent to patients
____ Practice Brochures
____ Public Relations Material
____ Seminars
____ Patient before and After Photo Information Sheets

If in the judgment of the physician, medical research, education or science will benefit by their use, the photographs and information relating to my case may be published and republished in professional journals and medical books, or used for any other purpose which she may deem proper in the interest of medical education, knowledge, or research. I understand that in such publications or use I will not be identified by name.

I understand that such photography may become the property of medical organizations or publications but not limited to the ASPS, PRS, ASAPS, ASIF, and Facial Plastic Surgery, Annals of Plastic Surgery or compatible journals and such organizations.

I understand that I may refuse to authorize the release of any photo documentation and that my refusal to consent to the release of photo documentation will prevent the disclosure of such information, but will not affect the health care services presently received, or will receive.

I understand that by signing below Luna Plastic Surgery, PC need not approach me again for authorization on these photos.

____ ____
Patient Signature Date Witness Signature Date

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HIPAA

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, ___________________________________ (print full name) have been informed that a copy of our office Notice of Privacy Practices is available upon request at any time.

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, and employers
- Healthcare Transactions & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself please complete the following:

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them, in writing, whenever this information changes.

Home telephone	Yes_____	No_______
Answering machine	Yes ____	No ______
Cell Phone	Yes ____	No______
Voice mail	Yes____	No______
Work phone	Yes ____	No______
Pager	Yes____	No______
E-mail	Yes____	No______

I fully understand and **ACCEPT** or **DECLINE** (circle one) the terms of this consent.

____ ____

Patient Signature Date Witness Date