Flora Levin MD
COSMETIC EYELID SURGERY & FACIAL REJUVENATION

Patient Intake Forms

Last Name: First :

Single ☐ Married ☐ Widowed ☐ Minor child ☐ Relation to minor child:

Student ☐ Retired ☐ Unemployed ☐ Employed ☐ Occupation:

Gender: M ☐ F ☐ SS#: DOB :

Address : City :

State : Zip: E-mail :

Preferred method of communication : Email ☐ Cell Phone ☐ Other:

Home Ph. Cell Ph. Work Ph.

Emergency contact: Phone:

FINANCIAL RESPONSIBILITY: (pertains to the person who is financially responsible for this visit)

Primary Insurance Carrier_____

Name of policy holder:_____ Self Spouse Parent Other

DOB of policy holder:_____ Contact number:_____

Referral source: Physician_____ Internet search_____

Friend _____ Other _____

Primary Care Physician:_____Phone No:_____

Preferred Pharmacy:_____Street/ Town_____

initial _____

HEALTH INFORMATION:

Current medications _____

Allergies to medications:_____

Do you smoke: Yes No Frequency:_____ Previous smoker: Yes No

EYE HISTORY: Do you have or have you had any of the following:

☐ Dry Eye :

☐ Eye drops:

☐ Eye/eyelid surgery:

☐ Family history of eye disease:

Please explain:_____

Please indicate if you have or have had any of these medical conditions:

☐ Allergies/ hay fever

☐ Asthma

☐ Cancer

☐ Diabetes

☐ Gastric/ stomach disorders

☐ Hard of hearing

☐ Kidney disorders:

☐ Headaches

☐ High blood pressure

☐ Heart attack

☐ Heart stent(s)

☐ Other heart condition

☐ Lung disorders

☐ Seizure disorders

☐ Seizure disorders

☐ Neurological disorders

☐ Sinus infections:

☐ Skin disorders

☐ Major surgery:_____

☐ Thyroid disorders

_____

☐ Currently pregnant or nursing

☐ Eye disease: _____

☐ Urinary disorders

_____

☐ Problems with local or general anesthesia

ADDITIONAL DETAILS OR PERTINENT FAMILY HISTORY:_____

_____

REASON FOR TODAY'S VISIT:_____

_____

initial _____

COMMUNICATION RELEASE

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services offices of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes, as stated below.

This waiver authorizes Flora Levin, MD to send or receive my medical information as noted (please circle):

Leave a **VOICEMAIL** recording, including my personal health information on my phone: **YES** **NO**

Use of electronic communication systems (i.e. **FAX, TEXT)** to transmit prescriptions, disorder related informations, lab results: **YES** **NO**

Use of **EMAIL** to transmit treatment or disorder related information which may include a diagnosis, lab or other results, even if the email is not encrypted: **YES** **NO**

PERSONAL REPRESENTATIVE

I permit the individual stated below (Personal Representative) to receive personal health information including prescriptions and/or test results: **YES** **NO**

NAME_____**RELATIONSHIP**_____

PHONE NUMBER_____**EMAIL**_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

On this date, I was given the opportunity to receive and review Flora Levin MD's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information. I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

_____ _____

Signature of patient or guardian Date

CONSENT FOR PHOTOGRAPHS

I grant permission to the staff of Flora Levin, MD to obtain photographs of me as they deem necessary to show response to treatment and to assist in treatment decisions. I understand that my photographs may be used for teaching/ educational purposes.

_____ _____

Signature of patient or guardian Date

OFFICE POLICIES

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as and essential element of your care and treatment.
Changes in healthcare have shifted many costs to the patient. If we participate with your insurance, you will be responsible to pay any co-pays, co-insurances, or deductibles at the time of service. You may also be responsible for payment of services that are not covered by your plan. If your insurance company denies payment of your medical bill for any reason, you are fully responsible for payment of services rendered and will be billed accordingly. Please be aware that your insurance company does not guarantee accuracy of it's confirmation of coverage and benefits.

initial_____

Preapproval and Precertification:
Prior to having a surgical procedure done, we will call your insurance company to find out if prior authorization or precertification is required. If it is required, we will supply the proper documentation to obtain approval. Some insurances do not require preapproval, but this does not guarantee payment of the claim. If your claim is denied for any reason, whether it was preapproved or did not require preapproval, we will do our best to appeal the denial and attempt to get the claim covered. If the claim is ultimately denied, financial responsibility for payment of medical services rendered will be yours.

Deductibles, Copays, and Coinsurance:
We will attempt to obtain your eligibility and coverage benefits prior to your procedure and inform you of any deductible or coinsurance you may be responsible for after your procedure. However, the information obtained is not always accurate or up to date. It is your responsibility to be aware of and understand the terms of your policy. You will be billed for any balance deemed "patient responsibility" by your insurance company.

Laboratory bills
If you should undergo a biopsy in our office, the lab will bill your insurance carrier separately. You may receive a separate bill from the lab for any uncovered charges.

Out-Of-Network, Cosmetic, and self-pay patients:
Charges for you care and treatment are due at the time of service.

Cancellation and No-Show policy:
We allow a significant amount of time for each appointment. If you do not show, or cancel a medical appointment with less than 24 hours notice, you may be subject to a $100 fee. There is a $250 fee for any surgical or procedural appointments that are missed or not cancelled with at least 7 days notice.

Payment Methods:
We accept cash, check, and all major credit cards as forms of payment. A returned check fee of $50 will be assessed for any returned checks.

ACKNOWLEDGEMENT OF UNDERSTANDING OF POLICIES:
I have read, understood, and agree to all the above financial policies and office policies of Flora Levin, MD. I certify that the information provided is correct to the best of my knowledge. I authorize release of my medical information as necessary to process insurance claims.

_____ _____
Signature of patient or guardian Date

CREDIT CARD ON FILE POLICY:
It is our policy that a credit card is left on file as most insurance companies have copays, deductibles, and/ or coinsurance. Your insurance company will determine the amount you will be responsible for after the claim is processed. We will automatically charge your card for the amount determined by your insurance. We will notify you of charges exceeding $50. Charges under $50 will automatically be charged to this card. Your credit card information will not be physically stored by us, but will be stored electronically by TransFirst in accordance with HIPAA and PCI regulations and standards. By signing below you are confirming that you are the owner of or an authorized user of this account and you are approving these charges.

Please fill out your credit card information on the following page. This page will be shredded once the information is entered and stored securely. No one in this office, or elsewhere, will have access to this information.

_____ _____
Signature of patient or guardian Date

CC TYPE: MC VISA AMEX DISC CC#:_____

NAME ON CARD:_____EXP DATE:_____CVV #:_____

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