PATIENT REGISTRATION

(Please Print Clearly)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status:
			❑ Single ❑ Married ❑ Divorced ❑ Sep ❑ Wid ❑ Other

Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
❑ Yes ❑ No			/ /		❑ M ❑ F

Email Address:

Spouse's name (if applicable):	Spouse's phone #:

Street address:	Apartment #:	City

State:	ZIP Code:	Home phone #:	Cell phone #:	Work phone #:
		( )	( )	( )

Occupation:	Employer:

Referral Source: Phone #: ( )

INSURANCE INFORMATION

(Please give your insurance card & photo identification to the receptionist.)

Subscriber's Name:	Address (if different):	Home phone no.:
		( )

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Name of primary insurance:	Policy no.:	Group no.:

Responsible Party (If different from subscriber):

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:	Group no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Name of tertiary insurance (if applicable):	Subscriber's name:	Policy no.:	Group no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

IN CASE OF EMERGENCY

Emergency Contact :	Relationship to patient:	Home phone #:	Cell phone #:	Work phone #:
		( )	( )	( )

The above information is true to the best of my knowledge. I authorize the release of any medical information including the diagnosis and all the records of any treatment or examination to third payers or other health professionals. I understand that my insurance company may pay less than the actual bill for services. I agree to be responsible for payment for all services provided to me or my dependents.

Signature: _____ Date: _____

FINANCIAL ARRANGEMENT

(Please initial on the lines below)

_____ The surgeons do not participate with insurance. Consequently, you are responsible for the total amount of the charges. As a courtesy, we will submit all medical claims to your insurance carrier on your behalf. Please keep in mind that your insurance will process your claim according to your contract with them. We will be happy to assist with any partial and/or denial reimbursement from your insurance.

_____ If you are covered by Medicare and the doctor participates with Medicare, the doctor will accept the Medicare assignment as payment, provided that Medicare deems your surgery medically necessary. You will be responsible for applicable co-payments and deductible.

_____ All cosmetic procedures will require payment of the surgical fee in advance of surgery. Please refer to the financial package for more details.

_____ Cancellations must be made within two business days prior to date of surgery. You may be subject to a cancellation fee of 20% of the total surgical fee.

PLEASE NOTE

The Surgeon's fee is a "global fee" which means it includes the surgical procedure itself as well as all post operative visits in the hospital and the office during the normal post operative period which is considered a three month period following surgery. After that 90 day period, all office visits will be billed. Each surgical event is a separate entity.

Facility fees and Anesthesia charges are separate and additional to the surgeon's fee.

You may incur additional expenses for medical photographs, autologous blood donation, private room, or private duty nursing.

I FULLY UNDERSTAND THE TERMS AS DESCRIBED ABOVE.

NAME (Print): _____

Patient Signature: _____Date:_____

Witness: _____Date: _____

FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY

DR. LEO KEEGAN
DR. CARLIN VICKERY
DR. TIKVA JACOBS
DR. DANIEL MAMAN

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for THE FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). THE FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY'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 singing this consent.

THE FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY 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 THE FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY Privacy Officer at:
1125 Fifth Avenue, New York, NY 10128

With this consent, FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY; Drs. Leo Keegan, Carlin Vickery, Tikva Jacobs and/or Daniel Maman 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.

With this consent, THE FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY; Drs. Leo Keegan, Carlin Vickery and/or Tikva Jacobs 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.

With this consent, THE FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY; Drs. Leo Keegan, Carlin Vickery, Tikva Jacobs and/or Daniel Maman 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 THE FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to THE FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY'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, THE FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY

DR. LEO KEEGAN
DR. CARLIN VICKERY
DR. TIKVA JACOBS
DR. DANIEL MAMAN

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of

FIFTH AVENUE MILLENNIUM AESTHETIC SURGERY'S Notice of Privacy

Practices.

_____ _____

Signature of Patient Date