PATIENT DEMOGRAPHIC INFORMATION FORM

Today's Date: ____________________

Name: ____

Birth Date: __________________ Age: _________ Social Security # ________________

Sex: M F   Marital Status: S M W D Spouse's Name: ____________________________

Home address: ____

Home #: __________________________ Cell #: __________________________________

Email address: ____

Occupation: ________________________________ Retired_____ Student____

Employer: __________________________________Work: ________________________

Work Address: ____

Insurance____________________________ ID #____________________________

Person Financially Responsible: Patient _____ Parent: _____ Spouse: ____ Other: ____

Subscriber Name: ______________________________ DOB: ______________________

Phone # _________________________ Social Security # __________________________

Address: ____

____

Emergency contact: ____

Phone: ________________________ Relationship to patient: _______________________

REASON FOR CONSULTATION:

____

REFERRED BY:

____

The undersigned hereby consents to medical care and treatment by Dr. Robert Morin now and in the future.

Patient Name____

Patient/Parent/Guardian Signature ____

Date___________________________

Federal Law does not allow us to share information about your medical services (including treatment, payment, insurance details, appointments, scheduling, etc.) without your written approval. Please provide us with the names and phone numbers of anymore with whom we are at liberty to share your information. Please include your spouse, parents if 18+, family members, emergency contact, attorney, and auto insurance adjustor if applicable.

Name: ______________________________ Phone # ____________ Relationship: _______

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Please circle the appropriate responses regarding telephone confirmation of future appointments.

May we leave a message on your cell phone? YES / NO

May we leave a message on your answering machine? YES / NO

May we leave a message with whoever answers the phone? YES / NO

The following information is required by Medicare, Medicaid and the United States Government through the Affordable Care Act.

Race ____

Ethnicity____

Primary Language ____

Pharmacy Name____

Pharmacy Address____

Pharmacy Phone Number ____

Patient Name____

Patient/Parent/Guardian Signature ____

Date___________________________

ROBERT MORIN MD
PLASTIC SURGEON

1. Do you have any **medical problems**?
Please list all medical problems in the space below.

2. Do you take any **medications**?
Please list all medications, vitamins and herbal supplements in the space below.

3. Do you take any **blood thinning medications** (aspirin, Coumadin, Plavix)? ____ YES ____ No
If yes, which blood thinning medication do you take?

4. Have you ever had any **surgery** before?
Please list all previous surgeries and the approximate dates in the space below.

5. Do you have any **allergies** to any medications?
Please list all medication allergies AND the **type of reaction** to each medication in the space below.

6. Do you have any medical problems in your **family**. Please list any medical problems in your immediate family (mother, father, sister, brother, son or daughter only) below.

7. Do you **smoke** cigarettes or use any other nicotine containing products?
YES____ No____ If yes, which product? ___________ how many per day? _________ and for how many years?________________? If you quit, how long ago?_________
Do you drink **alcohol**?
YES ____ No ___ If yes, how often?____
Do you use any other **recreational drugs**? Please answer this honestly as certain recreational drugs are extremely dangerous when combined with general anesthesia.
YES ____ No ____ If yes, which drug and how often? ________________________

8. Is there anything else bothering you today? YES____ No____
Please include all body **systems** including but not limited to nausea, vomiting, diarrhea, shortness of breath, fevers, chills, headache and chest pain.

9. What is your **height**? ____________ What is your **weight**? ________________

10. Have you ever had an eating disorder or have you ever taken diet or weight reduction pills?
YES ____ No ____

11. Are there any other medical problems you have that are not addressed by this form?
YES ____ No ____

12. Is there anything you would like to discuss with Dr. Morin today privately?
YES ____ No ____

13. Have you seen a **primary care doctor** in the past year?
YES ____ No ____
If YES, primary doctor's name ________________________ phone number ________________________

13. **Female** questions
Are you pregnant or breast-feeding? Yes ____ No ____
Are you taking birth control pills? Yes ____ No ____
Are you planning to become pregnant in the future? Yes ____ No ____
Are you planning to breast feed in the future? Yes ____ No ____
What was the date of your last mammogram (if applicable)? ____________________
How many times have you been pregnant? ____________________
How many times have you given birth? ____________________

14. **Signature**
I have provided a complete and accurate overview of my current medical problems and my past medical history to the best of my knowledge. I understand that this information is important in guiding my medical and surgical care and I understand that omissions and inaccuracies can increase my risk of medical and surgical complications.

Signature ________________________

Printed Name ________________________

Date ________________________

ASSIGNMENT OF BENEFITS
&
LIMITED POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/healthcare carrier/worker's compensation carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the New Jersey Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize the attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said Insurer on my claim, including date of payment and balance of benefits remaining.

I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospital, diagnostic centers, etc., and I specifically authorize such healthcare provider(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports, and any other report or information regarding my physical condition.

Patient Name____

Patient/Parent/Guardian Signature ______________________________

Date____________________

FINANCIAL RESPONSIBILITY CONSENT FORM

Insurance Coverage:

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier. Please contact your insurance carrier with any questions regarding your coverage.
- We make every effort to verify that your insurance is valid at the time of your visit. However, please understand that if your coverage has been terminated or suspended at the time of visit, you will be financially responsible for payment of services rendered.
- If your insurance changes, it is your responsibility to notify the office prior to your next visit so we can make the appropriate changes to help you to receive your maximum benefits.
- Verification of benefits with your insurance carrier is not a guarantee of payment for claims submitted by our billing company.

Office Policies:

- Post - operative office visits (for non-cosmetic surgery and emergency procedures) are not always included as part of the surgery fee. Surgery package guidelines vary based on the procedure performed.
- Post- operative cosmetic surgery office visits are included as part of the surgical fee.
- I have been informed that Dr. Robert Morin may not participate with my insurance plan. If I have No Out-of-Network coverage for non-emergent services, I am aware that my insurance carrier will not pay for my services rendered.
- If I have Out-of-Network coverage for non-emergent services, I am aware that my insurance carrier may pay benefits at a reduced rate.
- I accept financial responsibility for services provided to me by Dr. Robert Morin.

Deductibles:

- Deductibles are the patient's responsibility. The deductible is determined by the contract that you have with your insurance company. Our office does not know and is not responsible for knowing how much each patient's deductible is or how much has been met at the time of your visit.

Referrals:

- It is your responsibility to verify with your insurance carrier if you require a referral prior to your appointment. If you require a referral, it is your responsibility to obtain the proper referral prior to your appointment.

Release of Information:

- In connection with the medical services that I am receiving, I hereby authorize the release of my information and medical records, including copies of applicable hospital and medical records to:
- A. Any third-party payer covering the medical services of the patient
- B. Other health care professional and institutions involved in the delivery of health care to the patient
- C. The proponent of any legally sufficient subpoena, or in response to a court order
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of healthcare services and payment for such services
- E. Pharmacies
- F. As otherwise required by law

Insurance Request:

- It is your responsibility to comply with any request from your insurance carrier for further information. Your inability to provide the requested information will result in a denial of your insurance claim and you will be responsible for the outstanding amount.
- You agree to cooperate with our billing company if they request your assistance in appealing your claim to your insurance carrier.

Insurance Payments issued and sent to you:

- If insurance payments are sent to you, it is your responsibility to forward the payment to our office upon receipt with a copy of your "Explanation of Benefits" (EOB) received.

Collection Accounts:

- In the event that your account is forwarded to our attorney/collection agency you are responsible for payment of attorney, collection agency and court fees if applicable.

We emphasize that as a medical care provider that our relationship is with you, the patient, and not with the insurance company. We will assist you in understanding your insurance policy and coverage.

I, ____, have read and understand my financial responsibility and agree to abide by the above stated guidelines:

Patient Name ______________________________________

Patient/Parent/Guardian Signature ______________________________

Date ____________________

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPHS AND/OR VIDEO FOOTAGE

Name ____

Address ________________________________ ______________, ______ __________
Street City State Zip code

I consent to the taking of photographs and/or video footage ("Images") by **Robert Morin, MD** or his designee of me, or parts of my face and body, in connection with the plastic surgery procedure(s) discussed with and/or performed by Robert Morin, MD. I understand that such Images shall become the property of Robert Morin, MD and may be retained, released or used by Robert Morin, MD for the purpose of including them in any print, visual or electronic media, specifically including, but not limited to, websites, social media sites and applications, medical journals and books, for the purpose of informing the medical profession and/or the general public about plastic surgery procedures and methods. In addition, I specifically authorize Robert Morin, MD to uses these Images for the purpose of including them in any print, visual or electronic media, specifically including, but not limited to, websites, social media sites and applications, medical journals and books, for the purpose of advertising.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights regarding the privacy of my protected health information. I have received, read and understand these rights as described in the Notice of Privacy Practices. I understand that while I will not be identified by name in any publication, in some circumstances, the Images may portray features that will make my identity recognizable. I therefore waive my protected health information rights as they apply to these Images.

I provide this authorization as a voluntary decision. I understand that I may refuse to authorize the release of any protected health information and that my refusal to consent to the release of this information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Robert Morin, MD. I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it will not have any affect on any actions taken prior to my revocation.

I release and discharge Robert Morin, MD and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the Images.

I certify that I have read the above Authorization and Release and that I fully understand and voluntarily consent to its terms.

______________________________ ______________________________
Signature Date

I am the parent, guardian, or legal representative of the above-named patient. I have read the above Authorization and Release and I am authorized to sign this document on his/her behalf. I give this authorization voluntarily.

______________________________ ______________________________
Signature Date