CNY Cosmetic & Reconstructive Surgery, LLC
Dr. Gregory A Baum/Dr. Anthony R. Deboni/Beth Phillips RPA/ Rosa Cannata RPA/Elizabeth Daggett RPA
5898 Bridge Street
East Syracuse, NY 13057
(315) 663-0112 Fax (315) 663-0132
www.plasticsurgeryofsyracuse.com

We welcome you to our practice and look forward to providing you medical care at our office. Please do not hesitate to ask our staff if you have any questions.

PAPERWORK MUST BE COMPLETED BEFORE COMING TO YOUR APPOINTMENT.

If we do not participate with your insurance carrier, for certain carriers, we will file a claim. We will file these claims as a courtesy to you so that your insurance carrier reimburses you in a timely matter. We do not submit cosmetic appointments to insurance companies.

If your insurance requires a co-pay, we will collect it at the time of check-in.

If you do not have insurance or we do not participate with your carrier, we will collect payment over the phone when you make your appointment.

If your insurance procedure requires disability paperwork to be completed by our office, there will be a one-time $30 charge. This fee is payable prior to completion of the paperwork.

When booking a cosmetic appointment, you will be required to provide a current credit card number. If you no-show to your consultation, your card will be charged a $100 no-show, non-refundable fee. If you have no-showed for an appointment 2 times, or canceled your appointment 2 times with less than 24 hours' notice, we will ask to collect $100 non-fundable scheduling fee. The fee will be applied to your appointment services or used to cover losses if you no-show or cancel with less than 24 hours' notice.

Thank you for your understanding,
The CNY Beauty Team

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From Interstate 690:

Take 690 East or West to the Bridge Street exit. At the end of the exit, turn RIGHT. Take the first left (at the light).

From 81 North or South:

Take 81 to route 690. Take 690 East or West to the Bridge Street exit. At the end of the exit, turn RIGHT. Take the first left (at the light).

Our Address:

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New: Date: ____________________________

Updated: Date: ________________________

Who may we share your medical information with: ____

PLEASE REMEMBER TO BRING YOUR INSURANCE CARDS WITH YOU ON THE DAY OF YOUR APPOINTMENT.

Patient Name: ______________________________________ Date of Birth: ______________________ Age: ______
First Middle Last

Female: _____ Male: _____ Transgendered Legal Female: _____ Transgender Legal Male: _____

Address: ____ Social Security Number: _________________

City: ______________________ State: _______________ Zip: _____________ Home Phone #: ________________

Employer: ______________________________ Work Phone #: _______________ Cell Phone #: ________________

Email Address: ____________________________ May we send you electronic newsletters/reminders/specials: YES NO

Primary Care MD: _________________________ Address: ______________________ Phone: ___________________

Referred by: ____

Emergency Contact:

Name: __________________________________ Relationship: ________________________ Date of Birth: ___________

Address: ____

City: ____________________________ State: ____________ Zip: __________________Home Phone#: _____________

Work Phone #: _______________________________ Cell Phone #: ____

Insurance Information (Must Be Completed By All Patients):

Primary Insurance Name: ____

Subscriber Name & Address: ____ DOB: ___________________

Member ID#: ____ Group/Plan: __________________________________

Secondary Insurance Name: ____

Subscriber Name & Address: ____ DOB: ___________________

Member ID#: ____ Group/Plan: __________________________________

Medical History Information:

Patient Name: ______________________________ Date: ______________________________

Reason for Appointment: ______________________________

Who Referred You to Our Office: ______________________________

Who is Your Primary Care Physician: ______________________________

Height: ______________ Weight: ______________

PAST MEDICAL HISTORY:

Name of Cardiologist: ______________________________

Please Fill in Your Medical History:

No Medical Issues: ☐

Acid Reflux/Ulcer: ______________________________

Arthritis: ______________________________

Asthma: ______________________________

Bladder/Kidney Problems: ______________________________

Bleeding Disorders: ______________________________

Blood Clots: ______________________________

Cancer: ______________________________

COPD: ______________________________

Diabetes: ______________________________

Endometriosis: ______________________________

Glaucoma: ______________________________

Gout: ______________________________

Heart Disease: ______________________________

Other Conditions: ______________________________

High Blood Pressure: ______________________________

High Cholesterol: ______________________________

High Triglycerides: ______________________________

HIV: ______________________________

Intestinal Problems: ______________________________

Liver Disease: ______________________________

Neurological Problems: ______________________________

Pneumonia/Tuberculosis: ______________________________

Psychiatric Problem: ______________________________

Skin problems: ______________________________

Stroke: ______________________________

Thyroid/Parathyroid Disorder: ______________________________

Patient Name: ______________________________

Whom may we share information with? Please list names as well as relationship (example: Spouse, significant other, parent, child, doctor's office): ____

____

Please list ALL surgeries and surgeons who performed each (If none, please write "none"):

____

____

Allergies: ____

Current Medications: Please list any medications you are currently taking (include Aspirin, Motrin, vitamins and herbal supplements):

____

____

Pharmacy: What Pharmacy do you use and what is the location? ______________________________

SOCIAL HISTORY:

Alcohol: Do you drink alcohol? __________ If yes, how much/often? ______________________________

Do you use any illegal drugs: ____

Marital Status: (please circle one):
Single Married Separated Divorced Widowed Partnered

Occupation: ____

Smoking History:

Do you smoke tobacco products? _______________ if yes, how much/often? ______________________

Do you use any nicotine products: Chew, Tobacco, Gum, Patches, E-Cigarettes? __________________

FEMALE HISTORY:

Do you have regular periods? Yes No

Are you going through or done with menopause? Yes No

Are you pregnant or nursing? Yes No

During your pregnancy, did you have any skin pigment changes? Yes No

Number of Pregnancies? _________

Number of Children? __________

Are you using birth control? Yes No
If yes, please detail: ____
Patient Name: ______________________________________

FAMILY MEDICAL HISTORY:

No Contributing Family History: ☐

Adopted ☐

Who in Family

Abnormal Clotting ______________________

Acid Reflux/GERD _____________________

Adopted ______________________________

Anesthesia Problems ___________________

Arthritis _____________________________

Autoimmune Disorder ___________________

Brain Tumor __________________________

Breast Cancer ________________________

Cleft Lip _____________________________

Diabetes _____________________________

Endocrine Disease ______________________

Glaucoma ____________________________

Hearing Loss _________________________

Heart Disease _________________________

Who in Family

Kidney Disease _________________________

Liver Disease ___________________________

Lung Disease ___________________________

Malignant Hyperthermia ___________________

Neurological Problems ____________________

Ovarian Cancer _________________________

Prostate Cancer ________________________

Psychiatric Disease ______________________

Skin Cancer ___________________________

Stroke _______________________________

Substance Abuse _______________________

Thyroid/Parathyroid Problems _____________

Patient Name: ____

REVIEW OF SYSTEMS: Do you currently have, or had you in the past YEAR:

None Abnormal	☐	Burning Urination?	☐
Change in Weight?	☐	Blood in Urine/Stool	☐
Numbness in Limbs?	☐	Pain in Joints?	☐
Difficulty Swallowing?	☐	Heat/Cold Intolerance?	☐
Loss of Appetite?	☐	Dry Eyes?	☐
Blurred Vision?	☐	Skin Rash?	☐
Hair Loss?	☐	Diarrhea?	☐
Shortness of Breath?	☐	Nausea/Vomiting?	☐
Abdominal Pain?	☐	Constipation?	☐

VERIFICATION:

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

Printed Patient Name: ______________________________ Date: ______________________________

Patient Signature: ______________________________ Date: ______________________________

Parent/Guardian Signature: ______________________________ Date: ______________________________

Provider Signature: ______________________________ Date: ______________________________

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Assignment of insurance Benefits & Authorization to release information

To our Medicare Patients: Please complete #1: Statement of Authorization for payment of Medicare Benefits

1. I certify that the information by me in applying for payment under the Tittle XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to Social Security Administration, or it's carrier, any information about me to process my Medicare Claim. I request that payments under the Medical Insurance Program be made to CNY Cosmetic & Reconstructive Surgeons, LLC for services rendered to me during the period of Date to life.

Signature: ______________________________ Date: ______________

TO ALL OF OUR PATIENTS - COMPLETE #2 AND #3: ASSIGNMENT OF BENEFITS

2. I hereby assign all medical and/or surgical benefits, to include major medical benefits, private insurance, and any other health plan to CNY Cosmetic & Reconstructive Surgeons, LLC. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid or allowed by insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event my account is assigned for collection, I agree to pay off costs of collection including reasonable attorney fees and any future outstanding balances. I acknowledge that there will be a 1.5% finance charge on all balances over thirty (30) day's.

Signature: ______________________________ Date:______________

3. I understand and agree to pay for any services provided to me because it may not be a paid benefit under my health insurance policy and/or for one of the reasons outlined below. I further acknowledge that I am aware that I can be held personally responsible for payment of some or all medical expenses incurred for these services, I have been given the option of rescheduling my appointments for a later date if I elect not to be seen today

   a) Prior authorization was not received from the Primary Care Provider, or
   b) I do not have health insurance coverage, or
   c) The services may not be deemed medically necessary, or
   d) The service is not a covered benefit under the terms of the contract, or
   e) Service(s) applies toward deductible or co-insurance.

This waiver will stay in effect until such time I terminate treatment with CNY Cosmetic & Reconstructive Surgery, LLC by written letter.

THERE WILL BE A FEE FOR APPOINTMENTS MISSED OR CANCELLED WITH LESS THEN 24 HOUR NOTICE.

Any checks sent back to CNY Cosmetic & Reconstructive Surgery, LLC for insufficient funds will incur an additional fee by me. I accept responsibility for co-pays and/or balances at the **time of the service**. I, the patient or guarantor, authorize CNY Cosmetic & Reconstructive Surgery, LLC to call in prescriptions to my pharmacy, leave messages on my answering machine pertaining to appointments or billing issues & mail appointment cards to me. I authorize the release of medical information, including diagnosis, to my primary care physician/referring physician and any physician whom CNY Cosmetic & Reconstructive Surgery, LLC may refer me to.

Signature: ______________________________ Date:______________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.

- Obtain payment from third-party payers.

- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ___________________________________ Date: ___________________________
Relationship to Patient: (if not patient signing): ____
Signature: ____

OFFICE USE ONLY
I attempted to obtain the patients signature in acknowledgment on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

____

____

Authorization for Access to Patient Information

Through a Health Information Exchange Organization

CNY COSMETIC AND RECONSTRUCTIVE SURGERY

New York State Department of Health

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow ***CNY COSMETIC AND RECONSTRUCTIVE SURGERY*** to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. *ONE* box is checked to the left of my choice. **I can fill out this form now or in the future.** **I can also change my decision at any time by completing a new form.**	
☐	**1. I GIVE CONSENT for *CNY COSMETIC AND RECONSTRUCTIVE SURGERY* to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).**
☐	**2. I DENY CONSENT for *CNY COSMETIC AND RECONSTRUCTIVE SURGERY* to access my electronic health information through HealtheConnections for any purpose, *even in a medical emergency*.**

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)