PLASTIC SURGERY & DERMATOLOGY of NYC PLLC

Elie Levine, MD • Plastic Surgery | Jody A. Levine, MD • Dermatology

■ **Patient Information – Minor (under 18)** Today's Date: _____

Name (Last, First, Middle):_____

Gender: ☐ M ☐ F Age: _____ Birthdate: _____ Social Security: _____

Street Address: _____

City, State & ZIP: _____

Home Phone: _____ Cell Phone:_____

School Name:_____ Grade:_____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Race: ☐ American Indian ☐ Asian ☐ Black / African American ☐ Pacific Islander ☐ White ☐ Other ☐ Decline to Answer

Pharmacy Name:_____ Phone: _____

Primary Care Physician (PCP): _____ Phone: _____

Address: _____

Permission to contact PCP regarding care and to inform of treatment course? ☐ Yes ☐ No

■ **Medical Insurance Claims** *will be processed to primary insurance only. Patients may submit receipts to secondary insurance as applicable. Not all services are covered by insurance, not all our providers participate with insurance, and cosmetic services are not submitted to insurance carriers.*

Insurance Company _____

Insurance ID # _____ Group # _____

Please enter the policyholder's information below. If the patient is the policyholder, check this box ☐ *and skip to the next section.*

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Social Security: _____ Birthdate _____

Full Home Address _____ Best Phone _____

Employer _____ Work Phone _____

■ Parent /Guardian Information

Mothers Name:_____ Fathers Name:_____

E-mail:_____ E-mail:_____

Work Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Phone:_____

Home Phone:_____ Home Phone:_____

■ How did you hear of us? _____

■ Authorization

I hereby authorize medical treatment of the person named above, and agree to pay all fees and charges for treatments and services rendered. I understand that medical treatment may include a review of personal, social and medical history, discussion of the reason(s) for the visit(s), and may include photographs of the area(s) being discussed and or treated before and/or after treatment. Should Plastic Surgery & Dermatology of NYC agree to submit my charges to my health plan, I agree to assign it all plan payments, and agree to promptly pay any remaining balance. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: _____ **Date:** _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ **Relationship to Patient:** _____

Please note that we require a copy of your government-issued photo identification for your record.

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List the reason(s) for your visit today: _____

List all medical conditions for which you are presently being treated: _____

_____

List all skin conditions you have previously been diagnosed with and/or treated for: _____

_____

■ Personal Medical History

Please mark all past and present medical conditions:

Cardiovascular:
- ☐ High blood pressure
- ☐ Heart attack(s)
- ☐ Pacemaker
- ☐ Coronary artery disease
- ☐ Murmur / Mitral valve prolapse
- ☐ Irregular heartbeat / palpitations
- ☐ Other: _____

Pulmonary:
- ☐ Asthma
- ☐ Chronic lung disease
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Other: _____

Neuromuscular:
- ☐ Arthritis
- ☐ Muscle weakness
- ☐ Nerve damage
- ☐ Facial paralysis / Weakness
- ☐ Headaches
- ☐ Seizure disorder / Convulsions
- ☐ Spinal / Back disorders
- ☐ Other: _____

Psychological:
- ☐ Depression
- ☐ Anxiety
- ☐ Claustrophobia
- ☐ Receive(d) psychiatric treatment
- ☐ Drug/Alcohol dependency treatment
- ☐ Psychiatric hospitalization
- ☐ Other: _____

Ears / Nose / Throat:
- ☐ Nasal Difficulties
- ☐ Difficulty breathing by nose
- ☐ Previous nasal injury
- ☐ History of sinus infections
- ☐ Hearing difficulty
- ☐ Hoarseness
- ☐ Other: _____

Eyes:
- ☐ Dry eye
- ☐ Blurred / Double vision
- ☐ Cornea problems
- ☐ Glaucoma
- ☐ Thyroid eye disease
- ☐ Wears glasses or contacts
- ☐ Other: _____

Endocrine:
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus
- ☐ Other: _____

Hepatic:
- ☐ Hepatitis (Type: ___)
- ☐ Pancreatitis
- ☐ Cholecystitis
- ☐ Other: _____

Renal:
- ☐ Renal failure
- ☐ Dialysis
- ☐ Other: _____

Hematology:
- ☐ Blood transfusion
- ☐ Bleeding disorder
- ☐ Other: _____

Gastrointestinal:
- ☐ Colitis
- ☐ Reflux disease
- ☐ Stomach ulcers
- ☐ Other: _____

Allergic / Immunologic / Infectious:
- ☐ Hay fever
- ☐ HIV / AIDS
- ☐ Sexually transmitted disease
- ☐ Tuberculosis (TB)
- ☐ Autoimmune disorder
- ☐ Other: _____

Dermatological:
- ☐ Excessive sweating
- ☐ Cold sores / herpes
- ☐ Acne
- ☐ Rosacea
- ☐ Eczema
- ☐ Psoriasis
- ☐ Radiation to face / neck
- ☐ Scarring / Keloid formation
- ☐ Other: _____

Cancer:
- ☐ Basal cell cancer
  Location: _____
- ☐ Squamous cell cancer
  Location: _____
- ☐ Melanoma
  Location: _____
- ☐ Breast cancer
- ☐ Ovarian cancer
- ☐ Lung cancer
- ☐ Colon cancer
- ☐ Prostate cancer
- ☐ Other: _____

Please list any other conditions not listed above: _____

Do you faint easily? ..... ☐ Yes .....☐ No

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Patient Name: _____ Date: _____

■ Personal Surgical History

Procedure	Date

Have you ever had any surgical complications? ..... ☐ Yes ..... ☐ No

If yes, please describe: _____

■ Medications

List all medications you are currently taking, both by mouth and topically, including prescriptions (such as birth control, blood thinners, etc.), over-the-counter treatments, vitamins, herbal supplements and creams. Please let us know the reason you are taking each medication.

Medication	Dosage & Frequency	Length of Time Used	Reason Taking Medication

Are you currently, or have you recently, taken any medications containing Aspirin? ..... ☐ Yes ..... ☐ No

Have you been on Accutane therapy within the past 24 months? ..... ☐ Yes ..... ☐ No

Have you taken any steroid preparation(s) over the past year? ..... ☐ Yes ..... ☐ No

■ Allergies

☐ If you have no allergies at all, check this box and skip to the next section.

If you do have allergies, please check all items that you have had an allergic reaction to:

☐ Penicillin ☐ Sulfa ☐ Lidocaine ☐ Novocaine ☐ Eggs ☐ Latex

If you marked any of the above, please describe the reaction(s): _____

Please list all other drug and food allergies, including products such as tape, and the nature of your reaction:

_____

_____

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Patient Name: _____ Date: _____

■ Family Medical History

Please mark which of your relatives have or had the following conditions. List which blood relative are / were affected.

	Mother	Father	Blood Relative(s)
Allergies	☐	☐	_____
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Cancer (other than skin cancer)	☐	☐	_____
Diabetes	☐	☐	_____
Eczema	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Lung Disease	☐	☐	_____
Psoriasis	☐	☐	_____
Melanoma	☐	☐	_____
Basal Cell Carcinoma	☐	☐	_____
Squamous Cell Carcinoma	☐	☐	_____
Tuberculosis	☐	☐	_____
Other skin condition	☐	☐	_____

Were you adopted? ☐ No ☐ Yes If Yes, do you know your biological family's medical history? ☐ No ☐ Yes

■ **Social History**

Do you smoke? ☐ No ☐ Yes (#/Day: _____) ☐ I did, but I quit (Quitting date: _____)

Do you use electronic cigarettes/vape (i.e., Juul)? ☐ No ☐ Yes If Yes, frequency: _____

Do you smoke/use a hookah? ☐ No ☐ Yes If Yes, frequency: _____

Do you drink alcohol? ☐ No ☐ Yes If Yes, frequency: _____ Recreational drugs? ☐ No ☐ Yes. If Yes, frequency: _____

How often do you exercise? ☐ Daily ☐ 1 x per week ☐ 2-3 x per week ☐ 4-6 x per week

Do you use sunscreen? ☐ Daily ☐ Always if sunny ☐ Sometimes if sunny ☐ Rarely / Never

What brand facial soap do you use? _____ What brand moisturizer do you use? _____

What brand body soap do you use? _____

Are you using birth control? ☐ No ☐ Yes If Yes, method: _____

■ **Review of Systems**

Have you had any significant weight change in the past year? _____ lb loss _____ lb gain ☐ No

What is your height? _____ What is your current weight? _____

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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Plastic Surgery & Dermatology of NYC, PLLC for your cosmetic, aesthetic and/or dermatologic needs. For your convenience, and to avoid any future misunderstandings, we would like to share the following policies with you so that you understand your responsibilities regarding our charges and fees for the services provided by each physician.

Dermatology charges for evaluation and maintenance visits are determined by the complexity of the medical decision making and time involved in your visit. Procedures and materials are charged in addition to the fees for the consultation. If you require an advance estimate of such fees, please ask before services are rendered.

Dr. Jody Levine does not currently participate with any health insurance plans. Our general policy is:

a. You are responsible for all charges.
b. Payment in full is expected before completion of treatment unless other arrangements have been mutually agreed upon prior to the visit.
c. For the convenience of our patients with medical insurance, we will be happy to complete your insurance claim forms as a courtesy to you for your direct reimbursement.
d. In cases where charges are to be pre-paid, this will be explained prior to provision of those services.
e. To obtain a cosmetic appointment for Sculptra, a deposit of half of the price of the treatment is required. The balance is due upon exiting the office. If you should need to cancel your appointment, the balance will be reimbursed, provided your cancellation is made with at least three (3) business days notice. Because the product must be prepared in advance, and quickly expires, cancellations after this time will forfeit the deposit.

Plastic surgery charges are determined by the particular surgery being performed as well as the patient's medical conditions and the doctor's determination of the procedure's complexity. The fees for each surgery will be explained by our business manager after your consultation with the doctor. The fee for your initial consultation is nonrefundable – however, it will be deducted from your surgical procedure, if performed within 3 months of your consultation.

Dr. Elie Levine often accepts insurance plans with out of network benefits.

a. If your insurance plan requires a referral, please bring the referral with you to your appointment. Please call the office to determine how the referral should be completed. Patients whose plans require a referral, and who come to their appointment without a valid or properly executed referral, will be offered the choice of rescheduling their appointment and paying a $50 no-referral fee, or signing an insurance waiver and being seen as scheduled.
b. If your insurance plan determines that any portion of our charges are cosmetic, not covered services, are applied to your annual deductible, or otherwise are your responsibility to pay for, we will issue you an invoice. Services known to be cosmetic will not be submitted to your insurance carrier, and payment is due at the time of service.
c. Known cosmetic procedures require payment at the time services are rendered. To secure a surgical date, a deposit is required and full payment is required two weeks before the surgery.

Cancellation Policy: The office has instituted a 24 hour cancellation policy. The fee is $50. This policy will apply to all patients. We schedule our appointments in a certain way to maximize the time spent with each patient. Unanticipated no-shows or cancellations leave large gaps in the doctors' schedules and also increases the wait time to get an appointment. Patients will be asked to leave a credit card number on file and will be charged for any cancellations received less than 24 hours in advance and for no shows. Patients without a current card on file will be billed and payments are due before subsequent visits. We hope it is clear that our intent is only to be able to give each patient the time and attention he/she deserves. Any questions can be directed to our practice manager.

Health Insurance Cards: Please bring your most current health insurance membership card to each and every appointment. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report it. We will not engage in any fraudulent practices under any circumstances.

Health Insurance Plans: We do not know the details of every patient's plan, as we see many different plans every week. Although we will advise you whether we believe we participate with your insurance carrier, we are not responsible for any verbal assurances made to you regarding whether particular services rendered in this practice are covered by your plan. You and you alone are responsible to understand the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services in order to verify your financial responsibilities. Please bear in mind that, ultimately, carrier adjudications after the visits determine financial responsibilities.

Referrals: You are responsible to obtain all necessary referrals prior to your appointment, if required by your health plan. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours. If your plan requires a referral or authorization that you do not obtain, and your health plan refuses to pay for any claim for lack of a referral or authorization, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn't be (you are waiving that defense). If you come to an appointment that requires a referral and you do not have one, and you must reschedule, you may be charged a cancellation fee, as above.

Copayments: If your health plan has a copayment, if is your responsibility to pay it at the time of service, even if the amount it not printed on your insurance card. Please have your payment ready upon check-in. Please be aware that, should you not pay your copayment at the time of service, you will be responsible to pay an invoice fee of $20.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your financial responsibility to pay in full. In cases of retroactive disenrollment you are responsible immediately upon notification to us by the carrier. This policy applies equally to in-network and out-of-network plans.

Collections: Patients will be invoiced through the mail for any balance due. After a grace period following the first invoice, a second final-notice invoice shall be sent. Should payment in full not be received promptly following the second invoice, your account may be sent to collections, and you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. You may be dismissed as a patient by our practice for failure to meet your financial obligations.

Laboratory Fees: If you participate with a health insurance plan that requires you to have your laboratory specimens sent to a particular laboratory, and this office is informed, we will happily send your specimens to that laboratory, at your request, unless the doctor determines that another laboratory is preferred for medical reasons. However, regardless of which laboratory patient specimens are sent to for analysis, you are entirely responsible for all charges assessed by the laboratory, and shall handle financial matters directly with the laboratory.

I have read and understand the above. I fully understand and accept my financial responsibility for the charges I or my dependants may incur at this office.

Signature: _____ **Date:** _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ **Relationship to Patient:** _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT & CONSENT

♦ I have received the Notice of Privacy Practices and/or have been provided an opportunity to review it.

♦ I agree that I can be contacted regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), at the following telephone numbers, in addition to any other numbers provided to you by me:

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Home / Office / Cell / Other: _____

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Home / Office / Cell / Other: _____

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Home / Office / Cell / Other: _____

**as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its regulations, as may be amended from time-to-time*

♦ I understand that it is your policy not to reveal PHI on voicemail systems and answering machines, aside from upcoming appointment information. If I would like to permit you to leave non-appointment PHI messages on the voicemail systems or answering machines at the numbers I have provided, I will initial here: _____

♦ I understand that it is your policy not to reveal PHI to my spouse, unless I enter his/her name below. I understand that it is your policy, in compliance with the law, to reveal PHI with my other physicians.

♦ I understand that it is your policy to email information and confirmation messages to the email address(es) I provided you. I also understand that this method of communication is one-way only, and that I may not contact the practice via email, neither for medical nor administrative matters.

♦ I agree that my PHI may be shared with the following other people (please indicate relationship):

_____ (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

_____ (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

[Please place a star next to the name of the person you choose as your primary emergency contact.]

♦ I understand that it is your policy that, when you receive telephone calls to discuss my medical care or records, all callers, including myself, will have to supply information that uniquely identifies me, such as the last 4 digits of my social security number and/or my birth date, and that without such a match no PHI will be revealed.

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Plastic Surgery & Dermatology of NYC.

♦ In the event that I choose to discuss my care by this office on the internet, in social media or any other venue, Plastic Surgery and Dermatology of NYC reserves the right to respond with detailed relevant information to clarify the care administered. In choosing this venue, I also agree to waive my privacy rights and I further confirm that HIPAA will no longer apply with regard to the information posted.

Patient Name (print): _____

Signature: _____ **Date:** _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ **Relationship to Patient:** _____

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CONSENT FOR DIAGNOSTIC & TREATMENT PHOTOGRAPHS

I understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give Plastic Surgery & Dermatology of NYC, PLLC the right to decline my treatment.

Patient Signature:_____

CONSENT TO USE PHOTOGRAPHS

Sharing before and after images helps other patients understand cosmetic procedures. We request your permission to use your medical photographs/videos to showcase your before and after results. All patient images and videos are cropped so that you, the patient, are virtually unidentifiable, with particular attention to birthmarks and tattoos.

I grant permission for the use of my photographs and/or videos to be used on the Plastic Surgery & Dermatology NYC website, websites associated with Drs. Levine, their social media sites and published articles.

Patient Name _____

Date _____

Signature _____

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v.0 4.2022

PAYMENT SECURITY AUTHORIZATION

Dear Patient,

Insurance Based Services: As you know, there are charges for each of the medical care services that we will provide to you. As always, our office is pleased to work with your health benefit plan to coordinate your benefits, maximize the covered services you are entitled to, and minimize your financial and administrative burden.

You may not know that it can take months for your plan to process our claims, and when plans assign financial responsibility to patients for charges, many patients wait months to pay our invoices. Sadly, a significant number do not pay at all. This situation places an unfair burden on our practice and its employees. In addition, in recent years the number of plans with high deductibles (or where patients have Health Savings Accounts – HSAs) has increased dramatically. That means that we have to expend much effort and expense to collect many balances, often long after we have rendered services.

As a result, it is our policy to maintain credit card charge authorizations such as this on file in order to secure payment for patient balances. This method saves our patients the hassle of paying mailed invoices and avoids the potential risk to our patients of collection agencies and credit bureaus. You can feel secure sharing this information with us – it is our policy to treat your financial information with the same respect and privacy guidelines as your medical records. Your credit card information will be securely stored with end-to-end encryption with our credit card company, which is PCS DSS compliant.

In providing your information below, you authorize payment by credit card for services in the absence of coverage by your health benefit plan (including, but not limited to, co-payment, co-insurance, deductibles, invoice fees, and/or services deemed uncovered by your health plan), for charges up to $350 per each date of service obtained by the patient named below at any of our offices. If your financial responsibility exceeds that amount, the first $350 will be charged to your card upon our receipt of your insurer's Explanation of Benefits (either via mail or electronically), and you will be billed for any remaining balance by mail. That balance will be payable in full upon your receipt. We will mail you a receipt after your charges are processed. Unpaid balances may be sent to our collection agency for further collection attempts, according to our business practices, which may include reporting to credit agencies, and which includes a collection fee of 30% of the balance due.

Non-Insurance Based Services: Additionally, in providing your information below, you authorize payment by credit card for any cosmetic services or other services and/or products of which you are notified in advance will not be submitted to your insurance carrier, and for which you do not make payment in full before leaving the premises after services are rendered, for charges up to $3,500 per each date of service. If your charges exceed that amount, the first $3,500 will be charged to your card and you will be notified via telephone that payment on the balance is due immediately.

Patients' financial responsibility for these charges is legally bound by utilizing our services. Should you contest the credit card charges for any of these approved transactions and those charges are reversed, you will remain fully responsible for the charges, and your balance due may be immediately sent to our collection agency without any delay. Furthermore, in the event that you choose to contest the credit card charges for any of these approved transactions, Plastic Surgery and Dermatology of NYC reserves the right to respond with detailed relevant information and HIPAA will no longer apply with regard to the case(s).

Refunds: Any authorized refunds are subject to a 7% credit card processing fee.

By signing below, you affirm that you have read, understand and consent to all these policies. Thank you kindly for your assistance.

PLEASE PRINT CLEARLY

Patient's Name: _____

Name of Cardholder: _____ *Must match name as printed on card.*

Circle Brand of Credit Card: Visa MasterCard Discover American Express

Card Number: _____ Expiration date: _____

Security Code:_____ *This is the 3-digit code on the back of Visa, MC & Discover, and 4-digit code on front of AMEX.*

Street Address & ZIP code of the billing address: _____

By signing below, I authorize payment on this credit card to Plastic Surgery & Dermatology of NYC PLLC as explained above.

Authorized Signature:_____ **Today's date:** _____

Please give your credit card to the receptionist so that we may photocopy it.