

Faculty Group Practice Patient Demographic Form

Patient Information	Name (Legal Last, First, MI and <i>Chosen Name</i>)			Email address		
	Street Address		City	State	Zip	
	Home Phone ()	Preferred <input type="checkbox"/>	Work Phone ()	Preferred <input type="checkbox"/>	Cell Phone ()	Preferred <input type="checkbox"/>
	SSN	Date of Birth	Gender	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner <input type="checkbox"/> Other		
	Race	Ethnicity	Preferred Language		Country of Origin	
Financially Responsible Party	Is patient responsible party/guarantor? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)					
	Name		Address	City/State/Zip		Relationship to Patient
	Occupation	Employer		Email Address		Date of Birth
	Home Phone ()	Preferred <input type="checkbox"/>	Work Phone ()	Preferred <input type="checkbox"/>	Cell Phone ()	Preferred <input type="checkbox"/>
Emergency Contact	Name			Relationship to Patient		
	Home Phone ()	Preferred <input type="checkbox"/>	Work Phone ()	Preferred <input type="checkbox"/>	Cell Phone ()	Preferred <input type="checkbox"/>
Referral Info	Referring Physician's Name			Physician Phone/Fax (if known) ()		
	Physician Address					
PCP Info	Primary Care Physician's Name (Check if same as Referring Physician above <input type="checkbox"/>)			Physician Phone/Fax (if known) ()		
	Physician Address					
Insurance Information	Primary Insurance Company		Policy #	Group #		
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)		
	Subscriber's Social Security #	Gender	Date of Birth	Employer of Subscriber	Work Phone ()	
	Secondary Insurance Company		Policy #	Group #		
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)		
	Subscriber's Social Security #	Gender	Date of Birth	Employer of Subscriber	Work Phone ()	
<p>By signing below, I acknowledge that the information I provided is correct to the best of my ability.</p> <p>Patient Signature: _____ Date: ____/____/____</p> <p>Guarantor Signature (if other than patient): _____ Date: ____/____/____</p>						



Patient Pre-Visit Worksheet

Legal Name: _____

MRN (for office use): _____

Date of Birth: _____ Age: _____

Reason for Visit: _____

Medical History: None

Do you have a history of fainting or seizures? NO YES

Surgical History – Please list dates, if any: None

Allergies – Please list Reactions: None Latex: _____ Other: _____

Social History:

Highest Level of Education: _____ Occupation: _____

Marital Status (select one): Single Married Divorced Widowed Partnered

Tobacco Use: _____

Alcohol Use: _____

Illicit Drug Use: _____

Family Medical History: _____

Current Medication with Usage: _____

Is it okay to leave you a voicemail with possible confidential information: NO YES, PREF # _____

Patient Signature: _____ Date: _____

Name of Person completing this form (if not the patient): _____ Relationship to Patient: _____

Signature: _____ Date: _____

Thank you for choosing NYU FGP Plastic Surgery Associates for your healthcare needs. We appreciate you as a patient and intend to be as available and informative to you throughout your entire experience with us. We are providing you with an overview of common insurance terms and protocol so that you can better understand what your insurance coverage means.

As a patient at our practice, you may be responsible for some **out of pocket costs** (all non-reimbursed expenses for health care required to be paid by the enrollee or insured person) depending on your insurance coverage. The costs include, your **co-payment (co-pay)** (a fixed amount that a subscriber pays to the health care provider for a specified service), your **co-insurance** (a shared cost provision by which covered members of a health plan pay for a percentage of billed services, usually applied after the deductible has been met and in addition to any co-payment), and your **deductible** (fixed amount that a member pays out of pocket for health care, in addition to premiums, before insurance coverage or reimbursements is calculated). **You are expected to pay your copay and any other pertinent payments at the time of your visit.**

We will inform you when you make your appointment with us whether we participate with your insurance or not. If we participate with your insurance, you will be using your **in-network benefits**. If we do not participate with your insurance, please be sure that your insurance has **out of network coverage** (benefits for treatment obtained from a non-participating provider).

If you do decide to move forward with a surgical procedure with us, we will obtain a **pre-certification** (an authorization provided by your insurance company after a review of diagnosis and proposed treatment plans prior to treatment). The precertification is not a guarantee of benefits or payment and the procedure must meet the medical necessity guidelines in order for your insurance to cover it.

We can provide you with the procedure code(s) that corresponds to the procedure that is **anticipated** to be performed before your procedure takes place. You can contact your insurance company (by using the Member Services number located on the back of your insurance card) and provide them with the code(s) so that they can let you know what their **reasonable and customary** rate is. This will also allow the insurance company to provide you with an **estimate** of what your out of pocket responsibility may be based on your insurance benefits. **Please note that these codes are not guaranteed to be billed until after the procedure is performed; they might change if the physician deems necessary while performing the procedure.**

There is also a **post op** period associated with your procedure. This is a pre-set amount of time in which you will not be charged for any follow up office visits that are related to the procedure performed.

- The post-operative period for **most minor procedures that are performed in the office** is 10 days from the date of service.
- The post-operative period for **most surgical procedures performed in the hospital** is 90 days from the date of service.

However, any type of procedure, injection, x-ray, or office visit regarding a separate issue, performed within these 90 days, is billable to your insurance company and a copayment, coinsurance, or deductible may apply once the claim is processed per the insurance. Only post-operative office visits alone are not billable. After the 10 or 90 day period, all visits are billable in full.

INITIAL THAT I HAVE READ AND UNDERSTAND ALL ABOVE STATED _____



FACULTY GROUP PRACTICE FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

I understand that NYU School of Medicine, my treating physicians and their respective designees, will use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

- **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to NYU School of Medicine. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.
- **FINANCIAL LIABILITY:** I have been provided a copy of the NYU School of Medicine financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to NYU School of Medicine for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:
 - My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at NYU School of Medicine and I have not obtained such a referral or I receive services in excess of the referral, and/or
 - My health plan determines that the services I receive at NYU School of Medicine are not medically necessary and/or not covered by my Insurance plan, and/or
 - My health plan coverage has lapsed or expired at the time I receive services at NYU School of Medicine, and/or
 - I have chosen not to use my health plan coverage, and/or
 - The physician I see does not participate with my health care plan.
- **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient's Medicare Number _____ Patient Signature _____

- **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at NYU School of Medicine; such as, anesthesia, interpretation of cardiac tests, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payor.
- **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that, based on the policy of individual physician offices, I may incur a cancellation fee if I do not provide the required notice of cancellation, or if I do not keep my appointment and have not canceled.

I have been provided the Faculty Group Practice Patient Financial Policies. I understand the information listed above which has been fully explained to me.

Patient Signature

Date

Guarantor Signature

Date

FACULTY GROUP PRACTICE CELL PHONE CONTACT FORM



I understand that as a service to its patients, NYU Langone (Faculty Group Practice) provides bill pay reminders to patients that may be placed using a prerecorded message or text message. By providing my cell phone number to NYU Langone and signing below, I am giving consent to receive these calls or text messages at the number maintained in my NYU Langone medical record. I understand that if my cell phone number is updated at NYU Langone, I will receive the calls or text messages to the new number, unless I have opted out as described below. I also understand that this consent will apply to any NYU Langone Faculty Group Practice office that may use this service.

I GIVE CONSENT for NYU Langone to contact me regarding bill pay reminders on my cell phone.

I DENY CONSENT for NYU Langone to contact me regarding bill pay reminders on my cell phone.

I understand that I can opt-out at any time by emailing my name and date of birth (for verification) to NYUPhysicianServices@nyulmc.org, submitting a message via MyChart, or by providing written notice to: NYU Langone Physician Services, PO Box 415662, Boston, MA 02241

Patient (Parent/Guardian) Signature

Date

**HEALTH INFORMATION EXCHANGE,
CARE EVERYWHERE AND HEALTHIX
CONSENT FORM**

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYUL Health HIE") website <http://health-connect.med.nyu.edu/> ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYUL Health HIE. In order for a Care Everywhere Provider to know that information may be available through the NYUL Health HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Health program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at <http://www.healthix.org> or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYUL Health HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please check one box below:

- 1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYUL Health HIE website and Care Everywhere Providers to access ALL of my electronic health information through the NYUL Health HIE and I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.
- 2. I DENY CONSENT to ALL of the HIE Participants listed on the NYUL Health HIE website and Care Everywhere Providers to access my electronic health information through the NYUL Health HIE or HEALTHIX for any purpose, even in a medical emergency.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYUL Health HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

PRINT Name of Patient

Patient Date of Birth

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)



NYU Langone Health Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

By signing this form, I acknowledge that I have received a copy of NYU Langone Health's Notice of Privacy Practices.

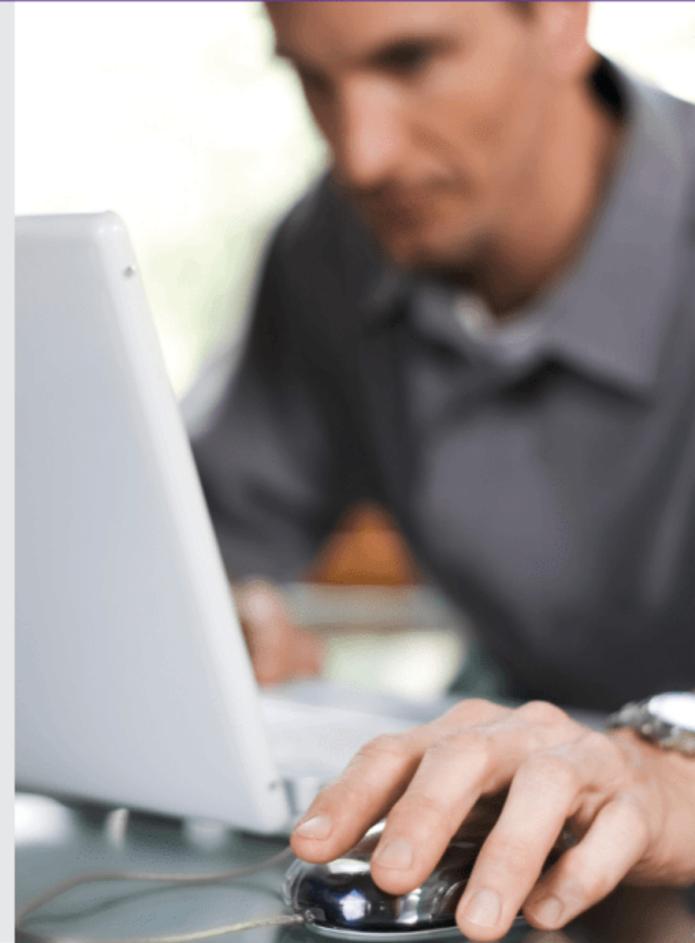
Patient Name: _____

Signature: _____ Date: _____

Personal Representative's Name (if applicable): _____

Personal Representative's Authority (e.g., parent, guardian, health care proxy):

Effective as of 11/01/2017.



BENEFITS OF MYCHART

- View your test and lab results
- Access your medical records, medications, immunizations, and more
- Schedule appointments
- Request prescription refills
- Send secure messages to your doctor's office
- Access your billing statements and make payments

SET UP YOUR ACCOUNT

Visit mychart.nyulmc.org and click **Sign Up Now** to create your username and password or download the app from iTunes.

MOBILE ACCESS



Once you have created your own username and password using a desktop or laptop computer, download the MyChart app on your Apple[®] or Android[™] device. Select NYU Langone Medical Center from the list of hospitals, and sign in.

SECURITY OF YOUR HEALTH INFORMATION

MyChart is password-protected and encrypted. This means your information is safe and secure from unauthorized access.

QUESTIONS

If you have questions about using MyChart, please call 866.262.6458.

Adult MyChart at NYU Langone Proxy Access Request and Authorization Form

Requirements and Procedures

- Proxy access to the MyChart at NYU Langone record of an adult may be granted by the patient or his/her legal representative.
- Both the person requesting access and the patient or his/her legal representative must sign this form.
- The proxy must have his/her own MyChart at NYU Langone account because the patient's chart will be accessed through the proxy's MyChart at NYU Langone record.

I understand that:

- MyChart at NYU Langone is intended as a secure online source of confidential medical information.
- **MyChart at NYU Langone is not to be used in an emergency.**
- Use of MyChart at NYU Langone is voluntary and I am not required to authorize proxy access.
- I must select a confidential password to maintain my password securely and change my password if I believe it may have been compromised in any way.
- If I share my MyChart at NYU Langone ID and password with another person, that person may be able to view my or my child's health information, as well as information about any adult who has authorized me as a MyChart at NYU Langone proxy.
- If I have proxy access, I must log in to my own MyChart at NYU Langone account and click on "View Other Records" to access another patient's record.
- MyChart at NYU Langone contains selected, limited medical information from a patient's medical record and is not the complete medical record.
- My activities within MyChart at NYU Langone may be tracked by computer audit and entries I make may become part of the medical record.
- Access to MyChart at NYU Langone is provided by NYU Langone Medical Center as a convenience to its patients and that NYU Langone Medical Center has the right to deactivate access at any time for any reason.

Completing this form will establish a MyChart at NYU Langone record for the patient and proxy. Return completed forms to your provider's office or to _____.

If you already have a MyChart at NYU Langone account, you will receive a MyChart at NYU Langone message when access to the additional patient's record is available, typically 5 to 7 business days after completed request and authorization form is received.

PROXY: I am requesting access to the medical information available on MyChart at NYU Langone for the patient named below and agree to abide by the above terms and conditions of MyChart at NYU Langone and all other terms and condition viewable online within MyChart at NYU Langone.

Name: _____ Date of Birth: _____ Email: _____

Address/Phone #: _____ / _____

_____/_____/_____

Proxy Signature Relationship to Patient Date

PATIENT OR PATIENT REPRESENTATIVE: I acknowledge that I have read and understand this Request and Authorization Form. I agree to its terms and choose to designate the person named above as my MyChart at NYU Langone Proxy, thereby allowing my proxy to access my MyChart at NYU Langone medical record.

Name: _____ Date of Birth: _____ Email: _____

Address/Phone #: _____ / _____

_____/_____/_____

Patient or Representative Signature Relationship to Patient Date



Pharmacy Information

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions. In addition, when you run out of refills on your medication, the pharmacist can now electronically send renewal requests to this office for approval.

**Note: Controlled medications are not eligible for e-prescribing.

Please complete the information below if you are interested in e-prescribing.

Patient Name: _____

Preferred Pharmacy	
Name of Pharmacy:	_____
Address:	_____
City:	_____
State:	_____
Zip Code:	_____
Phone Number:	_____
Fax Number:	_____

Alternate Pharmacy	
Name of Pharmacy:	_____
Address:	_____
City:	_____
State:	_____
Zip Code:	_____
Phone Number:	_____
Fax Number:	_____

Laboratory Information

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to NYU laboratory.**

LabCorp	<input type="checkbox"/>
Quest Labs	<input type="checkbox"/>
NYU Lab	<input type="checkbox"/>
Other External Location	<input type="checkbox"/>

Please provide name of external location: _____



Hansjörg Wyss Department of Plastic Surgery
305 East 33rd Street
New York, NY 10016
Tel. 212-263-3030 Fax 212-263-8492

Patient Name: _____

Date of Birth: _____

Consent for Diagnostic & Treatment Photographs

I understand that photographs may be taken in connection with consultation, diagnostic testing, surgical procedures and treatments by the physicians of NYU Plastic Surgery, Drs. Daniel Ceradini, Roberto Flores, Alexes Hazen, Jamie Levine, Eduardo Rodriguez, Pierre Saadeh, Sheel Sharma, David Staffenberg, Vishal Thanik, and Barry Zide or the Nurse Practitioners Amanda Young, Kimberly Morrone, Whitney Saia and Nicole Sweeney. I understand that failure to consent to these photographs will give NYU Plastic Surgery the right to decline my treatment.

Print Patient/Guardian Name

Relationship to Patient

Patient/Guardian Signature

Date

Email / Call Consent

Join our online newsletter to receive announcements, news and learn about exciting offers at NYU Plastic Surgery and The Institute of Reconstructive Plastic Surgery.

To join, please provide us with your:
(Please Print)

Name: _____

Email Address: _____

Protecting your privacy is important to NYUPS and the IRPS. We strive to keep your personal information confidential. We will never share your information.

If you wish to be called with our exciting offers please provide the best number to call you.

Telephone Number: _____

[] By checking this box, you agree we can leave a message at the number provided about our offers.

Best time to call: [] 8-10am [] 12pm - 2pm [] 4pm-6pm

To unsubscribe from our emailing or call list, please send an email to NYUPlasticSurgery@nyumc.org with the words "Unsubscribe Me" on the subject line.

Date: _____ Signature: _____