

# Oleh Slupchynskyj, MD

## PATIENT INFORMATION

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male Female SSN: \_\_\_\_\_ Marital Status: M S W D

Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_ ext. \_\_\_\_\_ Phone (C): \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Did another physician **refer** you to Dr. Slupchynskyj? YES NO Referring Physician: \_\_\_\_\_

If you were not referred by a physician, please tell us how you did hear about us: \_\_\_\_\_

Email: \_\_\_\_\_

Drivers License number (if a minor, please use guarantor) Issuing State: \_\_\_\_\_ Number: \_\_\_\_\_

## GUARANTOR INFORMATION

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

**How patient is related to me: (circle one) self spouse my child other: \_\_\_\_\_**

Date of Birth: \_\_\_\_\_ Gender: Male Female SSN: \_\_\_\_\_ Marital Status: M S W D

Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_ ext. \_\_\_\_\_ Phone (C): \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

## INSURANCE INFORMATION - Primary

Insurance: \_\_\_\_\_ **How patient is related to me: self spouse my child other: \_\_\_\_\_**

Policy holder last name: \_\_\_\_\_ Policy holder first name: \_\_\_\_\_

Policy holder Date of Birth: \_\_\_\_\_ Policy holder employer: \_\_\_\_\_

Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_ ext. \_\_\_\_\_ Phone (C): \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy holder SSN: \_\_\_\_\_ Insurance Group number: \_\_\_\_\_ Policy number: \_\_\_\_\_

# Aesthetic Facial Surgery Center of New York

Patient Name: \_\_\_\_\_

## Acknowledgment and Consent

I understand that Aesthetic Facial Surgery Center of New York (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

**By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.**

|                        |             |
|------------------------|-------------|
| By: _____<br>(Patient) | Date: _____ |
|------------------------|-------------|

-OR-

|   |             |
|---|-------------|
| By: _____<br>(Patient representative)           | Date: _____ |
| Description of Representative's Authority _____ |             |

# Aesthetic Facial Surgery Center of New York

Patient Name: \_\_\_\_\_

## STATEMENT OF FINANCIAL RESPONSIBILITY

### PAYMENT OPTIONS

We accept Visa, MasterCard and cash.

### INSURANCE

**Dr. Slupchynskij does not participate with any insurance plan.** If we bill your insurance you **MUST have out-of-network benefits.** We will verify this information prior to your appointment. Please fax the front and back of your insurance card to our office prior to your first visit. Fax number: (212) 628-4083. I understand that it is my responsibility to fulfill any preadmission or second opinion requirements contained in my insurance policy. I realize that failure to do so may result in significant reduction in my insurance benefits.

**Please read carefully:** your insurance company might not fully reimburse you for hospital admissions or surgical procedures!

### ACCOUNT BALANCES

Every four weeks, a statement will be sent out with a message that explains the status of your account. Once your insurance pays, the next statement will request that you pay any remaining balance. Any balance left after your insurance has paid must be remitted within 30 days or each month an interest charge will be applied to your account of \$10 or 10% whichever is greater.

**After 60 days, we will no longer pursue your insurance company; all balances will be due in full from the patient.**

We reserve the right to send all accounts with balances over 60 days old to an outside collection agency. All accounts sent to collections will be charged a \$20.00 processing fee and any additional fees associated. You may be responsible for all reasonable collections and attorney costs incurred.

## AUTHORIZATIONS

I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I am signing this as a lifetime authorization Oleh Slupchynskij, MD to bill my insurance, Medicare, Medicaid and/or Medigap for these services; and to accept assignment of the benefits for Medicare, Medicaid, and/or Medigap. I authorize Oleh Slupchynskij, MD to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Oleh Slupchynskij, MD determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Oleh Slupchynskij, MD.

I understand that I am responsible for any balance due for professional services in excess of the benefits provided by my policy. I agree to pay for services not covered by my insurance policy. I understand I am responsible for obtaining any prior authorizations required by my insurance policy. I understand that in the event of collection action, I am responsible for any legal fees incurred.

I, the undersigned, have read the above and realize that all medical and surgical charges incurred by myself, or my dependants for services rendered by Oleh Slupchynskij, MD are my financial responsibility. All court fees, attorney fees, or other fees necessary to collect this account are payable by me.

## MEDICARE ASSIGNMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Aesthetic Facial Surgery Center of New York

## MEDICAL HISTORY

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### ALLERGIES

List all Allergies:

Describe your Reaction:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### CURRENT MEDICATIONS

Drug Name (brand/generic)

Dosage:

Schedule (frequency)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### PAST MEDICAL HISTORY

Have you ever had any of the following? Please circle all that apply

Anemia

Depression

Heart Disease

Shortness of Breath

Ankle Swelling

Diabetes

Heart Attack

Stroke

Bleeding Tendency

Dizziness

Hearing Problems

Thrombophlebitis

Cancer

Emphysema

High Blood Pressure

Ulcer

Chest Pain

Endocrine Problem

HIV (AIDs)

Vision Problems

Coughing Blood

such as thyroid

Pneumonia

| Illnesses | Date | Hospitalizations | Date | Injuries | Date | List all surgeries | Date |
|-----------|------|------------------|------|----------|------|--------------------|------|
|           |      |                  |      |          |      |                    |      |
|           |      |                  |      |          |      |                    |      |
|           |      |                  |      |          |      |                    |      |

### FAMILY HISTORY

| Relative   | Current Health | Age if Living | Age of Death | Cause of Death | Known Illnesses |
|------------|----------------|---------------|--------------|----------------|-----------------|
| Mother     |                |               |              |                |                 |
| Father     |                |               |              |                |                 |
| Brother(s) |                |               |              |                |                 |
| Sister(s)  |                |               |              |                |                 |

### HISTORY OF TOBACCO

# Aesthetic Facial Surgery Center of New York

Have you ever smoked? Yes No If yes, when? \_\_\_\_\_

Are you currently smoking? Yes No

Cigarettes \_\_\_\_\_ How many a day? \_\_\_\_\_ How many years? \_\_\_\_\_

Cigars \_\_\_\_\_ How many a day? \_\_\_\_\_ How many years? \_\_\_\_\_

Smokeless tobacco \_\_\_\_\_ How many a day? \_\_\_\_\_ How many years? \_\_\_\_\_

## HISTORY OF ALCOHOL

Do you drink alcohol? Yes No Recovery Alcoholic? Yes No Probably an Alcoholic? Yes No

Drink Alcohol \_\_\_\_\_ How many times a week? \_\_\_\_\_ OR times a month? \_\_\_\_\_

Cigars \_\_\_\_\_ How many a day? \_\_\_\_\_ How many years? \_\_\_\_\_

Preferred beverage? \_\_\_\_\_

## HISTORY OF RECREATIONAL DRUGS

Have you ever used illicit drugs? Yes No

Do you currently use illicit drugs? Yes No Drug(s) of choice \_\_\_\_\_

## COSMETIC HISTORY

Have you had (Restylane, Collagen, etc.) injections? \_\_\_\_\_ Last injection? \_\_\_\_\_

Have you had Botox injections? \_\_\_\_\_ Last injection? \_\_\_\_\_

Have you ever been pregnant? YES NO How many times? \_\_\_\_\_ Live births? \_\_\_\_\_

Are you currently pregnant? YES NO Are you planning more children? YES NO

Have you used Accutane? \_\_\_\_\_ For how long? \_\_\_\_\_

Have you recently had facial surgery? \_\_\_\_\_ Type and date: \_\_\_\_\_

Have you ever had laser resurfacing? \_\_\_\_\_ Type and date: \_\_\_\_\_

Have you had a bad reaction to local or general anesthesia? YES NO If yes, explain \_\_\_\_\_

Have you had significant emotional problems? YES NO If yes, explain \_\_\_\_\_

Have you had psychiatric care? YES NO If yes, explain \_\_\_\_\_

Have you seen other plastic surgeons about this same problem? YES NO If yes, explain \_\_\_\_\_

Do you have high blood pressure? YES NO If yes, explain \_\_\_\_\_

Do you bleed easily from cuts or surgery? YES NO If yes, explain \_\_\_\_\_

Do you form large scars or keloids? YES NO If yes, explain \_\_\_\_\_

Do you have frequent infections or boils? YES NO If yes, explain \_\_\_\_\_

I hereby consent to be examined and treated by Oleh Slupchynskij, MD and that the above information is correct.

**SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

DATE