PATIENT INFORMATION SHEET **DATE:**

Patient Name:_____ DOB:_____

Address: _____Town:_____Zip Code_____

Telephone: _____Cell#:_____SS#:_____

Patient's Employer:_____Work Phone#:_____

Name of Spouse:_____DOB:_____

Telephone #: _____SS#:_____Email:_____

EMERGENCY CONTACT

Name:_____ Telephone #:_____

Primary Care Physician:_____ Telephone#:_____

Name of Referring Physician:_____Telephone#:_____

……

If patient is a minor, Please Complete:

Father's Name:_____DOB:_____SS#:_____

Father's Employer:_____Work #:_____

Mother's Name:_____DOB:_____SS#:_____

Mother's Employer:_____Work #:_____

……

INSURANCE: **(**Please circle) MEDICAL AUTOMOBILE WORKERS COMP SELF PAY

Co. Name:_____ Policy #:_____

Subscriber:_____ DOB:_____

Address:_____ Phone #:_____

Secondary Ins.:_____ Policy#:_____

Subscriber:_____ DOB:_____

Address:_____ Phone#:_____

Adjustor/ Contact Name_____

……...

Attorney's Name:_____Telephone #:_____

If there is a suit files in this case, I agree to have Dr. Samra paid from the proceeds of that settlement should any balance on my account exist.

****

Please let us know how you referred to our office: (Circle One)

Website **Facebook** **Pinterest** **Google** **Email Message** **RealSelf.com**

Community Magazine **Meridian Healthviews** **Patient** **Doctor/ Which Doctor?**

Other/ Please explain:

****

I authorize the release of any medical information necessary to process my claim. I hereby authorize payment directly to Dr. Said A. Samra of group insurance benefit otherwise payable to me. I understand I'm financially responsible to the doctor for charges not covered by this assignment. I understand the balances for which I am responsible are subject to interest charges if payments are delinquent (1.5% per month).

Cost of Collection: If this account becomes delinquent, I may be responsible for additional billing costs; and if this account is assigned to a collection agency or attorney for collection, I agree to the addition of a collection fee of $50.00 or 35% of the balance owed, whichever is greater. I acknowledge a fee of $40.00 or the actual bank charge, whichever is greater, for any returned check.

Authorization for Disclosure of Information:

I authorize Dr.Samra to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr.Samra's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

A photocopy of this form shall be considered as valid as the original.

Patient/ Subsciber Signature_____Date_____PI-1/16

THE SAMRA GROUP, LLC
COSMETIC & RECONSTRUCTIVE SURGERY

733 North Beers Street
Suite U1
Holmdel, NJ 07733
(732) 739-2100

300 Perrine Road
Suite 333
Old Bridge, NJ 08857

PATIENT RESPONSIBILITY FOR OUT-OF-NETWORK PROVIDER WAIVER

I _____understand and acknowledge that I have been advised by The Samra Group that my insurance carrier is out-of-network. I further understand and acknowledge that I will be financially responsible for any fees or charges that are not covered by my insurance carrier. I was informed that it is my responsibility to verify network providers with my carrier. The Samra group will make every effort possible to minimize my out of pocket expense.
Patient/ Guardian Signature:_____Date:_____

APPOINTMENT CANCELLATION / NO SHOW POLICY

We charge a fee for missed appointments. It is not our intent to inconvenience any of our patients, but in order to run our office efficiently as possible we need to utilize cancelled appointments for other patients. Please read our cancellation policy carefully.

We ask that you give the office a minimum of 24 hour notice if you are unable to keep your office appointment. Please DO NOT cancel your appointment with our after hours service. You MUST speak directly with someone in our office. There will be a $75.00 charge for missed or no show office appointments.

ELECTIVE SURGERY CANCELLATION POLICY

There will be a fee of 10% of the charges for any elective surgical procedure cancelled by the patient less than **ONE WEEK** from the scheduled date, and 20% fee for cancellation less than **TWO BUSINESS DAYS** and 50% fee if cancelled **THE DAY OF SURGERY**.

Patient/ Guardian Signature:_____Date:_____

Witness by:_____ Date:_____
Department Staff Signature

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Consent for the use and disclosure of Protected Health Information

With my consent, The Samra Group may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to The Samra's Group Notice of Privacy Practices for a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Samra Group reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: The Samra Group Privacy Officer 733 North Beers Street, Suite U1 Holmdel NJ 07733.

With my consent, The Samra Group may speak with fellow staff members, fax, email, text, call my home, cellular or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others whether it may be by secure or non-secure means.

With my consent, The Samra Group may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statement.

I have the right to request The Samra Group restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Samra Group's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Samra Group may decline to provide treatment.

Patient Protected Health Information Disclosure Authorization

Please print.

1. Name:_____

   Relationship:_____

2. Name:_____

   Relationship:_____

3. Name:_____

   Relationship:_____

Listed above are the names of relatives and/or friends with whom the physicians and staff of The Samra Group have my permission to disclose and discuss my protected health information.
Information includes my past, present, or future physical or mental health condition and related healthcare services. I understand that this authorization will remain in effect until I make a written request to rescind this permission.

Date:___Patient's Name:_____

Signature of Patient/ Legal Guardian:_____

PI3/16

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DISCLOSURE OF FINANCIAL INTEREST

Public law of the State of New Jersey and rules of the Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service.

Accordingly, take notice that practitioners in this office do have a financial interest in the following health care service (s) to which patients is referred:

The Ambulatory Surgery Center of Old Bridge
Jeunesse Medical Spa

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

FINANCIAL OBLIGATION
PLEASE READ THIS NOTICE CAREFULLY

Dear Patient,

We will submit a claim directly to your insurance carrier for services rendered by Samra Plastic & Reconstructive Surgery. However, if we are not in-network your carrier will make payment directly to you within thirty (30) days. This money is not yours to keep but rather is payment for the doctor's services.

DO NOT CASH THE INSURANCE CHECK

Please endorse the back of the check and write "Payable to The Samra Group" below your signature. As soon as you receive the insurance check, you must forward it to:

SAMRA PLASTIC & RECONSTRUCTIVE SURGERY
733 NO. BEERS ST., SUITE U1
HOLMDEL NJ 07733

FORWARD A COPY OF THE EXPLANATION OF BENEFITS

All payments will be accompanied by an explanation of benefits (EOB) which explains how your insurance carrier arrived at the amount of money it issued. Failure to provide this copy to our office may impact the balance we consider to be your obligation.

PLEASE COOPERATE WITH OUR BILLING STAFF.

Our billing staff is here to help you. At times, they may request you to contact your insurance carrier to reprocess the claim for prompt payment and/or reconsideration of the final payment.

I have read the above and clearly understand my responsibility.

Please sign below to acknowledge this form.

Thank you.

_____
Date

_____ _____Print Name
Signature

PI4.16

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PHOTO CONSENT

PATIENT NAME:_____

In connection with the medical advice and/or surgical services which I am receiving from my physician, Dr._____, I consent that photographs and/or video may be taken of me, or parts of my body. The photographs and/or video shall be used for medical records and if, in the judgment of my physician (s), medical research, education or if science will be benefited by their use. Such photographs, videos and information relating to my case may be published and republished either separately or in connection with each other, in professional journals or medical books or used for any other purposes which my physician may deem proper in the interest of medical education, knowledge, or research. Additionally, I consent for these photographs and/or video be used by my physician(s) on their website, presentations or other venues that they may see fit. It is specifically understood that in any such publications or use, I shall not be identified by name.

_____ _____
PATIENT PRINT DATE

_____ _____
PATIENT SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

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Samra Plastic and Reconstructive Surgery, LLC
Patient Financial Obligation and Agreement

I have read this Samra Plastic and Reconstructive Surgery Patient Financial Obligation and agree to the terms.

I, _____ agree to allow Samra Plastic and Reconstructive Surgery to bill the below named credit card for any outstanding balance not covered by my Insurance Carrier due to coinsurance, deductible and/or co-pay.

I understand that my credit card number will be treated with extreme confidentially in accordance with HIPPA (Health Insurance Portability and Accountability Act) and PCI (Payment Card Industry) compliant guidelines and the card will not be used for any other purposes.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date

_____
Card Holder's Address City Zip Code

_____
Phone Number

MC VISA AMEX DISCOVER

_____ _____
Credit Card Number Exp. Date

_____ _____
Name on Credit Card SCV Code