Advanced Oral and Facial Reconstructive Surgery

Gilbert T. Selkin, MD, DMD

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P: 972-914-9869 F: 469-609-2962

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Previous Name (maiden, etc.): _____ Preferred Name: _____

Date of Birth: _____ /_____ /_____ Sex: ☐ Male ☐ Female SSN: _____ - _____ - _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Parent/Legal Guardian (if patient is a minor): _____

Date of Birth: _____ /_____ /_____ Relationship: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____ - _____ Secondary Phone: (_____) _____ - _____
☐ Home ☐ Cell ☐ Work ☐ Home ☐ Cell ☐ Work

Email: _____

Race: ☐ African American ☐ Asian ☐ Asian Indian ☐ Caucasian/White ☐ Native American ☐ Other ☐ Declined to Specify

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unreported/Refused

Primary Care Physician: _____ Phone: (_____) _____ - _____

Dentist: _____ Phone: (_____) _____ - _____

Adult Emergency Contact: _____ Phone: (_____) _____ - _____

Relationship: _____

INSURANCE INFORMATION

Primary/Medical Insurance Co: _____ Member ID: _____
Policy Holder: ☐ Patient ☐ Legal Guardian (listed above)
☐ Other (fill out) - Full Name: _____ Relationship: _____
Date of Birth: _____ /_____ /_____ SSN: _____ - _____ - _____

Secondary/Dental Insurance Co: _____ Member ID: _____
Policy Holder: ☐ Patient ☐ Legal Guardian (listed above)
☐ Other (fill out) - Full Name: _____ Relationship: _____
Date of Birth: _____ /_____ /_____ SSN: _____ - _____ - _____

PHARMACY INFORMATION (local, cannot be mail-order)

Name: _____ Phone: (_____) _____ - _____

Address (or intersection): _____ City: _____

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Patients, or legal guardians of patients under the age of eighteen, MUST sign and date all sections below before medical or dental care can be rendered.

FINANCIAL POLICY

Payment is required in full for all services at the time they are rendered. For patients with an insurance plan we participate with, the estimated patient payment responsibility (applicable co-payments, deductibles, co-insurance, and fees for non-covered services) will be collected at the time services are rendered. We accept payment in the form of cash, money order, cashier's check, and credit card. For cash payments, the office does not break bills of denomination $50 or higher. Our office does not offer payment plans or accept personal checks.

A 24-hour notice is required to cancel or reschedule your consultation; otherwise, a $25.00 fee will be added to the account which must be paid prior to rescheduling. At the time of scheduling surgery, a non-refundable deposit of $150.00 (or your estimated patient payment responsibility in full, if less than $150.00) is required. A 24-hour notice is required to reschedule or cancel surgery; otherwise, the deposit is forfeit and will be applied towards our $150.00 cancellation fee. The forfeit deposit is not an account credit and will not be applied towards any surgery should you choose to reschedule.

By signing this policy, the patient/patient's legal guardian authorizes payment of insurance benefits directly to the doctor or dental group, otherwise payable to me. The patient/patient's legal guardian is financially responsible for prompt payment for the full balance of all accounts, in the event that the patient's insurance carrier or the insurance payor pays less than the actual bill for services. Refunds are only issued after all claims are finalized and at the patient's request. Unpaid balances are subject to transfer to a collections agency and an additional fee of $25.00.

If any services were performed in cooperation with a third-party provider (including but not limited to pathology, radiology, or surgical facility), the patient may receive a separate bill from the corresponding provider. Our office cannot quote services performed by a third party.

PATIENT ACKNOWLEDGEMENT: I have read and understand the financial policy statement above and agree to comply with the terms described therein. A copy of this agreement may be used in place of the original and remain valid unless revoked in writing.

Signature of Patient/Legal guardian: _____ Date: _____

ASSIGNMENT OF BENEFITS (AOB)

I, the patient/patient's legal guardian, hereby authorize Advanced Oral and Facial Reconstructive Surgery to release any medical or other information necessary to process insurance claims on my behalf and to obtain payment for medical or dental services rendered. I further authorize direct payment of insurance benefits to Advanced Oral and Facial Reconstructive Surgery for services provided to me or my dependents by their physicians or staff. A copy of this agreement may be used in place of the original and authorization will remain valid unless I revoke it in writing.

Signature of Patient/Legal guardian: _____ Date: _____

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CONSENT TO TREAT

I, the patient/patient's legal guardian, hereby give my voluntary and informed consent for evaluation, including but not limited to consultation and diagnostic X-rays, as deemed necessary by the provider for medical and dental care.

Signature of Patient/Legal guardian: _____ Date: _____

COMMUNICATION OF MEDICAL INFORMATION

I, the patient/patient's legal guardian, authorize the office to leave detailed messages for me by voicemail/email, including appointment confirmations, billing, test results, and diagnoses at the following contacts:

Primary Phone: (_____) _____ - _____ ☐ Home ☐ Cell ☐ Work

Secondary Phone: (_____) _____ - _____ ☐ Home ☐ Cell ☐ Work

Email: _____

Signature of Patient/Legal guardian: _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone other than the patient/patient's legal guardian without consent. I, patient/patient's legal guardian, authorize this facility to speak to the following family members or my personal representatives regarding:

☐ All medical information, including but not limited to: appointments, billing, test results, diagnoses, and procedures.

☐ Only the following type(s) of information: _____

The above information shall only be released to the following person(s):

1. Name: _____ Phone: (_____) _____ - _____
   Relationship to the patient: _____
2. Name: _____ Phone: (_____) _____ - _____
   Relationship to the patient: _____
3. Name: _____ Phone: (_____) _____ - _____
   Relationship to the patient: _____

Signature of Patient/Legal guardian: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES (HIPAA)

We are required by law to protect your health information and provide you with this Notice. It explains how we may use and disclose your medical information and outlines your rights regarding that information. We must follow the terms of this Notice and may update it at any time. Updated versions will be available at our office. You may also request a paper copy at any time.

We may use and share your health information without written authorization for purposes such as treatment, payment, and healthcare operations. For treatment, we may share information with other healthcare providers involved in your care. For payment, we may use your information to bill insurance or other third parties. For healthcare operations, we may use your information to evaluate and improve the quality of our services, conduct training, comply with licensing requirements, and perform administrative tasks. We may also share your information with family members or individuals involved in your care when appropriate or in emergency situations.

We are permitted and sometimes required by law to disclose your information in certain situations. These include public health activities, law enforcement purposes, reporting abuse or neglect, complying with court orders, fulfilling oversight obligations, and supporting national security. We may also disclose your health information to comply with workers' compensation laws or in the case of organ donation or coroners' requests. In all other cases, we will not share your information without obtaining your written authorization. You may revoke that authorization at any time in writing, unless we have already acted based on it.

You have several rights concerning your health information. You have the right to receive a copy of this Notice at any time. You may request to inspect or receive copies of your medical records in paper or electronic format. You may ask us to correct information you believe is incorrect or incomplete. You may request an accounting of certain disclosures we have made, and you may ask us to limit what we share, particularly if you paid for a service in full out-of-pocket and request that it not be shared with your insurer. You also have the right to request that we contact you using a specific method or at a specific location, and we will accommodate reasonable requests. In the event of a breach of your unsecured health information, we will notify you promptly with details and recommendations.

PATIENT ACKNOWLEDGEMENT: I have read and understand the Notice of Privacy Practices.

Signature of Patient/Legal guardian: _____ Date: _____