ADVANCED PLASTIC SURGERY CENTER

1635 N George Mason Drive STE 380
Arlington, VA 22205
Phone: 703.841.0399
Fax: 703.243.8737
www.advancedplasticsurgerycenter.com

PATIENT INFORMATION

Today's Date: ☐Mrs. ☐Mr. ☐Ms. ☐Miss ☐Dr.

Last Name: First Name: Middle: Nickname:

Birthdate: Age: Sex: ☐Female ☐Male

Address: City: State: Zip Code:

Cell Phone: Home Phone: Work Phone:

Email Address: Employer:

Marital Status: Spouse Name:

Responsible Party (if under 18): Relationship to Patient:

EMERGENCY CONTACT

Name: Relationship to Patient:

Phone Number:

APPOINTMENT INFORMATION

Referred by: Previous Patient? ☐Yes ☐No

Patient's Height: Patient's Weight:

Reason for today's consultation:

INSURANCE (NON-COSMETIC PATIENTS)

Subscriber Name: Relationship to Patient:

Insurance Company:

Subscriber ID: Subscriber D.O.B:

Group Name: Group #:

Insurance Address:

Insurance Phone Number:

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MEDICAL HISTORY

Primary Care Physician:	Phone Number:

Have you experienced any of the following: **(check yes if applicable)**

☐Abnormal blood pressure	☐Heart murmur	☐Rheumatic fever
☐Anemia/blood disorder	☐Heart palpitations	☐Skin disease
☐Anxiety/depression	☐Hepatitis (if yes, please circle: A, B, or C)	☐Sleep problems
☐Arthritis/joint pain	☐Hiatal hernia (reflux)	☐Stroke
☐Asthma	☐High cholesterol	☐Thyroid disease
☐Autoimmune disease	☐HIV/AIDS	☐Urinary infections
☐Blood transfusions	☐Jaundice	☐Varicose veins/phlebitis
☐Bowel disease	☐Kidney disease	☐Vascular disease
☐Cancer	☐Liver disease	☐Weight gain
☐Diabetes	☐Mental illness	☐Weight loss
☐Epilepsy/Neurological disease	☐Osteoporosis	☐Other:
☐Headaches	☐Peptic ulcer	

SOCIAL HISTORY

Smoker (if yes, # of years):	Smoking (Cig. /Day):	Street Drugs:
Alcohol (oz/week):	Coffee(Cups/Day):	Herbal Supplements:

Are you taking any medication, if so which ones?

Are you allergic to any medication, drugs, or local anesthetic?

PREVIOUS HISTORY

Please list any previous cosmetic procedures (surgical, injections, laser treatments, etc.):

Are there any physical conditions we should know about?

May we request medical records, if needed? ☐Yes ☐No

WOMEN (ONLY)

Are you pregnant? ☐Yes ☐No	Are you nursing? ☐Yes ☐No
Signed:	Date:

Relationship (if not patient):

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CANCELLATION POLICY

In an effort to provide our patients with the best possible care, we require advanced notice of 24 business hours to cancel or reschedule an appointment.

A fee of $70 will be charged to patients who cancel/reschedule less than 24 business hours before the scheduled time or fail to show up for an appointment.

As a courtesy to other patients, we reserve the right to reschedule your appointment if you are more than 15 minutes late. This will result in a $70 missed appointment fee.

A valid credit card is required at time of scheduling to hold your appointment.

Please print, sign and date below stating that you have read this policy even if Credit Card information is not completed at this time.

CREDIT CARD INFORMATION

Card Type ☐AMEX ☐Discover ☐Mastercard ☐Visa ☐Other______________________

Cardholder Name (as shown on card)____
Card Number____
Expiration Date______________________ Security Code________________________
Billing Address____

I,_________________________, authorize Advanced Plastic Surgery Center to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. I have read and agreed to the above statements.

Signature___________________________________ Date___________________________

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ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. Assignment of Benefits: I request that payment of authorized Medicare, Medicaid, insurance, or health plan benefits be made on my behalf to Talal Munasifi, MD, PC and/or James Economides, MD, for any services furnished to me by or in APSC. I authorize any holder of medical or other information about me to release to such payer or their agents any information needed to determine these benefits for related services. I agree that my insurance can be billed for Workers Compensation visits that are determined not payable by Workman's Compensation. I agree to pay for any charges not covered by any third-party payer. I understand that medical insurance policies are an arrangement between an insurance carrier and me. I understand that charges for some services may be more than what some insurance companies choose to call "usual and customary" and that unless I am covered by and in compliance with a health plan with which APSC has a participation agreement to provide covered services, I am responsible for all charges applied to my account. If a minor patient presented by someone other than the responsible party, the person who brought the minor will be accountable for charges incurred (except those covered by insurances).

Any member of my immediate family	☐Yes ☐No
Spouse Only	☐Yes ☐No
Referring Physician	☐Yes ☐No
Other (please specify)	

Patient Signature ____ Date ____

Responsible Party Signature (if not patient):____

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Pharmacy Information

Patient Name:________________________ Date:____________________

Pharmacy Name:____

Pharmacy Phone Number:_________________________________

Pharmacy Address:_______________________________________

____

Medication Allergies? _____________________________________

____

____

Advanced Plastic Surgery Center

1635 N GEORGE MASON DRIVE SUITE 380 | ARLINGTON VA, 22205 | (703) 841-0399

Written Financial Policy

Thank you for choosing Advanced Plastic Surgery Center. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash/check, Apple Pay, Visa®, MasterCard®, American Express® or Discover Card®
- Convenient Monthly Payment Options[1] from GreenSky Surgical Loans
  - No Interest if Paid in Full within 6 to 18 Months*
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - No Interest if Paid in Full within 6 Months*

For cosmetic procedures Advanced Plastic Surgery Center requires payment prior to your procedure. These terms will be provided to you in your quote prior to procedure.

Please note that our practice is not contracted with most health insurance plans, and all services rendered at Advanced Plastic surgery center will be considered out of network level if submitted to insurance. Patient are responsible for knowing their insurance policy. Our team can assist you with finding out your plan benefits. For patients with insurance we are happy to work with your carrier to maximize your benefit and provide you with the documentation you need to receive reimbursement for your procedure. If your health insurance plan is contracted with our office, we will file a claim on your behalf, however, you are responsible for any copayments, deductible, coinsurance and non-covered services at the time of your service. Any outstanding balances are due within thirty (30) days upon receipt.

Cancelation/ No Show fee

In effort to provide our patients with the best possible care, we require advanced notice of 24 business hours to cancel or reschedule an appointment. A fee of $70 will be charged to the credit card of file (or billed to your account) to patients who cancel/ reschedule less than 24 business hours or fail to show up for an appointment. As a courtesy to other patients, we reserve the right to reschedule your appointment if you are more than 15 minutes late. This will result in a $70 missed appointment fee.

No show/ late cancelation fees for procedures and/or surgery will be provided to you on your quote based on the proposed procedure(s).

A valid credit card is required at the time of scheduling to book your appointment.

Advanced Plastic Surgery Center charges $25 for returned checks.

*Subject to credit approval

Print Name: ________________________ Signature: ____________________ Date: ______________