NEW FACE NY

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NEW FACE NY

PATIENT INFORMATION

LAST NAME | **FIRST NAME**

FEMALE ☐ MALE ☐
MARITAL STATUS: ☐S ☐M ☐W ☐D

DATE OF BIRTH: / /

HOME ADDRESS:

CITY STATE ZIP

HOME # ( ) -
CELL # ( ) -

EMPLOYER:

WORK ADDRESS:

CITY STATE ZIP

WORK # ( ) -
EMAIL ADDRESS:

What is your preferred means of Contact ? ☐ Home ☐ Cell ☐ Email

Please give me appointment reminders and office updates with email ☐ YES

EMERGENCY CONTACT

NAME: RELATIONSHIP: TELL # ( ) -

PHYSICIAN INFORMATION

REFERRING PHYSICIAN:

SPECIALTY:
NAME
ADDRESS
TEL # ( ) -

OTHER PHYSICIANS:
SPECIALTY:
NAME
ADDRESS
TEL # ( ) -

PRIMARY CARE PHSYICIAN:

NAME
ADDRESS
TEL # ( ) -

SPECIALTY:
NAME
ADDRESS
TEL # ( ) -

INSURANCE INFORMATION

PRIMARY

POLICY #

SUBSCRIBER: ☐ SELF
SPECIALIST COPAY: $_____
EFFECTIVE DATE: / /
INSURANCE ADDRESS:

SECONDARY

POLICY #

OTHER ☐ RELATIONSHIP TO COVERED _____
NAME:
ADDRESS:

DOB: / /

AUTHORIZATIONS

I hereby assign to Richard Westreich MD any insurance or other third party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual agreement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that, in the event that services rendered are not covered by "insurance," I will accept

financial responsibility for all services provided to me. If benefits are not assigned to this practice, I will forward to the practice all insurance payments that I receive for services rendered to me.

SIGNATURE: DATE:

I authorize the release of any medical or personal information as is necessary to process this claim based upon the “HIPAA notice of Privacy Practices” information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary

SIGNATURE: DATE

New Patient Intake Questionnaire

Name:_____ Weight:___ Height:____

How were you referred to the office? (Please circle all that apply)

Google Search Friend _____ Physician _____ Other _____

Current Medical Survey

Are you currently experiencing any of the following symptoms? Please comment where necessary.

- General (Weight change, fatigue, fever) **NO** **YES** _____
- Nasal obstruction? (Please indicate side(s)) **NO** **YES** _____
- Post nasal drip or "runny nose" (Please indicate color of discharge) **NO** **YES** _____
- Headaches or facial pressure symptoms lasting more than a day (please provide location) **NO** **YES** _____
- Chest pain, palpitations, abnormal heart beat **NO** **YES** _____
- Asthma, cough, or shortness of breath **NO** **YES** _____
- Problems with bleeding or bruising **NO** **YES** _____
- Reflux, stomach pain, difficulty swallowing solid or liquid food **NO** **YES** _____
- Arthritis, joint swelling, muscle pain **NO** **YES** _____
- Skin rash or other skin lesion **NO** **YES** _____
- Isolated muscle weakness, or memory loss **NO** **YES** _____
- Double vision, blurry vision, or dry eyes **NO** **YES** _____
- Hearing loss, ear discharge, ear infection, wax **NO** **YES** _____
- Voice or Throat Problems **NO** **YES** _____
- Dental problems **NO** **YES** _____
- Do you currently use any illegal drugs **NO** **YES** _____

Past Medical History

Have you ever been diagnosed with any of the following disorders? Please comment when necessary.

- Heart disease **NO** **YES** _____
- Hypertension (high blood pressure) **NO** **YES** _____
- Emphysema or COPD **NO** **YES** _____
- Asthma **NO** **YES** _____
- Bleeding disorder **NO** **YES** _____
- Diabetes **NO** **YES** _____
- Thyroid disease **NO** **YES** _____
- Stroke or other neurological disorder **NO** **YES** _____
- Psychiatric disorder **NO** **YES** _____
- Kidney or bladder disease **NO** **YES** _____
- Immune disorder (HIV or Other) **NO** **YES** _____
- Cancer **NO** **YES** _____
- Sleep Apnea **NO** **YES** _____

Are you a current or past smoker? YES NO If past smoker, quit: _____
For women: Are you pregnant or currently nursing? YES NO

Allergies: Do you have any allergies to prescription medication?

NO YES _____

Please provide PHARMACY NAME/PHONE NUMBER/zip code:
So that we can electronically prescribe or call in any medications for you

_____

Medication History:

Please list all medications currently taking, including herbal or dietary supplements.
*We do **not** need information on the dose or frequency:*

_____ _____
_____ _____
_____ _____
_____ _____

Surgical History: Please list any Surgery under General Anesthesia.

If related to current problem, please provide the name of previous surgeon.

Surgery	Year

Surgery	Year

Are there any conditions or diseases related to your visit today that run in your family?
NO YES _____

Have you visited Dr. Westreich's website, www.newfaceny.com? YES NO
Have you seen Dr. Westreich's comments on www.realself.com? YES NO

Is there any additional information you would like the Dr. Westreich or his staff to know? _____

_____

Do you have any concerns for cosmetic appearance? If so, describe below:

_____

Would you like to learn about specific cosmetic services that are offered such as Botox, Fillers, Laser treatments, Elective Facial Surgery, or Aesthetician treatments (Facials, Peels, Dermabrasion, and skin care products)? YES NO

Signature of Patient:_____ Date____/____/____

FINANCIAL POLICY

Patient Name:_____

Please review our office policy regarding financial responsibility for care provided in our office.

Please initial the following:

_____1**. I am a patient with both cosmetic and medical needs therefore I consent for Dr. Westreich to bill pertinent visits and treatments to my insurance in addition to already agreed upon cosmetic fees. I may also be responsible for:**

- Copays: Please pay at the time of service. If billing is done later, then a handling fee may be applied
- Deductables and Coinsurance: Payment of deductibles or co-insurance may be required at the time of the visit. If these expenses are not collected up front, the outstanding balances is billed or collected from any deposits left for future services.
- Care considered "not medically necessary" or "cosmetic" by your insurance company.

Due to the prohibitive costs of billing for small balances, we ask that you keep a credit card on file with the office. As with all your personal and medical information, we will not release this information without your permission. We regret the need for this policy and hope that you understand the necessity.

I authorize Richard W. Westreich MD PLLC to charge my credit card for amounts not to exceed $_____.

Credit Card #:_____ Exp Date: _____ CV2: _____

Cardholder's Name:_____ Signature:_____

Patient responsibility

_____ I understand that it is my responsibility to know the terms of my insurance coverage and to monitor compliance with the limits of my plan. I understand that I will be responsible if services exceed the limits of my plan.

I have read and agree to the Financial Policy.

Signature:_____

Name: _____ Date:_____

Office Cancellation Policy

We are fortunate that the office has a high demand for patient appointments. Our office, as a policy, does not overbook and makes every attempt to create a schedule which will remain, in most instances, on time. On order to ensure that every patient has fair access to schedule timely appointment, we have adopted the following policy towards last minute cancellations and no shows.

Office Visit

We expect our patients to inform us in a timely manner of changes to their schedule. While your personal reasons may vary, the ultimate result of a late cancellation or no show is time that another patient was not given for their personal health needs.

For non-emergent circumstances, **we expect 2 business day notice of cancellation for routine appointments**. If compelling issues are present, please let the office know.
Failure to cancel your appointment in a timely manner will result in the following payment prior to rescheduling:

$50 late cancellation fee
$100 no-show fee

Office Procedures

Office based Procedures require a large block of time in order to be performed. Office procedures include but are not limited to Mohs closures, ear lobe repair, scar revisions, micro-needling, exilis, Fractora, chemical peels, and facials.
The office reserves the right to require a deposit for any scheduled procedure.

We expect 1 week notice of cancellation for all in office procedures. If compelling reasons are present, please let the office know. Failure to cancel your procedure appointment in a timely manner will require the loss of your deposit.

Rescheduling is not an exception to this policy.

Thank you in advance for your cooperation in this matter.

Signature_____ Print_____

Date_____

SURGERY CANCELLATION POLICY

My Staff and I understand the great amount of trust that is given when choosing NewFace NY for your surgery. Often times planning for a specific timeline can take some preparation which is why we have created a RISK FREE deposit policy to encourage patients to take the time they need in making this big decision while knowing they can reserve their favorable date in advance. That being said, we also ask for similar courtesies.

Surgery Deposits taken at the time of consultation are refundable to the patient with 4 weeks notice of any cancellation or date change.

On or Before_____.

Surgery Deposits taken over the phone or after the consultation date are NOT refundable but are transferrable to a new surgical date with 4 weeks notice.

A surgery deposit is taken in the amount of $1,000 up to 20% of the surgical fee. Consultation fees are not refundable and would be subtracted from any deposit given if surgery is cancelled.

Please note that Cancellations with less than 2 week notices result in a penalty of 50% of the full surgical fee.

The cost of implants will be subtracted from any refund.

Thank you in advance for your cooperation in this matter.

Signature_____ Print_____

Date_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

Please select one:

☐ I have received, read, and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

☐ I decline to receive a new copy of the Notice of Privacy Practices, as I have previously received it.

I understand that this organization has a right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations.

I also understand that you are not required to agree with these requested restrictions. However, if you do agree then you are bound to abide by such restrictions.

I designate other individuals, who may be contacted about my private health information:

_____

_____ _____

NAME SIGNATURE

_____ _____

RELATIONSHIP (if not patient) DATE