PATIENT INFORMATION This info is requested so that we can keep your records up to date and correct.

Last Name:______________________________First Name:______________________________Middle:_______

Date of Birth:_______/______/_______ Age:_______ Social Security#:__________________________

Sex: M_______F______Other______

Marital Status: Married____Single____Divorced____Separated___Widowed____

Address:________________________________ Apt/Floor:_____________ City:___________________________

State:___________ Zip:_____________ Email:____

Cell #:____________________________Home #:__________________________Work #:__________________________

Can we text you appointment reminders on your cell #? Yes_______No________

Preferred Method of Contact: Cell #______Home #______ Work #______

Do you grant permission for another person to be knowledgeable of your appointments? Yes______No______

With whom?____

EMERGENCY CONTACT:

Name:____________________________Relationship:__________________________Phone#:______________________

INSURANCE INFORMATION:

Primary Insurance Company:____ID#_______________________________

Policy Holder's Name:____________________Employer:_________________________ Policy Holder's DOB:___/___/___

Secondary Insurance Company:______________________________________ID#_______________________________

Policy Holder's Name:____________________Employer:________________________Policy Holder's DOB: ___/___/___

I hereby assign the policy rights and benefits to the doctor, and authorize direct payment for professional services rendered. I further authorize the attending doctor to release any information concerning my examination or treatment to my insurance company or any other physicians and medical facilities.

I agree to be personally responsible for any unpaid balance or co-payment to the doctor. If my cosmetic consult is deemed medically necessary, and I request that my claim be submitted to insurance, I agree to be billed for the office visit and services. If I receive any payments from my insurance company in the mail, I will sign them directly over to the doctor.

X____ **Date:**_________________________________

Patient Signature

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Aesthetic & Reconstructive Surgeons, LLC and Richard Winters MD, Stephanie Cohen MD, Janet Yueh MD (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.
In the event the insurance carrier responsible for making medical payments to Aesthetic & Reconstructive Surgeons, LLC and Richard Winters, MD, Stephanie Cohen MD, Janet Yueh MD for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including the Law Offices of Cohen and Howard) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation: 1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees. 2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit
information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA. 3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be
provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents. 4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan. 5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.
I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third- party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.
This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers. I acknowledge receipt as of the date set forth below of a copy of the Practice's 'Notice of Privacy Practices',in which a further description of these anticipated uses and disclosures of my health information appear.

Patient Name: ____________________________ **Date:**________________________

Patient Signature:x_______________________

NAME:____

PAST MEDICAL ILLNESS:____

____

____

____

LAST MENSTRUAL PERIOD:__________________________________

 # OF CHILDREN:____

 # OF PREGNANCIES:____

PAST SURGERIES:____

____

PRESENT MEDICATIONS:____

____

____

HISTORY OF SMOKING:_______________________________**ALCOHOL:**____________________________

NAMES OF OTHER PHYSICIANS:____

____

____

____

ALLERGIES:____

____

____

PHYSICAL CONDITION
(exercise):____

____

____

HEIGHT:___________________________________**WEIGHT:**___________________________________

I, ___________________________________(print first and last name) was informed on

____________________________________ (date) that Aesthetic & Reconstructive Surgeons, LLC does not participate with my insurance plan and I will be using my out-of-network benefits. I understand that I am responsible for any balances.

Patient Signature:X____

Informed Consent

Telemedicine

©2020 American Society of Plastic Surgeons®. Purchasers of the *Informed Consent Resource* are given a limited license to modify documents contained herein and reproduce the modified version for use in the Purchaser's own practice only. All other rights are reserved by the American Society of Plastic Surgeons®. Purchasers may not sell or allow any other party to use any version of the *Informed Consent Resource,* any of the documents contained herein, or any modified version of such documents. Refer to you state laws regarding telemedicine/telehealth rules.

INSTRUCTIONS

This document explains the purpose of telemedicine – also known as “telehealth” and referred herein, collectively, as “telemedicine” – and outlines the benefits and risks of telemedicine.

It is important that you read the whole document carefully. Please initial each page. Doing so means you have read the page. Signing the consent agreement means that you agree to a telemedicine session with your doctor or one of the doctor’s assistants (i.e. nurse practitioner, physician assistant, etc.).

GENERAL INFORMATION

Telemedicine is the distribution of health-related services and information via electronic and telecommunication technologies, such as computers and mobile devices, to access and manage health care services remotely. Telemedicine may include technologies you use from home or that your doctor uses to improve or support health care services. Telemedicine allows out-of-office patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions. Examples of telemedicine include videoconferencing, teleconferencing, transmission of images, ehealth including patient portals, and remote monitoring of vital signs.

ALTERNATIVE METHODS OF MEDICAL CARE BESIDES TELEMEDICINE

In-person care is an alternative method of medical care to telemedicine.

BENEFITS OF TELEMEDICINE

The benefits of telemedicine include the following:

- Make health care accessible to people who live in rural or isolated communities.
- Provide long distance clinical care.
- Make services more readily available or convenient for people with limited mobility, time or transportation options.
- Obtain expertise of specialists.
- Improve communication and coordination of care among members of a health care team and patient.
- Provide support for self-management of health care.
- Quick and efficient medical evaluation and management.

RISKS OF TELEMEDICINE

As with any medical care options, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and assistant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- Security protocols could fail, causing a potential breach of privacy and/or inadvertent disclosure of personal identifying information and/or protected health information;
- Lack of access to complete medical records may result in adverse drug interactions, allergic reactions or other judgment errors;
- Overuse of medical care;
- Unnecessary or overlapping care.

 ©2020 American Society of Plastic Surgeons®
This form is for reference purposes only. It is a general guideline and not a statement of standard of care. Rather, this form should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual states. The American Society of Plastic Surgeons® does not authorize the use of these documents for purposes of any research or study. The ASPS does not certify that this form, or any modified version of this form, meets the requirements to obtain informed consent for this procedure in the jurisdiction of your practice.

CONSENT FOR THE USE OF TELEMEDICINE

1. I understand that the purpose of telemedicine is to provide health care services.
2. I permit my doctor and the doctor's assistants to use telemedicine in my care.
3. I understand that telemedicine means using phone and/or video to communicate with my health care team instead of seeing my team in person (face-to-face).
4. I understand that reasonable efforts will be made to protect my privacy, though there may be risk of inadvertent disclosure of my personal identifying information and/or protected health information.
5. I understand that I can ask questions and discontinue the use of telemedicine at any time I choose.
6. I understand that telemedicine does not replace other types of medical assessment and care. If I am not improving and have serious health concerns, I will seek immediate medical attention at an emergency facility.
7. ALL OF MY QUESTIONS REGARDING TELEMEDICINE WERE ANSWERED, AND THE FOLLOWING WAS EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
   a. THE CONCEPT OF TELEMEDICINE
   b. RISKS AND BENEFITS OF THE USE OF TELEMEDICINE
   c. ALTERNATIVE METHODS OF MEDICAL CARE

I CONSENT TO THE USE OF TELEMEDICINE IN MY MEDICAL CARE AND THE ITEMS THAT ARE LISTED ABOVE (1-7). I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS.

____

Patient or Person Authorized to Sign for Patient Date/Time

Witness ____Date/Time____

I have been offered a copy of this consent form (patient's initials) _______

 ©2020 American Society of Plastic Su