Farrell Plastic Surgery & Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center

PATIENT INFORMATION – Please Print

Patient's Last Name		First		M.I.	
Age	Date of Birth □ M □ F	Street Address			Apt. #
City	State	Zip Code	Social Security #		Marital Status
Home Phone	Work Phone	Cell Phone	E-Mail Address		
Patient's Occupation	Employer's Name	Address			
Person to Notify in case of an emergency				Phone #	
Referred By	Address				
Family Physician	Address				

FINANCIAL RESPONSIBILITY

Relationship to Patient	Last Name	First	M.I.	SS #	Date of Birth
Street Address	City	State	Zip Code		
Home Phone	Work Phone	Employer's Name and Address,* **Employer Paid Deductible Yes/No**			

INSURANCE – Please present your insurance card to the receptionist

Insurance Company Name & Address		
Identification #	Group	Effective Date
Policy Holders Name and Address		Date of Birth

SECONDARY INSURANCE – Please present your insurance card to the receptionist

Insurance Company Name & Address		
Identification #	Group	Effective Date
Policy Holders Name and Address		Date of Birth

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and/or family physician and insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by Farrell Plastic Surgery & Laser Center, P.C. whether or not paid by said insurance.
I agree to pay all reasonable attorney fees and collection cost in the event of default of payment of my charges.
I authorize and request that insurance payments be made directly to Farrell Plastic Surgery & Laser Center, P.C. as applicable.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I have read and fully understand the above and sign with the intent to be legally bound.

_____ _____

Date Signature of Patient or Responsible Party

Farrell Plastic Surgery & Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center

Name _____ Date _____

Height _____ Weight _____

PATIENT HEALTH HISTORY: (Check any illnesses you have had)

☐ Artificial joints/implants/ stents/shunts	☐ Collagen Disorder/Lupus	☐ Gold Therapy (ever)	☐ Psoriasis/Eczema
☐ Accutane Date_____	☐ Collagen Vascular Disorders	☐ HIV/AIDS	☐ Rheumatoid Arthritis
☐ Acne	☐ Depression/Anxiety	☐ Heart Disease	☐ Rosacea
☐ Asthma/Emphysema	☐ Diabetes	☐ High Blood Pressure	☐ Skin Cancer/Melanoma
☐ Bleeding Tendencies	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Skin Disease/Condition
☐ Cancer/Type_____Date_____	☐ Fibromyalgia	☐ Liver Disease/Hepatitis	☐ Sleep Apnea
☐ Cold sores/Fever Blisters	☐ Gastrointestinal Disease	☐ Mental/Emotional Disorder	☐ Stroke
	☐ Glaucoma/Eye Disorder	☐ Phlebitis/Venous Disease	☐ Thyroid Disease

SOCIAL HISTORY:

Occupation _____ Hobbies _____

FAMILY HISTORY: (Check any listed conditions which have occurred on either side of your family)

☐ Bleeding Tendencies	☐ Gastrointestinal Disease	☐ Kidney Disease	☐ Mental Disease
☐ Breast Cancer	☐ Heart Disease	☐ Malignant Hyperthermia	☐ Skin Cancer
☐ Diabetes	☐ High Blood Pressure	☐ Melanoma	☐ Other _____

Have you ever used Prednisone, Cortisone or other steroids? ☐ No ☐ Yes
If yes, when _____

Do you exercise? ☐ No ☐ Yes If so, how frequently? _____

Have you used insulin? ☐ No ☐ Yes Do you use tobacco? ☐ No ☐ Yes
Do you use alcohol? ☐ No ☐ Yes Do you use narcotics? ☐ No ☐ Yes

ALLERGIES: (Check if you are allergic to any of the following) ☐ None

☐ Aspirin ☐ Codeine ☐ Demerol ☐ Latex ☐ Lidocaine ☐ Morphine ☐ Penicillin ☐ Sulfa
Other allergies: _____ Reaction: _____

OPERATIONS: Type	**Month/Year**	**Hospital**
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS: (List all medications you are presently taking including aspirin, vitamins & herbs)

Medication	**Strength**	**Dosage**	**Medication**	**Strength**	**Dosage**
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Current Skin Care _____
_____

I understand the above information will be used for my medical care. I agree that the information I have provided is true and correct to the best of my knowledge.

Patient Signature _____

Farrell Plastic Surgery & Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center
Leo D. Farrell, M.D. • Deborah M. Farrell, M.D.

FINANCIAL POLICY

Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

PAYMENT OF COPAYS IS DUE AT THE TIME OF SERVICE, unless you are instructed otherwise, or other arrangements have been made.

**** WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER CARDS ****
A fee of $30.00 will be charged for any returned check.

CREDIT CARD DISCLOSURE: Services that are paid with a credit card are not eligible for post – care payment challenges.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We will bill your insurance carrier according to our agreement with them based on the insurance information you have provided to us. **We file insurance claims as a courtesy to you.** We will not become involved in disputes between you and your insurance company regarding deductibles, copays, referrals, covered and non-covered services, secondary insurance, etc., other than to supply factual information as necessary. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

Any service provided to you that is determined to be cosmetic or non-covered for any reason by your insurance company is your responsibility. Preauthorization or precertification by your insurance company, or a referral, is no guarantee that they will cover your treatment. It is important to understand that your insurance company may at any time, after charges have been paid on your behalf, ask for a refund of payment. If this should occur, you are responsible for payment.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY.
PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING OUR FEES, FINANCIAL POLICY, OR YOUR FINANCIAL RESPONSIBILITY.

I understand that I am financially responsible for all charges, whether or not covered by my insurance. I understand that if I have not made any attempt to make payment or set up a payment schedule after my account is 90 days delinquent, I may be sent to a collection service and incur additional costs related to that.

I agree to release protected health information to my insurance, financial, and credit card companies, when requested, to facilitate payment. I further agree that I will not challenge credit, debit, or financing card payments once the services are provided, and that this non-challenge agreement is irrevocable.

Responsible Party Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Mail: Farrell Plastic Surgery& Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center
Attn: Privacy Officer
2025 Technology Parkway, Suite 204, Mechanicsburg, PA 17050
Telephone: (717) 732-9000
Fax: (717) 732-9011

Acknowledgement and Consent

I have received the Notice of Privacy Practices for Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center. Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center are authorized to use and disclose health information about **_____(pt name)**
for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of patient(or patient's personal representative) Date

_____
Witness (Staff Representative)

Personal representative information (if applicable):

_____
Name of personal representative

_____
Relationship to patient (or other authority)

Farrell Plastic Surgery & Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center

RELEASE OF PATIENT HEALTH CARE INFORMATION TO FAMILY/FRIENDS

Patient Name:_____ Date:_____

Date of Birth:_____

Address:_____

Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center **may release my patient health care information to** the following individual(s):

_____		_____
name	(relationship)	phone number
_____		_____
name	(relationship)	phone number
_____		_____
name	(relationship)	phone number
_____		_____
name	(relationship)	phone number
_____		_____
name	(relationship)	phone number

I hereby request that Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center **restrict the release and disclosure of health care information** contained in my medical record to the following individual(s):

_____
name

_____
name

_____
name