Joel P. Maier, M.D., F.A.C.S.
Advanced Cosmetic Surgery & Laser Center
3805 Edwards Rd., Ste. 100
Cincinnati, OH 45209
(513) 351-3223

CONFIDENTIAL PERSONAL INFORMATION
(PLEASE COMPLETE PRIOR TO YOUR APPOINTMENT)

Date: ________________________ **Reason For Visit:**____

Referral Source: ☐ Doctor ___________________________ ☐ Established Patient ☐ Internet ☐ Newspaper
Yellow Pages ☐ Word Of Mouth ☐ Seminar ☐ Other_______________________________________
Type of Visit: ☐ Insurance ☐ Cosmetic ☐ Second Opinion ☐ Legal
Full Legal Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

_____________________________________/_____________________________________/___________
(Last Name) (First Name) (Middle Initial)

Preferred Name: ________________ Age: ______ Date of Birth: ___________ S.S.#: __________________

Address:
____/_________________/______/______________
(Street#/PO Box) (City) (State) (Zip Code)

Telephone # (check box for preferred phone):

_(____)_____________________/_(____)______________________/_(____)_________________________
☐ (Home) ☐ (Work) ☐ (Cell phone or other)

E-mail address: ____ Gender: ☐ female ☐ male

Are you (check one): ☐ Single ☐ Married ☐ Other; Partner's Name: _______________________________

Occupation: ____ ☐ Full time ☐ Part time ☐ Student ☐ Retired

Employer/School: ____

Address: _________________________________/__________________________/_______/_____________
(Street / PO Box) (City) (State) (Zip code)

Emergency Contact ____
(Name) (Relationship)

_(_____)_______________________________________(_____)_____________________________________
(Day Phone) (Evening Phone)

HEALTH INSURANCE INFORMATION

Policy Holder : ____

Relation To Guarantor: ☐ Self ☐ Child ☐ Spouse ☐ Other__________________ Date of Birth__________

Guarantor Employer: ________________________________ Work Phone: (____)_____________________

Primary Insurance Company: ____________________________________ Copay Amount: ______________

Primary Insurance Address: _______________________/____________________/______/____________
(Street / PO Box) (City) (State) (Zip code)

Subscriber ID No.: ______________________________ Group No.: ________________________________

Secondary Insurance Company: __________________________________ Copay Amount: ______________

Secondary Insurance Address: _______________________/___________________/______/___________
(Street / PO Box) (City) (State) (Zip code)

Subscriber ID No.: _______________________________ Group No.: _______________________________

PLEASE COMPLETE THIS SECTION ONLY IF YOU SEEKING TREATMENT OF AN INJURY THAT WAS A RESULT OF AN ACCIDENT

Accident/Injury Date: ______________ Location (city & state)_____________________________________

Insurance Coverage: ____

Claims Phone: (_____) ______________________ Claim No: ______________________________________

Claims Address: ______________________________/_______________________/______/___________
(Street / PO Box) (City) (State) (Zip code)

Joel P. Maier, M.D., F.A.C.S.
Maier Plastic Surgery

PAYMENT POLICY

Payment is due in full at the time of service for all office visits, ancillary services and product. We accept cash, check, VISA, MasterCard, American Express, and Discover for your convenience. There is a 30-day exchange policy for all products purchases.

Insurance

Insurance billing is provided. It is your responsibility to pay any copays or obtain any necessary referrals prior to your appointment, as directed by your plan. In order to provide insurance billing you must supply your social security number with complete and accurate insurance information. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim after 90 days or for negotiating a disputed claim.

Surgical Payments

Payments for all elective cosmetic surgeries are collected in full two-weeks prior to the procedure date.

Lab Fees/Prescriptions/Surgical Pathology

All labs, EKG, surgical pathology and prescriptions are the responsibility of the patient. In most cases, your insurance will cover these services.

Payment Plans

Monthly payment plans are available for consideration on any unpaid balances by insurance. Monthly payment plans require signature and completion of standard budget agreement.

Late Fees

After 90 days from the date of service, all accounts are subject to a Finance Charge of 1.5% per month, which is 18% per annum.

Cancelled Checks

A $35.00 NSF charge will be applied to my account for any checks returned for insufficient funds.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. All accounts assigned to collections will be charged a $150.00 collection fee. I hereby authorized the doctor to release information necessary to secure the payment of benefits. I authorize payment of insurance benefits directly to Maier Plastic Surgery, Inc. I authorize the use of this signature on all insurance submissions.

______________________________ Date

______________________________ Signature of Patient (for patients over the age of 18

______________________________ Signature of Guarantor of Legal Guardian (for patients under the age of 23)

Maier Plastic Surgery, Inc. Protected Health Information Consent

Recipient Authorization to Use or Disclose Protected Health Information

Patient Records of Disclosures

In general, the HIPPA privacy rules give individuals the right on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of the PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone___________________________
- ☐ O.K. to leave a message with detailed information
- ☐ Leave message with callback number only

☐ Work Telephone___________________________
- ☐ O.K. to leave a message with detailed information
- ☐ Leave message with callback number only

☐ Staff may talk with:

Name__________________________________

Relationship_____________________________

☐ O.K. to contact by email.

Email__________________________________

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

I have read/received the notice of Privacy Practices Acknowledgement and been provided the opportunity to review it.

Name: ____ Date of Birth______________________

Signature____ Date__________________________

Federal Law Requires That We Have This Consent In Every Patient Chart

Maier Plastic Surgery

Joel P. Maier, M.D., F.A.C.S.

Thank you for choosing Maier Plastic Surgery.
In order for us to fully understand your needs, we greatly appreciate you taking a moment to answer the following questions about your health and habits. Please answer each question to the best of your knowledge.
All information will be held in the strictest confidence.

Health Questionnaire

Date: ____________________ Reason For Visit ____________________________________

Name: ______________________________________ Age: __________ Height: __________

Weight: Current____________ Highest_____________ Bra size: ______________

Referral Source: ☐ Doctor ________________________________ ☐ Established Patient
☐ Internet ☐ Newspaper ☐ Yellow Pages ☐ Word Of Mouth ☐ Seminar
☐ Other____

1. Please list any medical illnesses you are being treated for:

____

____

2. Please list any operations that you have had including minor or cosmetic surgery:

____

____

3. Any reactions to anesthesia? Malignant Hyperthermia? ☐ YES ☐ NO
Please explain: ____

4. Are you allergic to any drugs or foods? ☐YES ☐NO

Please explain: ______________________________

5. Please list ***any*** medications you are taking (including: aspirin, vitamins and herbal preparations):

____

____

6. Have you been treated for any of the following? **Check ALL that apply:**

☐Asthma ☐High Blood Pressure ☐Cold Sores ☐Hepatitis ☐HIV/AIDS ☐Heart Disease ☐Eye problems ☐ Dry Eye ☐Diabetes ☐Varicose Veins ☐Chest Pain ☐ Shortness of Breath ☐Leg Swelling ☐Stroke ☐Gastrointestinal problem ☐Bleeding problem

Please explain: ______________________________

7. Have you or anyone in your family suffered from a blood clot, Deep Venous Thrombosis (DVT) or Pulmonary Embolism (PE)? ☐YES ☐NO

Please explain: ______________________________

8. Do you or any family members have a history of breast cancer or other breast problems? ☐YES ☐NO

Please explain: ______________________________

Last mammogram: ______________________________ Lasts PAP: ______________

9. Do you have children? C-section? ______________________________

10. Have you had any miscarriages? If so, how many? ______________________

11. Do you smoke? If so, how much? ______________________________

12. Do you drink alcohol? If so, how much: ______________________________

13. Do you form large scars? ☐YES ☐NO

14. Have you used Accutane? If so, when last taken? ____________________

15. Do you diet? ☐ YES ☐ NO or Exercise? ☐ YES ☐ NO

Please comment: ____________________

16. What is your occupation? ____________________

FOR PATIENTS CONSIDERING COSMETIC SURGERY, PLEASE ALSO COMPLETE THE FOLLOWING:

Please describe your daily skin care regimen: ____________________

____

I am interested in learning about:

- ☐ Facial Skin Rejuvenation
- ☐ Facial Wrinkles/Laser Treatment
- ☐ Botox/Dysport
- ☐ Injectable Facial Fillers
- ☐ Breast Implants
- ☐ Tummy Tuck
- ☐ Cellulite Treatment
- ☐ Facial Skin Rejuvenation
- ☐ Aging Face, Neck & Brow Lifting
- ☐ Aging Eyes/ Eyelid Surgery
- ☐ Nasal Surgery
- ☐ Facial Implants
- ☐ Breast Reduction/Lift
- ☐ Liposuction
- ☐ Spider Veins
- ☐ Surgery After Massive Weight Loss
- ☐ Other: ____________________

Comments:

____

____

Patient Signature: ____________________ Date: ____________