**Maxillofacial and Facial Aesthetic Surgery, Ltd.**
Kevin R. Haddle MD

## Registration Form

### PATIENT INFORMATION

Legal First Name:_____ MI:_____ Last Name:_____
Address:_____
Number/ Street City State Zip Code

Home Telephone:( )_____ Cellular Phone:( )_____ Work Phone:( )_____
Driver's License Number:_____
__
Date of Birth:___/___/___Gender: Male/Female Marital Status: Married/Single/Divorced/Widowed
Nearest Relative:_____ Relationship:_____ Phone #:( )_____
Emergency Contact: _____ Relationship:_____ Phone #:( ) _____
Employer:_____ Position:_____ Social Security #:_____

### GUARANTOR INFORMATION ☐ Same as Above

Legal First Name:_____ MI:_____ Last/Other Name(s):_____
If Divorced or Separated, Other Parents' Full Name:_____
Relationship to Patient:_____
Address:_____
Number/ Street City State Zip Code

Home Telephone:( )_____ Cellular Phone:( )_____ Work Phone:( )_____
Home E-Mail Address:_____ Driver's License Number:_____
Date of Birth:___/___/___ Gender: Male/Female Marital Status: Married/Single/Divorced
Employer:_____ Position:_____ Social Security #:_____

### INSURANCE INFORMATION

**DENTAL INSURANCE**

Insurance Company Name:_____ Effective Date:_____
Address: _____
Number/ Street City State Zip Code

Policy Number:_____ Subscriber Number:_____
Subscriber Name:_____ Subscriber DOB:___/___/____SS#:_____
Relationship to Patient:_____ Employer:_____

**MEDICAL INSURANCE**

Insurance Company Name:_____ Effective Date:_____
Address: _____
Number/ Street City State Zip Code

Policy Number:_____ Subscriber Number:_____
Subscriber Name:_____ Subscriber DOB:___/___/___SS#:_____
Relationship to Patient:_____ Employer:_____

**Patient Name** _____
_____

**Patient/Guardian Signature** _____ **Date** _____
_____

# Financial Policy for Maxillofacial and Facial Aesthetic Surgery, LTD.

**It is the goal and commitment of our doctors and staff to provide you with the highest level of care available, for years to come. In this spirit, we believe it is possible to avoid miscommunications by having clear expectations and therefore have outlined the following policies regarding your patient account:**

**PLEASE INITIAL EACH LINE AND SIGN:**

_____**PAYMENT IS DUE *IN FULL AT THE TIME OF SERVICE.***

We accept Cash, Checks, Credit and Debit Cards. NSF checks will cost the patient appropriate additional fees.

_____**IF YOU HAVE INSURANCE, AS A COURTESY WE ARE HAPPY TO SUBMIT CLAIMS TO MOST CARRIERS*.**

**Payment for deductibles and out of pocket expenses *will be 20% of your total out of pocket* and *is due at the time of service.***

1. **Insurance carriers do not guarantee coverage or payment until a claim as been submitted and processed**. Therefore, the account holder is responsible for out of pocket expenses at the time of service **AND** all unpaid balances after insurance has either paid their portion, or determined otherwise.
2. 60 days after your date of service it is your responsibility to follow up with your insurance company if they have not made any payments to your account.
3. Any balance remaining after insurance is complete, it will be due ***within 30 days***. Likewise, if an insurance company pays more than estimated, we will refund the excess paid by you or apply it to a current balance due on your account. You may also leave it on account for future use.
4. In the event that the insurance carrier makes an overpayment error, we will refund payment to them.
5. The patient is responsible to inform our office of any changes regarding their insurance provider or job status that might affect coverage or claim filing.
6. Most insurance companies require the insured's ***social security and date of birth***. If you do not wish to provide this information, we will be unable to file claims on your behalf. Therefore, payment in full will be due at the time of service.
7. Signature below will be used as ***Signature on File*** for claims submission. It may also be used for Credit Application and Debit/Credit Card payments initiated by the account holder via phone.

_____**IF YOUR INSURANCE PROVIDER REQURES A REFERRAL FROM YOUR PRIMARY CARE PYHSICIAN, IT IS YOUR RESPONSIBILITY TO OBTAIN THE REFERRAL FROM ALL VISITS PRIOR TO THE APPOINTMENT DAY/TIME. FAILURE TO DO SO MEANS YOU ACCEPT FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED.**

_____ **IF YOUR INSURANCE PROVIDER REQURES A PREAUTHORIZATION FOR A PROCEDURE IT IS YOUR RESPONSIBILITY TO OBTAIN THE PREAUTHORIZATION FORM PRIOR TO THE APPOINTMENT DAY/TIME. FAILURE TO DO SO MEANS YOU ACCEPT FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED.**

_____**OUTSTANDING BALANCES ARE DUE WITHIN 30 DAYS OF THE STATEMENT DATE.**

_____**TO AVOID BILLING FEES AND MONTHLY FINANCE CHARGES…**

Please call our office promptly so we can facilitate a resolution to any/all of your concerns, any balance 120+ days past due can be subject to being submitted to a collection agency.

_____**MISSED APPOINTMENT FEES WILL BE CHARGED (100.00 FEE FOR MISSED APPOINTMENTS OR CANCELATION WITHOUT MORE THAN 24 HOUR NOTICE, THIS FEE WILL NOT BE BILLED TO INSURANCE)**

_____**ADMINISTRATIVE SERVICES (NOT COVERED BY INSURANCE) COPY OF MEDICAL RECORDS:$25 DOCTOR DICTATED LETTER: $35 (REQUESTED BY INSURANCE OR PATIENT INSURANCE APPEALS)**

***WE ARE NOT CONTRACTED WITH MEDICARE/MEDICAID, THEREFORE WE CANNOT SUBMIT CLAIMS.**

**Please call our office at least 24 hours in advance to cancel or reschedule an appointment.*

**In the event that I fail to make payment in full (in a timely manner) or if I fail to make a <u>reasonable</u> payment arrangement and my account is past due, I shall be liable for and I agree to pay, all collection agency fees (not to exceed 50%), reasonable attorney's fees and court costs.**

Patient Name _____

Patient/Guardian Signature _____ Date _____

Revised 07/2015

**Maxillofacial and Facial Aesthetic Surgery, Ltd.**
Kevin R. Haddle MD

# Health Insurance Portability and Accountability Act

Our notice of privacy practices provides information about how we use and disclose protected health information about you. This Notice contains a Patient Rights section describing your rights under the law. By signing this form, you acknowledge that you have received a copy of, read, and understand our Notice. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has reviewed this notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

## AUTHORIZATION FOR DISCLOSURE

_____, I hereby authorize **Maxillofacial & Facial Aesthetic Surgery, LTD**
(Full Name)
to use or disclose my protected health information related to _____ to
(type of information)
_____for the purpose of _____.
(Recipient) (ex: any inquires about account)

1. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Dr. Kevin R. Haddle. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____

2. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: **Dr. Kevin R. Haddle** Privacy Officer for: **Maxillofacial and Facial Aesthetic Surgery, LTD.**

Signature:_____

This consent was signed by:_____
Printed Name – Patient or Patient Representative

Relationship to patient (if other than patient):_____

Date:_____ Witness:_____

**PLEASE NOTE:** This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.

**Authorization for Contact**
*Maxillofacial & Facial Aesthetic Surgery, LTD*

This form is to authorize the staff at **Maxillofacial & Facial Aesthetic Surgery, LTD.,** as to how we may contact you in regards to your health care information.

I, _____ authorize **Maxillofacial & Facial Aesthetic Surgery, LTD.,** to contact me in the following manner:

***In order to reduce waste, our facility prefers electronic statements. Please check your preferred method of statement correspondence.***

**Emergency Contact Information**

Name: _____ Phone: _____Relationship: _____
_____

Name: _____ Phone: _____ Relationship: _____

***Please enter your contact information below, and check all that apply***

□ **EMAIL CORRESPONDENCE:** _____@_____
_____Permission to correspond via email with details pertaining to health care information

□ **HOME PHONE**
_____Voice message with details pertaining to health care information
_____Voice message with call back number only
_____Verbal message with individual, please specify name and relation:_____

□ **CELLULAR PHONE**
_____Voice message with details pertaining to health care information
_____Voice message with call back number only

□ **WORK PHONE**
_____Voice message with details pertaining to health care information
_____Voice message with call back number only
_____Verbal message with individual, please specify name and relation:_____

□ ***PLEASE CHECK IF YOU WOULD LIKE TO RECIEVE EMAIL PROMOTIONS FROM US.***

***Signature of Patient or Parent/Guardian if minor*** ***Date***

Revised 07/2015

# Kevin R. Haddle DDS, MD

**Maxillofacial and Facial Aesthetic Surgery, Ltd.**

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***Patient Responsibilities***

***This practice regards the care of patients as a team effort. In order to uphold our commitment to provide our patients with the best possible care, we respectively request that all patients do their part to fulfill the following patient responsibilities:***

1. ***To read all permits and/or consents that he/she signs. If the patient does not understand, it is the patient's responsibility to ask the nurse or practitioner for clarification.***

2. ***To answer all medical questions truthfully to the best of his/her knowledge; providing complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies and sensitivities.***

3. ***To inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.***

4. ***To read carefully and follow the preoperative instructions that his/her practitioner has given.***

5. ***To notify the organization if he/she has not followed the preoperative instructions.***

6. ***To provide transportation as directed to and from the organization appropriate to the medications and and/or anesthetics that he/she will be receiving.***

7. ***To read carefully and to follow the postoperative instructions and treatment plan prescribed that he/she receives from the practitioner or nurses. This includes postoperative appointments.***

8. ***To contact his/her practitioner if he/she has any complications.***

9. ***To assure that all payments for services rendered are on a timely basis and, that ultimately responsibility for all charges is his/hers, regardless of whatever insurance coverage he/she may have.***

10. ***To be respectful of all the health care providers and staff, as well as other patients.***

11. ***To notify the Medical Director if he/she feels that any of his/her Patient's Rights have been violated or if he/she has a significant complaint or a suggestion to improve services or the quality of care. This can be done by filling out our patient satisfaction questionnaire, by direct contact or by telephone/fax/email.***

**Patient Signature** _____

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