



THE NEW YORK
AESTHETIC CONSULTANTS
PLASTIC, LASER & DERMASURGERY

DERMASURGERY
RON M. SHELTON, M.D., F.A.A.D.

NEW YORK OFFICE-BASED SURGERY, PLLC

PLASTIC SURGERY
TED CHAGLIASSIAN, M.D., F.A.C.S.
WILFRED BROWN, M.D., F.A.C.S.



Accredited by The Joint Commission

PATIENT DEMOGRAPHIC INFORMATION

Name, as appears on your Insurance Card _____
(First) (M.I.) (Last)

Name you prefer to be called _____ **Sex** _____ **Date of Birth** ____/____/____

Social Security _____ **Marital Status** _____ **Age** _____

Address _____
(street) (apt.#) (city) (state) (zip code)

Cell (____) _____ **Home Phone** (____) _____ **Work Phone** (____) _____ **Fax**(____) _____

At which number(s) do you prefer to be contacted? Cell Home Work

At which number(s) do you authorize us to leave a message? Cell Home Work

Email Address (please PRINT clearly): _____

Can we use your email for practice promotions/gift rewards/appointment reminders/newsletters? Yes No

Parent/Legal Guardian Name (if patient is under 18 y/old) _____

Emergency Contact Name _____

Relationship _____ **Phone** (____) _____

Pharmacy Name _____ **Pharmacy Phone** (____) _____

Referring Physician _____ **Phone** (____) _____

Address _____
(street) (city) (state) (zip code)

Primary Insurance _____ **Policy/ID#** _____

Policy Holder Name, If Not a Patient: _____ **Soc. Sec. #** _____ **Date of Birth** ____/____/____

Secondary Insurance _____ **Policy/ID#** _____

Policy Holder Name, If Not a Patient: _____ **Soc. Sec. #** _____ **Date of Birth** ____/____/____

How did you hear about us?

NYAC website ____ Citysearch/Citygrid ____ Google ____ Yellow Pages ____ Patient of Practice ____ Other: _____

Patient's Occupation _____ **Employer's Name** _____

Employer's Address _____

TURN OVER =>

THE NYAC FINANCIAL POLICIES

PAYMENT: As a matter of policy, payment in full is due at the time of service except for those services which have been pre-authorized in advance. We accept cash, bank checks, American Express, Mastercard and Visa. WE DO NOT ACCEPT PERSONAL CHECKS FOR COSMETIC PROCEDURES.

YOUR RESPONSIBILITIES: Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. With the exception of Medicare, we are non-participating providers. As such, for your insurance company to consider reimbursement, you must have out-of-network benefits. We will attempt to pre-certify scheduled procedures to help insure that you have those benefits and to determine your co-payment rate and/or unmet deductible, we will make every effort to work with you in order to minimize your out-of-pocket expense, but ultimately, all charges are your responsibility.

MEDICARE PATIENTS: We are participating providers in the Medicare program. We will accept assignment on all *pre-approved* claims. Patients are responsible for meeting their annual deductible and paying for the 20% coinsurance. We will also file with secondary/ supplemental carriers if applicable. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

OFFICE-BASED SURGERY (OBS): Due to our accreditation, the office is entitled to submit an additional claim to your insurance company for an office-based surgical facility fee named New York Office Based Surgery PLLC. If you have questions concerning this ask to speak to a billing representative.

AUTHORIZATION OF TREATMENT: I hereby authorize The New York Aesthetic Consultants, LLP to give me reasonable and proper care by today's standards. I further authorize and direct the above named clinical practice to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information requested to substantiate payment for medical services rendered. I also permit representatives thereof to examine and make copies of all records relating to such treatment. I hereby assign and transfer over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care, to cover the costs of medical services rendered.

GOVERNANCE POLICY: A copy of the following information has been made available to me: information regarding the ownership of the practice; expertise of the physicians associated with this practice; Patient Bill of Rights; HIPAA Privacy Policy; DNR policy; and the Grievance policy of this organization.

PRODUCTS RETURN POLICY: If you are dissatisfied with your purchase for any reason, please feel free to return the product for office credit within 30 days of the purchase date. Please note that if you buy the same product in more than one quantity, they must remain in the original sealed packaging at the time of return. We will not issue a credit on more than one package of the same product if they were opened. Trial sizes will not be accepted for a credit or refund.

RELEASE OF INFORMATION: I authorize the release of medical information to my primary care or referring physician, to the consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physicians of The New York Aesthetic Consultants, LLP.

By signing below, I acknowledge I have read and agree to the above terms and conditions.

Patient Signature _____ *Date* ____/____/____

Parent/Legal Guardian (if patient is under 18 y/old) _____ *Date* ____/____/____