



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. We accept cash, bank checks, American Express, Mastercard, Visa, Discover, and financing through CareCredit. Checks must be made payable to The New York Aesthetic Consultants, LLP. 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 contact your insurance to confirm your out-of-network benefits, your coinsurance rate, and unmet deductible amount. We will also pre-certify scheduled procedures; however, pre-certification is not a guarantee of payment. Ultimately, all charges are your responsibility.

**MEDICARE PATIENTS:** We are participating providers in the Medicare program. Patients are responsible for meeting their annual deductible and paying for the 20% coinsurance. We will file a claim with secondary/supplemental insurance carrier, if applicable. However, in the event that the secondary insurance does not pay within 60 days from the date of service, you will receive a statement from us for the outstanding balance.

**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, please 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.

**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* \_\_\_\_/\_\_\_\_/\_\_\_\_