CIRILLO CENTER
PLASTIC SURGERY

Plastic Surgery
CIRILLO INSTITUTE

New Patient Welcome Packet

Demographics, Protected Health Information, and Insurance

Patient Information Patient Date of Birth* _____ /_____ /_____

Last Name* _____ First* _____ Middle _____

Address _____

City _____ State _____ Zip _____

Birth Sex*: Female___ Male___ Unknown___ *(*required by insurance)*

eMail**_____

Mobile (_____) _____ Home (_____) _____ Other (_____) _____

Best Contact Method (Please Circle): Mobile Home Other May we leave a detailed message*? Yes____ No____

Primary Care Physician _____ Primary Care Phone (_____) _____

Emergency Contact Name _____ Emergency Contact Phone (_____) _____

Emergency Contact Relationship to Patient _____

Authorization to Disclose Protected Health Information (PHI) *to Someone Other than Yourself*

PHI Name _____ Relationship to Patient _____

Mobile Phone (_____) _____ Home Phone (_____) _____

Primary Insurance

Health Insurance Provider Name _____

Policy Holder Name_____ Relationship to Patient _____

Policy Holder DOB _____ /_____ /_____ Phone Number Mobile (____) _____ Home (____) _____

Policy Holder eMail** _____

Policy Holder Address _____

Policy Holder City _____ State _____ Zip _____

Policy Holder Employer _____

Policy Holder Occupation _____

**By providing my email address and mobile phone number, I give CCPS permission to send me appointment & billing reminders, practice newsletters, and online review requests. I understand that I may opt-out at any time, and that CCPS will never sell or share my email/mobile with any external entity. Appointment reminder eMails are HIPAA compliant, and all texts are encrypted and HIPAA compliant to protect your privacy. Normal SMS charges apply.

Check to opt-out of reminders/newsletter/review eMail. [ ] *Check to opt-out of reminders/review text.* [ ]

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Patient Financial Responsibility

Thank you for choosing **CIRILLO CENTER FOR PLASTIC SURGERY (CCPS)**. We are committed to providing the highest quality care. Please read and sign this form to acknowledge your understanding of our patient financial responsibility policies.

- You are **responsible** for any fees from the provider and the facility the procedure was performed at, if your insurance company determines that the procedure you underwent is **not covered**.

Referrals, and **"In Network" vs. "Out of Network" Insurance:**

- It is **your responsibility** to verify that we are currently under contract with your insurance as an "in network" provider and, if required, that you have obtained a referral before your appointment; otherwise, you may need to reschedule.
- Your insurance coverage and benefits are a contract between you and your insurance company. Disputes must be handled between you and your insurance company. If you come to the office knowing we are an "out of network" provider under your insurance, then your insurance company may not cover the services, leaving you responsible for 100% of the payment.
- We bill your insurance company; however, you are ultimately responsible for the payment of the bill.
- While we can help, it is your responsibility to know your insurance plan and to understand the extent of that coverage.
- Insurance companies are obligated to you, the insured, not to our office. Typically, they won't even speak with us.
- If you have a **High Deductible Health Plan** and have not met your deductible, we collect payment prior to your procedure.

Payment is Due at the Time Services are Rendered:

- Co-pays and non-covered items/charges are the insured/patient's financial responsibility and are due the day of your visit.
- **Self-Pay Patient** fees are due at the time services are rendered. Our staff will give you an estimate of your appointment fees, but please keep in mind it is often impossible for us to quote what will be done during your appointment.
- **Please be advised that your visit to the plastic surgeon is for evaluation. There may be treatment at the time of your visit, such as a biopsy requiring special stains that may render additional charges that will be submitted to your insurance.**

Auto Pay *(optional – for patient convenience, eco-friendly, paperless)**:***
*I authorize **CCPS** to charge my card on file for any balance due following receipt of any applicable insurance payments in connection with healthcare services rendered by us. Following each service, **CCPS** will submit any relevant insurance claim on my behalf. Upon receiving notice of adjudication of such insurance claim, **CCPS** may charge my card on file for the amount of patient responsibility, according to my insurance company. I understand that **CCPS** will not be required to provide any further notice to me before charging my card. The maximum amount that **CCPS** will charge my card under this authorization is $150.00. I understand that I will be responsible for any remaining amount due after **CCPS** charges my card, or if **CCPS** cannot charge my card for any reason.*

Auto Pay Authorization Consent: _____ *Date:* _____/_____/_____

Payment Plans:

- Our office will work with you if you need a payment plan for a balance due to our practice.
- Payment plan payments are done via **credit card on file (preferred)**, or via check payments mailed to our office at:

CIRILLO CENTER FOR PLASTIC SURGERY
919 Conestoga Road, Suite 2-106
Bryn Mawr, PA 19010

or **by phone**: 610.672.0500 ext. 802

Patient Consent:

By signing this document, I _____, have fully read, understand and consent to the financial policy of **CIRILLO CENTER FOR PLASTIC SURGERY**. I hereby consent to allow **CCPS** to reach me if needed, concerning any billing questions or concerns. I will cooperate with the billing department to ensure payment for my services. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.

Print name of Patient/Guardian_____ *Date:* _____/_____/_____

Signature of Patient/Guardian_____

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HIPAA Privacy - Consent

Patient Name: _____

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. 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. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. 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, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review 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, except in certain limited instances.
- 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.

Consent signed by _____ Date: _____/_____/_____

Patient or Representative

Relationship to Patient _____

if other than patient

In front of _____

Practice Representative - Print Name