ANDREW H. ROSENTHAL, MD
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Patient Information

NAME:_____ **SS#:**_____
PHONE:_____ CELL: _____
ADDRESS:_____
CITY:_____ **STATE**:_____ **ZIP CODE**:_____
Date of Birth:_____ Age:_____ Sex:_____ Marital Status_____
Employer:_____ Occupation:_____
Business Phone: _____ **E-Mail** _____
Spouse's Name: _____ Phone:_____
Emergency Person: _____ Phone_____
Physician/Internist_____ Pharmacy Name & #:_____
List All Previous Surgeries/Hospitalizations:_____
_____
_____
Are you Allergic to any Medications? _____ **If yes, list**_____
List All Medications and Vitamins You Are Taking (Including Oral Contraceptives):
Medications Dosage How Often
_____
_____
Have you ever taken Accutane? _____ If so, when did you stop? _____

PERSONAL DATA:

*Height*_____ *Weight*_____ *#Children*_____
*Previous Mammogram (date)*_____ *Result*_____
History of Breast Masses _____ *Previous Biopsy*_____
Family History of Breast Cancer (Who) _____

Check Any Of The Following Diseases Which You Have Or Have Had:

( ) Excessive Bleeding
( ) Headaches/Migraines
( ) Fainting Spells
( ) Psychiatric Care
( ) Cataracts
( ) Glaucoma
( ) Dry Eye Syndrome
( ) Thyroid Disorder
( ) Liver/Hepatitis/Jaundice
( ) High/Low Blood Pressure
( ) Heart Attack/MI
( ) Angina
( ) Heart Murmur
( ) Mitral Valve Prolapse
( ) Irregular/Fast Heartbeat
( ) Rheumatic Fever
( ) Seizure Disorder/Epilepsy
( ) Stroke
( ) Stomach Problems
( ) Blood Transfusion Reaction
( ) Prostate Problems
( ) Gout/Arthritis
( ) Pancreas Disorders
( ) Gall Bladder
( ) Kidney/Bladder
( ) Tuberculosis
( ) Cancer
( ) Ulcers
( ) Circulatory Problems
( ) Pneumonia
( ) Bronchitis
( ) Emphysema
( ) Asthma
( ) Diabetes
( ) HIV/AIDS
( ) Herpes/Cold Sore

PT INITIALS _____ M.D. INITIALS_____

FAMILY HISTORY: List immediate family members either deceased (with cause of death and age) or living with serious illness:

_____

SOCIAL HISTORY: Please check and answer all of the following questions:

YES	NO	
( )	( )	Have you or anyone in your family had a problem with Anesthesia? If yes, please explain: _____
( )	( )	Do you have any skin problems? If yes, please describe: _____
( )	( )	Do you have vision problems? If yes, please explain: _____
( )	( )	Do you wear eyeglasses?
( )	( )	Do you wear contact lenses?
( )	( )	Do you wear removable dental appliances/denture?
( )	( )	Any illegal drug use?
( )	( )	Do you wear hearing aids?
( )	( )	Do you have breathing problems? If yes, explain: _____
( )	( )	Do you have a cough? If yes, describe: ( )moist ( ) dry
( )	( )	Are you on a special diet? If yes, describe: _____
( )	( )	Do you have any disease, condition or problem not listed above that you think the doctor should know about?____ If yes, please explain: _____ _____
( )	( )	Do you have any reason to believe that you are pregnant?

I have read (or have had read to me) the above medical information listing and I hereby certify that I have disclosed all of my medical history to the best of my knowledge that the information I have provided above is correct. I understand that I am financially responsible for all charges related to my procedure.

PT INITIALS:_____ MD INITIALS:_____

I would like information on:

- ❑ Liposuction
- ❑ Tummy Tuck
- ❑ Laser Surgery
- ❑ Scar Revision
- ❑ Facial Implants
- ❑ Facelift
- ❑ Browlift
- ❑ Midface Lift
- ❑ Endoscopic Facial Surgery
- ❑ Otoplasty
- ❑ Breast Augmentation
- ❑ Breast Lift/Reduction
- ❑ Nasal Surgery
- ❑ Anti-Aging Treatment
- ❑ Age Spot Removal
- ❑ Weight Loss
- ❑ Facials
- ❑ Eyelid Surgery

Are you interested in our skin care program? YES_____ NO_____

May our office contact you by phone?_____ May we leave a message?_____

Are you interested in our E-Mail newsletter?_____

PLEASE TELL US HOW YOU HEARD ABOUT OUR PRACTICE:

- ❑ Physician_____
- ❑ Web Site _____
- ❑ Paper/Magazine_____
- ❑ Friend_____
- ❑ Patient_____
- ❑ Other_____

Do you Smoke? _____ Per day_____ Quit_____
Do you Drink?_____Per day_____Per Week_____
Did you receive your Pneumonia Vaccine this year?_____Flu_____

Advance Care: Do you have a health care proxy in the event you are unable to make your own medical decisions? If yes. Name:_____Contact info:_____

Do you have a living will? Yes_____NO_____

Do you have a health care proxy in the event you are unable to make your own medical decisions?

Which statement best reflects your wishes on advanced care recommendations?

- ○ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ○ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.
- ○ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Initials_____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACE NOTICE

I acknowledge that I have received the attached Privacy Notice.

_____ _____

Patient Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

_____

Witness

****

Breast Reconstruction:

_____ _____

Patient Signature Date

I understand that in order to schedule a surgery, a 10% deposit or $500.00, whichever is greater, must be paid the day surgery is booked
I understand that all surgical fees are non-negotiable.

_____ _____

Patient Signature Date

Andrew Rosenthal, M.D.

Consent to Obtain External Prescription History

I, _____ , whose signature appears below, authorize Andrew Rosenthal, MD. to view my external prescription history via the Rx link via EMA.

I understand that prescription history from multiple other unaffiliated medical providers, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____ Patient

Date

_____ _____ Witness

Date

9897 Hagen Ranch Road, Boynton Beach FL 33472

www.bocasurgeon@yahoo.com

ANDREW H. ROSENTHAL, M.D.

Cosmetic Plastic and Reconstructive Surgery

Our office is committed to providing you the best possible care. Our professional relationship requires honest financial accountability. The following is a statement of the office's financial policy. We require you to read and sign this document as part of that relationship. By signing, you acknowledge that you have read and understand these policies, accept them, and agree to be financially obligated for any and all charges which arise as a result of your (or your dependent's) treatment. Any deviation from these policies is solely at the discretion of Dr. Rosenthal on a case-by-case basis.

The office will accept the following for methods of payment for services rendered: most major credit cards, cash, money order, check. The office also offers financing through a third party vendor. We regret that we cannot provide in-house financing or payment plans. It is our policy to submit any insufficient funds to the appropriate legal authorities. A $25 charge will be added to your account for each returned check. All co-payments and deductibles for office appointments are due the day services are rendered. Payment of all account balances is due in full by you within 30 days of service regardless of insurance claim status. The office reserves the right to turn over any past due accounts to a collection agency at any time following this 30 day period. A 35% fee will be added to any balance owed immediately upon referral to collections. This 35% fee is not payable by insurance. By signing below, you agree to pay all costs of collection including but not limited to attorney fees, collection fees, interest charges, and other fees to collection agencies, such fees to be added and collected by the collection agency immediately upon default and our referral to said collection agency.

No surgeries or procedures may be scheduled or performed for any patient whose account has a balance due.

The office will not be involved in any third-party liability cases. We do not file with automobile or homeowner's insurance liability policies. The office is not a provider for Workers' Compensation Plans.

This office does not accept "reasonable and customary charge" calculations by outside parties unless we are a participating provider. You are solely responsible for assuring that we participate with your insurance.

We wish to make any open appointment slots available to patients who need them. Therefore, patients who miss an office appointment will be charged a $75 No-Show fee. These charges are not billable to your insurance company and will be your sole responsibility. If you must cancel an appointment we require at least 24 hours notice.

The most common misconception concerning insurance is that your policy will cover the total cost of surgical fees charged. Insurance is designed to reduce your out of pocket cost, but usually will not eliminate it entirely.

Often procedures in plastic surgery may not be able to be easily classified as entirely cosmetic or reconstructive. Dr. Rosenthal will assist you in providing justification for surgery to your insurance company to help with determination of your benefits for procedures which he believes are medically necessary. Every plan is different and each insurance company determines what is covered. Your surgical treatment is not dictated by what your insurance will cover. Together, you and Dr. Rosenthal

Initial _____

7280 WEST PALMETTO PARK ROAD, SUITE 305, BOCA RATON, FLORIDA 33433
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will create your treatment plan based on your medical needs. Just because a particular service is not covered (which may include but is not limited to determinations such as "not medically necessary," "cosmetic," "pre-existing condition," or "uncovered benefit"), it does not relieve you of financial responsibility for the charge related to that service.

Dr. Rosenthal may define a procedure as cosmetic if he feels that the procedure is primarily cosmetic in nature. Dr. Rosenthal's designation of a procedure as cosmetic is final and binding. You agree that an insurance claim cannot and will not be filed by you, the office, or any third-party for any procedure which Dr. Rosenthal considers primarily cosmetic in nature.

Prior to surgery, we will attempt to estimate your surgical fees. All estimated fees for surgical procedures are due in full prior to surgery (except for Medicare patients who will only be required to pay their 20% coinsurance and deductible). Once we have received payment from your insurance company, we will reconcile the account and return any overpayment to you as soon as possible. You, as the beneficiary of the insurance policy, are responsible for knowing all policy limitations and exclusions. The contract for benefits is between you and your insurance company. Please note that these charges are estimated and may not represent all charges or balances due. Neither we, nor the insurance company, can guarantee the estimated payment amounts as they are based on many variables.

Insurance is filed as a courtesy and does not relieve you of financial responsibility nor suspend payments until the insurance has paid.

Insurance will only be filed for plans with which we participate at the time of service. We will not "back file" any claims. You must provide all insurance information at the time of service. It is your responsibility to inform the office of any changes to insurance and document those changes. It is the patient's responsibility to know if their insurance plan requires a referral from their primary care doctor.

** Please remember that insurance is filed solely as a courtesy to our patients. Please help us to keep this service available to all patients. **

I, _____, have read, understand, and agree to the above financial policies. I have had the opportunity to ask any questions about these policies and have had any questions answered to my satisfaction.

_____ _____ _____

Signature Patient name Date

I agree that, rather than having my account sent to collections and incurring the fees and penalties as listed above if I fail to pay within thirty (30) days, I would prefer that my account balance be charged to my VISA or MASTERCARD. This card is only to be charged if I fail to pay my balance within 30 days.

[ ] Visa [ ] Mastercard Number: _____

Expiration date: _____ Signature: _____