PATIENT REGISTRATION FORM

Patient's Name (Last, First, MI) _____ **SS Number**_____

Home Phone Number_____ **Cell Phone Number**_____

Date of Birth: **Age:** **Sex:** Male Female **Marital Status**:

E-Mail Address

Home Address **City** **State** **Zip Code**

Mailing Address if different from home address:

Address City State Zip Code

Employer Name_____ Employer Phone#_____

Employer Address

Emergency Contact_____ Relationship to Patient_____

Address Phone #

Primary Care Physician Name and Phone Number _____

Pharmacy Name **Pharmacy Phone #**

INSURANCE INFORMATION **We will request to scan your ID and insurance card**

Primary Insurance_____ Member ID#_____ Group#_____

Patient is Subscriber/Policy Holder **Yes** **No**

Subscriber/Policy Holder Name_____ Relationship to Patient_____

Address_____

SSN_____DOB_____Employer_____

Work Phone

Secondary Ins._____ Member ID#_____ Group#_____

Patient is Subscriber/Policy Holder **Yes** **No**

Subscriber/Policy Holder Name_____ Relationship to Patient_____

Address_____

SSN_____DOB_____Employer_____

Work Phone

Is your visit related to Worker's Compensation or a Motor Vehicle Accident? **Yes** **No** If so, we will need you to complete an additional form, please ask for the MVA form. Thank you

Responsible Person: (if different from patient)

Last Name_____ MI_____ First Name_____ Relationship_____

Date of Birth_____ Telephone Number_____

Address_____

Street City State Zip Code

How did you hear of our office?

Physician_____Patient_____Friend_____ Radio_____

Billboard Newspaper Seminar Other

Patient/Parent/Guardian Signature **Date**

Authorization and Consent for Care

I request care from Michael W. Nagy, MD, LLC, or one of their affiliates of my medical care condition. This care may include medical test, exams, or other treatments that are needed for my condition. I agree to this care.

Assignment and Coordination of Insurance Benefits- I agree to provide information regarding all group, hospitalization, health maintenance organization, Worker's Compensation, automobile, and all other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Michael W. Nagy, MD, LLC and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to Michael W. Nagy, MD, LLC (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care. I agree to let my doctor(s) submit claims and required treatment information to my insurance company, Medicare, or other third party payment program for my care, and receive payments directly. I understand I must pay all charges, co-payments, co-insurances, and deductibles that are not covered by my insurance company, Medicare, or third party payment program.

Unauthorized, Non-Covered, or Out of Plan Services- I agree to be fully responsible for payment to Michael W. Nagy, MD, LLC, if my Insurance Plan(s) does not consider this appointment or any services rendered a non-covered service. I also understand and acknowledge that in the case of Out Of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge. In the event my Insurance Plan(s) does not reimburse these service provided to me, I acknowledge I will be responsible for any remaining balance.

For Medicare Recipients Only- I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare Benefits be made on my behalf to Michael W Nagy, MD, LLC for any services furnished to me by your group and providers. I authorize any holder of medical information about me to be released to Centers for Medicare and Medicaid Services and its agents and any information needed to determine these benefits or the benefits payable for the related services. In case of Medicare Part B benefits, I request payment to Michael W. Nagy, MD, LLC.

Residents, Interns, or Medical Students- I understand residents, interns, medical students and other healthcare professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of Michael W. Nagy, MD, LLC education programs.

Permission to Communicate with Your Primary Care Physician and/or Other Care Providers- In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, other care providers, and to your insurance company. These communications may include information about your medical treatment. This information is limited to that which is necessary to the determination of coverage for and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or Health Insurance Company.

By signing below, I certify I have read and understand the foregoing, have the opportunity to ask questions and have them answered and accept above conditions and terms and agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductible, co-payments, co-insurances, and non-covered services. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and collection costs incurred by Michael W. Nagy, MD, LLC. *I understand and agree this document will remain in effect for all future physician office visits, procedures, out-patient services to Michael W. Nagy, MD, LCC, unless specifically rescinded in writing by me.*

Patient/Parent/Guardian Signature: _____ **Date:** _____

Print Patient Name: _____

Relationship to Patient_____

Acknowledgment of Receipt of Notice of Privacy Practices
Dr. Michael Nagy Surgery of the Face the Body

I hereby acknowledge that I have received a copy of Dr. Nagy Plastic Surgery of the Face and Body Notice of Privacy Practices pursuant to HIPAA guidelines.

Print Name_____ **Date** _____

Patient/Parent Representative **Signature**_____

Name of Representative, if applicable_____Relationship_____

- May we leave a detailed message for you at your home phone number? **YES** **NO**
- May we leave a detailed message for you on your cell phone number? **YES** **NO**

Patient Consent for use of Credit Cards, Debit Cards & Financing Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Michael W. Nagy, MD, LLC to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

Patient Signature_____**Date**_____

Authorization for Release of Information

The Health Insurance Portability Act (HIPAA) regulates how your Protocol Health Information (PHI) is "Used and Disclosed." The regulations are being enforced to protect your privacy, and Dr. Nagy and his staff are committed to complying with all applicable laws and regulations. By completing the appropriate lines below, you are allowing Dr. Nagy Plastic Surgery of the Face and Body to release limited health care information. You may revoke this consent, at any time, in writing, to our practice. I,_____ give my consent to Michael W. Nagy, MD, LLC, to speak with my family members/spouse regarding office visits, procedures, appointment scheduling, collection of demographic information and insurance billing inquiries.

List the names of people that we are allowed to release information to, and their relationship to you: list as many or as few as you would like. You do not need to name anyone if you do not want to.

Name_____Relation_____

Name_____Relation_____

Name_____Relation_____

Print Patient Name_____ Date_____

Patient Signature_____

Witness/Office Staff Signature_____

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.[1] This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____, by marking [x] and signing below, I agree to:

☒ representation by [Michael W. Nagy, MD, LLC] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☒ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

[1] If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807
You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by Michael W. Nagy, MD, LLC and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

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Contact Information of Personal Representative

Provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____ RELATIONSHIP: _____

ADDRESS:_____

_____

PHONE: _____ EMAIL: _____

MICHAEL W. NAGY, MD, LLC
Plastic Surgery of the Face and Body

MEDICAL INTAKE FORM, pg. 1 **Today's Date:**

Patient Name: **Date of Birth:**

Drug Allergies/Intolerance. *List reactions, include metal allergies (additional sheet available)*

Your Doctor's Name: **Phone Number:**

Your Pharmacy: **Phone Number:**

MEDICAL HISTORY

Have you ever hand problems with anesthesia? No Yes Describe problem

GASTROINTESTINAL

Nausea/Vomiting	No	Yes
Heartburn	No	Yes
Food sticking in throat	No	Yes
Painful swallowing	No	Yes
Vomiting blood	No	Yes
Black stool	No	Yes
Red blood in stool	No	Yes
Abdominal pain	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Loss of appetite	No	Yes
Feeling full quickly	No	Yes
Bloating	No	Yes
Hepatitis	No	Yes
what type _____		
Ascites (fluid in abdomen)	No	Yes
Gallstones	No	Yes
Liver Disease	No	Yes
Pancreatitis	No	Yes
Stomach Ulcer	No	Yes
Diabetes	No	Yes
Type: _____		

DERMATOLOGICAL

Rash	No	Yes
Acne	No	Yes
Rosacea	No	Yes

CANCER

What type? _____

CARDIOVASCULAR

Arrhythmia (A.Fib/SVT/A.Flutter, etc..)	No	Yes
Chest pain	No	Yes
Palpitations	No	Yes
Heart Attack, Stroke, TIA	No	Yes
High Blood Pressure (HTN)	No	Yes
Congestive Heart Failure (CHF)	No	Yes
Coronary Artery Disease (CAD)	No	Yes
Bleeding disorder	No	Yes
Peripheral Vascular Disease	No	Yes
Rheumatic Fever	No	Yes
Do you bruise easily?	No	Yes
Are you taking blood thinners? (Aspirin, Coumadin, Warfarin, Plavix, Pletal, Pradaxa, Xarelto, etc..)	No	Yes

GENITOURINARY

Frequent Urination	No	Yes
Kidney failure/dialysis	No	Yes
Painful urination	No	Yes
Kidney Stones	No	Yes
Endometriosis	No	Yes
Is there a chance you may be pregnant?	No	Yes

NEUROLOGICAL

Seizures	No	Yes
Headaches	No	Yes
Migraine Headaches	No	Yes

RESPIRATORY

Hoarseness	No	Yes
Cough	No	Yes
Wheezing	No	Yes
Shortness of breath on exertion?	No	Yes
Shortness of breath at rest?	No	Yes
Asthma	No	Yes
Emphysema or COPD	No	Yes
Sleep Apnea	No	Yes

CONSTITUTINAL

Recent weight gain # of pounds _____	No	Yes
Recent weight loss # of pounds _____	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Thyroid Disease	No	Yes

MUSCULOSKELETAL

Joint pain	No	Yes
Arthritis	No	Yes

PSYCHIARTRIC

Dementia	No	Yes
Depression	No	Yes
Anxiety	No	Yes
Other	No	Yes

List: _____

Current medications with dosages, include Over the Counter and Herbal/Homeopathic (additional sheet available)

MICHAEL W. NAGY, MD, LLC
Plastic Surgery of the Face and Body

MEDICAL INTAKE FORM, pg. 2 **Today's Date:**

Patient Name: **Date of Birth:**

SURGICAL HISTORY

Abdominal Surgery	No	Yes	Defibrillator?	No	Yes
What type?			Gallbladder Removal	No	Yes
Appendectomy	No	Yes	Heart Valve Replacement	No	Yes
Bowel or Intestinal Surgery	No	Yes	Joint Replacement?	No	Yes
What type?			Hysterectomy (abdominal or vaginal)	No	Yes
Cancer Surgery	No	Yes	Laparoscopy	No	Yes
What type?			Pacemaker	No	Yes
Cardiac (heart) surgery	No	Yes	Salpingo-oopherectomy (BSO)	No	Yes
What type?			(tube and ovary removal)		
Coronary Stent	No	Yes	Spinal Surgery	No	Yes
Cosmetic Surgery	No	Yes	What type?		
What type?			Tonsillectomy	No	Yes
			Vascular Bypass/Grafts	No	Yes

Other, not listed:

FAMILY HISTORY

Family Medical History (Mother, Father, Sister, Brother)			**If Yes, please list relative and age**
Anesthesia problems	No	Yes	
Describe problem			
Colon Cancer	No	Yes	
Inflammatory Bowel Disease	No	Yes	
Cancer of:			
Breast	No	Yes	
Skin	No	Yes	
Endometrial	No	Yes	
Esophagus	No	Yes	
Kidney	No	Yes	
Ovarian	No	Yes	
Pancreas	No	Yes	
Bowel, small or large	No	Yes	
Stomach	No	Yes	

SOCIAL HISTORY

Children: No Yes How many? **Planning more?** No Yes Time frame:

OB/GYN Name: **OB/GYN Phone:**

Alcohol Use: No Yes How much?

Tobacco Use: No Yes How many packs per day? **Nicotine Replacement product:**

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

Patient or Authorized person signature Date