John F. Farella, M.D., F.A.C.S.

Plastic & Reconstructive Surgery

PLEASE BE SURE TO FILL OUT ALL SECTIONS RELEVANT TO YOU

DATE: _____

PATIENT INFORMATION -

Name(Last, First, Middle Initial)			**How referred to Dr. Farella**
Home Address			**City** **State** **Zip**
Birthdate ____/____/____	**Home Phone#** ( )_____	**Cell Phone #** ( )_____	**Sex** **Male** **Female**
E-mail Address			

Primary Physician	**Phone #** ( )	

Pharmacy Name	**Phone #** ( )	
Street Address **City**	**State**	**Zip**

BILLING INFORMATION - *Who Is Responsible for Payment of this Account?*

Guarantor's Name (Last, First, Middle Initial)			**Relationship to Patient**
Home Address		**City**	**State** **Zip**
Birthdate ____/____/____	**Home Phone #** ( )	**Sex** **Male** ☐ **Female** ☐	**Social Security #**
Employer	**Employer's Address (City, State, Zip)**		**Work Phone #** ( )

IN CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?
PLEASE LIST SOMEONE LIVING AT A RESIDENCE OTHER THAN THOSE LISTED ON THIS FORM.

Name		**Work Phone #** ( )	**Home Phone #** ( )
Street Address **City**	**State** **Zip**		**Relationship to Patient**

ASSIGNMENT OF BENEFITS

In consideration of services rendered, I hereby assign to the provider of services and/or his assignee benefits be made on my behalf to the provider. I understand that I am financially responsible for any balance not covered by my insurance carrier, I also understand that I will be responsible and agree to pay attorney's fees which is equal to 1/3 of the total balance plus any processing fees that might be incurred to collect payment in full. I authorize release of medical information to my insurer when needed to determine benefits payable.

Patient's/Responsible Party Signature _____

PLEASE READ THESE TERMS CAREFULLY

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAT FIXED ALLOWANCES FOR CERTAIN PROCEDURES, AND OTHERSPAT A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE CONPANY.

IN ORDER TO CONTROL *YOUR* COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

IF THIS ACCOUNT IS ASSIGNED TO AN ATTORNEY FOR COLLECTION AND/OR SUIT, THE PRACTICE SHALL BE ENTITLED TO REASONABLE ATTORNEY'S FEES AND COST OF COLLECTION.

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE MY ABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT ON ANY CLAIM INCLUDING, BUT NOT LIMITED TO, PHOTOS, DIAGNOSIS CODES, PROCEDURE CODES AND ALL WRITTEN REPORTS,

I REQUEST THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS WHICH I AM ENTITLED, INCLUDING MEDICAIRE, PRIVATE INSURANCE AND OTHER HEALTH PLANS, PAYABLE TO THE PRACTICE OF JOHN F. FARELLA, M.D..

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME, IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT THEY ARE PAID BY SAID INSURANCE.

_____ _____

PATIENT'S SIGNATURE OR LEGAL GUARDIAN **DATE**

_____ _____

GUARANTOR'S SIGNATURE **DATE**

MEDICAL INFORMATION

PLEASE STATE THE REASON FOR YOUR VISIT:

Please list ALL medications, including over the counter medications, supplements and herbs:

Do you have any allergies to medications or other substances? ( ) Y or ( ) N
If yes please list:

Please list Prior or Current medical problems:

Please list all Surgeries and Hospitalization information:

HAVE YOU EVER BEEN INSTRUCTED TO TAKE ANTIBIOTICS PRIOR TO ANY MEDICAL PROCEDURE?

If yes, please explain:

SMOKING INFORMATION

Do you smoke? YES ? NO ?	**What do you smoke?** Cigarettes ? Cigars ? Pipe Tobacco ? Other ?
If so, how much do you smoke per day?	**How many years have you been smoking?**

FEMALE MEDICAL HISTORY

Date of last menstrual period:	**Date of last PAP smear:**	**Date of Mammogram:**
# of Pregnancies:	**# of Children:**	

PLEASE COMMENT ON CONCERNS REGARDING YOUR PLASTIC SURGICAL PROCEDURE:
