The Kaplan Center for Plastic
& Reconstructive Surgery
1033 River Road Unit 1, Edgewater NJ 07020

COSMETIC PATIENT INTAKE FORM

Date: ___/____/____

Name: _____ Date of Birth: _____☐ Male ☐ Female

Address: _____ [Apt.] _____ Age: _____

City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____ EMail : _____

Marital Status: ☐ Single • ☐ Married • ☐ Other

Messages

Please call [ ] my home [ ] my work [ ] my mobile phone:_____. If unable to reach me :

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call

The best time to reach me is (day)_____ between the hours of _____

SPOUSE / PARENT / GUARDIAN CONTACT

[If applicable]

Name: [First]_____ [Last] _____ Mobile Tel: _____

Employer: _____ Work Tel: _____

EMPLOYMENT INFORMATION

☐ Full Time • ☐ Part Time • ☐ Student • ☐ Retired • Other Occupation: _____

Employer/School: _____ Work Tel: _____

Work/School Address: _____ City: _____ State: _____ Zip:_____

EMERGENCY CONTACT

Name: [First]_____ [Last]_____ Home Tel: _____

Relationship to Patient: _____ Work Tel: _____

Address: _____ City: _____ Mobile Tel: _____

SELF PAY

I, the undersigned, understand that I am financially responsible for payment of services rendered to me by The Kaplan Center. I am responsible for full payment on the day of my appointment for my consultation and for non-surgical procedures such as Botox, Fillers,etc.

Patient Signature:_____ Date:_____

Private Insurance authorization for assignment of benefits / Information Release

I, the undersigned, authorize payment of medical benefits to Gordon M. Kaplan MD for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release my insurance company or their agent information concerning healthcare, advise, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits

Patient Signature:_____ Date:_____

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Referral Information

Referring by: _____

Have you visited our website [www.TheKaplanCenter.com]? ☐ Yes • ☐ No If yes, was our website helpful? ☐Yes • ☐ No If

No, Please list reason: _____

Procedure Information

What is the reason for your visit today?

Face	Breast	Body	Skin
☐ Facelift ☐ Cheek Lift ☐ Brow Lift ☐ Neck Lift ☐ Liquid Facelift ☐ Facial Fat Transfer ☐ Facial Implants ☐ Lip Augmentation ☐ Chin Augmentation ☐ Ear Reshaping ☐ Upper Eyelids ☐ Lower Eyelids ☐ Rhinoplasty Other: _____ _____	☐ Breast Augmentation ☐ Breast Lift [Mastopexy] ☐ Breast Revision / Repair ☐ Breast Implant Exchange ☐ Breast Reduction ☐ Breast Asymmetry ☐ Breast Reconstruction ☐ MaleBreast [Gynecomastia] Other: _____ _____	☐ Liposuction ☐ Tummy Tuck ☐ Mommy Makeover ☐ Body Lift ☐Buttock Augmentation ☐ArmLift [Brachioplasty] ☐ Thigh Lift ☐ Fat Transfer ☐ Cellulite Reduction Other: _____ _____	☐ Botox ☐ Facial Fillers ☐ Juvederm ☐ Radiesse ☐ Latisse ☐ Fat Injections ☐ Skin Resurfacing ☐ Skin Tightening Laser ☐ Hand Rejuvenation ☐ Hyperhidrosis ☐ Skin Care ☐Mole Removal ☐ Scar Revision Other:_____

Please describe why you are interested in having the procedure(s) listed above: _____

_____

Have you consulted with other physicians about procedure(s) indicated above: ☐ Yes • ☐ No

If No, please list reason: _____

Is this procedure from a previous surgery? ☐ Yes • ☐ No

If Yes, how many previous surgeries? _____

Are you interested in being evaluated for Carpal Tunnel Syndrome, Scar Revisions or Mole Removal? ☐ Yes • ☐ No

Surgery Scheduling Questionnaire

To help us understand your particular needs and time preferences of your surgery, please provide us with the following information:

What is your time preference for your procedure? Within the next: ☐ Month • ☐ 3 Months • ☐ 6 Months • ☐ 1 Year

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Patient Name: _____ Date: _____

As a new patient, it is important that you provide us with an accurate medical history.
The information you provide will further assist us in caring for you.

Health Information

PAST MEDICAL HISTORY

Please list any medical problems & prior hospitalizations. [Include year] :

_____

_____

Please list all medications [Include dosage]: _____

_____

ALLERGIES to medication [Include reaction]: _____

_____

PAST SURGICAL HISTORY [Include year & hospital] _____

_____

FAMILY HISTORY [Parents, Children, Siblings; include age, disease, and if deceased]: _____

_____

SOCIAL HISTORY

Smoke? ☐ Yes • ☐ No If Yes, How many packs per day? _____

Drink? ☐ Yes • ☐ No If Yes, How many Drinks? _____

Drugs? ☐ Yes • ☐ No If Yes, List all drugs_____

NOTICE OF PRIVACY PRACTICES "I have been offered a Notice of Privacy Practices by the office of Dr. Gordon M. Kaplan, MD The Kaplan Center for Plastic & Reconstructive Surgery and I fully understand and accept the terms of this consent. I understand that as part of this organization's treatment, payment, or other health care operations, it may be necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax or email."

Print Name:_____ Date:_____

Signature (Patient, Parent or Guardian):_____

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Payment Policy

For all cosmetic patients, during your visit you will be given a fee estimate for your proposed cosmetic procedure(s). This quote will include fees for Dr. Kaplan, the hospital of your choice & fees for the anesthesiologist. Please note that Dr. Kaplan's portion of the quote is good for 90 days only. If you choose to schedule the procedure more than 90 days in the future, it is possible that the fee will be different from the original quote. The hospitals & surgery centers control their own fee schedules, and may increase their fees at any time. Payment for surgery may be made by major credit card. A 50% deposit must be made the day of booking. Full payment must be made 1 week prior to your surgical date. We also offer patient financing through CareCredit and Alphaeon. Payment of non-surgical treatments such as Botox & Fillers are made at the time of service by cash, credit card, Care Credit or Alphaeon. We are unable to accept personal checks for treatments. At times, a revision or "touch up" procedure may be desired. Should that be the situation, you, the patient will be responsible for additional fees including but not limited to Operating Room or Anesthesia.

Dr. Kaplan is not responsible for refunding any surgical fees or rescheduling fees that result from a patient's non compliance. The failure to follow pre-surgical instructions includes: nicotine, alcohol, or drug use, failure to avoid or take specific medications as instructed, and failure to follow day of surgery instructions. Any surgical procedure rescheduled by the patient less than fourteen (14) days prior to surgery or as a result of non-compliance, will incur a surgeon's rescheduling fee; this does not include fees that may be charged by the surgical facility. All fees must be paid prior to confirming any new surgical date.

If you pay for your procedure with a credit card or CareCredit / Alphaeon and cancel the procedure for any reason, a 5% usage fee of the initial amount charged will be assessed. Surgery fees are to be paid in full 1 week prior to your surgery date. There will be a $1,000.00 fee if you cancel or reschedule your procedure up to 14 days of your procedure. This fee increases to 50% of your surgery fee if you cancel between 10 and 14 days of your procedure. If you cancel within a week (7 days) of your procedure, you will forfeit 100% of your surgery fee. These penalties do not apply to illness related cancellations where a Doctor's note is provided.

We encourage you to contact our office staff for any questions that you may have, so that this policy may be clarified for you prior to scheduling any procedures.

Statement of Financial Responsibility

"I, the undersigned, have read the above & understand that I am responsible for all surgical charges incurred by myself or my dependants. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by The Kaplan Center for Plastic & Reconstructive Surgery.

Print Name:_____

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

Witness Signature:_____ **Date:**_____

Do you plan to use one of the following financing options (Care Credit / Alphaeon)? [ ] YES [ ] NO

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or other health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relate to your past, present, or future physical or mental health or condition and related health care services.

Uses and disclosures of protected health information

Your protected health information may be used and disclosed by your physician, our office and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, this includes the coordination or management of your health care with a third party.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the assessment activities, employed review activities, training of medical students, licensing, and conduction or arranging for other business activities.

We may use or disclose your protected health information in the following situations without your authorization:

These situations include: As Neglect: Food and Drug Administration Requirement, Legal Proceedings, Law Enforcements, Coroners, Funerals, Criminal Activity, Military Activity & National Security. Worker's Compensation: Inmates, Required Uses and Disclosures. Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164-500.

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Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your PHI: Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes: information compiled in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI.

You have the right to request restriction of your PHI: This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or other health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this NOTICE OF PRIVACY requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare provider.

You have the right to request receiving confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.

Upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, of any of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to The Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will NOT retaliate against you for filing a complaint.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. This notice was published and became effective on April 14, 2003.