**ADAM T. SILVERMAN, MD**

NAME (LAST)______________________________ (FIRST)_______________________

PREFERRED NAME _________________ PRONOUN ___________________

ADDRESS_________________________________________________________________

CITY____________________STATE_____________ZIP CODE__________________

D.O.B_____-_____-_____ AGE_________ SS#______-_______-_______

HOME PHONE # ( ) ______-_________ WORK PHONE# ( )______-_________

CELL PHONE # ( ) _______-_________ May we contact you via text message? Y / N

EMAIL ADDRESS ________________________ May we contact you via email? Y / N

SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ PARTNERED ___

PARENT/GUARDIAN OF CHILD NAME (LAST) ______________(FIRST)________

**EMERGENCY CONTACT INFORMATION**

NAME (LAST) _________________________(FIRST)_____________________

RELATION _________________________ PHONE # ( )_______-_________

**EMPLOYER**_______________________________ TITLE _____________________

ADDRESS_______________________________________________________

CITY_________________________STATE_________ZIP CODE___________

**PRIMARY CARE PHYSICIAN** ___________________________________________

LOCATION___________________________ PHONE # ___________________

**REFERRING PHYSICIAN** ___________________________________________

LOCATION___________________________ PHONE # __________________

**PHARMACY** ____________________________________________________________

LOCATION___________________________ PHONE # ___________________

## PRIMARY INSURANCE

SUBSCRIBER'S NAME ________________________ DOB_____________________
SUBSCRIBER'S RELATIONSHIP TO INSURED ______________________________
NAME OF INSURED _____________________________________________________
INSURANCE CARRIER ___________________________________________________
POLICY # _________________________ GROUP # ____________________________
CARRIER ADDRESS _____________________________________________________
PHONE# (      )______-_________

## SECONDARY INSURANCE

SUBSCRIBER'S NAME ______________________________DOB________________
SUBSCRIBER'S RELATIONSHIP TO INSURED _____________________________
NAME OF INSURED _____________________________________________________
INSURANCE CARRIER___________________________________________________
POLICY # _________________________ GROUP # ____________________________
CARRIER ADDRESS _____________________________________________________
PHONE# (      )______-_________

Is your visit related to a car accident or work injury?    Y / N Date of injury____________

## WORKERS COMP/ NO-FAULT INSURANCE

NO FAULT CARRIER'S NAME ___________________________________________
CARRIER'S ADDRES___________________________________________________
CARRIER'S PHONE NUMBER____________________________________________
CLAIM NUMBER_________________________POLICY NUMBER_______________

WORKERS COMP CARRIER NAME________________________________________
CARRIERS ADDRESS___________________________________________________
CARRIER'S PHONE NUMBER____________________________________________
CLAIM NUMBER_______________________________________________________

ADJUSTER'S NAME___________________________________________________
ADJUSTER'S PHONE NUMBER___________________________________________
ADJUSTER'S FAX NUMBER______________________________________________

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier. I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to DR SILVERMAN or the group indicated on the claim. I understand that I am responsible for any balance not covered by my insurance carrier. In the event my account is placed in collection with an attorney or agency, I will pay the collection fees (33 1/3 of balance and all court costs incurred by the doctor in addition to my balance). A copy of this signature is valid as the original.

SIGNATURE________________________________________ DATE__________________

# PATIENT HEALTH HISTORY

NAME ____________________________________________________________
ALLERGIES TO MEDICATIONS _______________________________________
TAPE ________________ LATEX ______________

CURRENT MEDICATIONS ___________________________________________
VITAMINS ____________________________________________________
HERBAL MEDICATIONS/DIET PILLS _____________________________

DO YOU TAKE MOTRIN, ADVIL OR ASPIRIN REGULARLY? Y / N

LAST TETANUS SHOT ____ - ____ - ____

## ARE YOU CURRENTLY OR HAVE YOU EVER BEEN TREATED FOR

ASTHMA Y / N DIABETES Y / N HYPERTENSION (HIGH BP) Y / N
STROKE Y / N CANCER Y / N TYPE___________________
HEART DISEASE Y / N INTESTINAL Y / N THYROID DISEASE Y / N
VASCULAR Y / N BLOOD DISORDER Y / N HEPATITIS Y / N
HIV /AIDS Y / N SKIN DISORDER Y / N OTHER ___________________________________
NEUROLOGICAL DISEASE (MS, Myasthenia Gravis, etc) Y / N _________________________________________

Do you have a bleeding disorder or do you bruise easily? Y / N ____________________________
Have you ever used anabolic steroids or growth hormone? Y / N ____________________________

**SURGICAL HISTORY** – PLEASE LIST ALL PREVIOUS OPERATIONS AND YEAR
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

**TOBACCO USE Y / N Cigarettes /Packs per day? _______Year Start_____ Year Quit________**

**ALCOHOL USE Y / N Frequency: Daily _____ Weekends _____Rarely _____**

**RECREATIONAL DRUG USE Y / N Frequency: Daily _____ Weekends _____Rarely _____**

## FAMILY HISTORY

Cancer __________________ Collagen/Vascular Disease_____________________ Diabetes ___________________________
Hypertension ______________ Skin Cancer_________________________________ Other _____________________________

## BREAST HISTORY (If Applicable)

LAST MAMMOGRAM _______- _______ -_______ RESULT _________________________________________
Lumps / Masses? ____________________________ Nipple Discharge? Y / N
Is there a family history of breast cancer? Y / N Relationship to patient _______________________________________
Current breast cup size 30 – 32 – 34 – 36 – 38 – 40 - _____ A – B – C – D – DD – DDD - _____

**REASON FOR TODAY'S VISIT _________________________________________**
**IS TODAY'S VISIT A COSMETIC CONSULTATION? Y / N**

How did you hear about us?

Friend _____ Phone Book _____ Newspaper _____ Television _____
Hospital Referral _____ Physician _____ Internet _____ Facebook _____
Twitter______ Instagram_______ Radio ______
Please list the name of your referral (optional) ______________________ May we thank them for referring you? Y / N

# PHOTOGRAPHY RELEASE FORM

I hereby release, authorize, and grant permission to New Beginnings Plastic & Reconstructive Surgery, Dr. Adam T. Silverman, M.D., his employees, agents and staff members to take and use photographs, videotapes, and other images and likenesses of me before, during, and after any treatment by Dr. Silverman for the following purposes:
(**initial all that apply**):

_____ to document my medical record and/or to use in my medical record for current and/or future diagnosis and treatment;

_____ to use for teaching purposes, for research purposes, and/or for publication in medical textbooks and journals;

_____ to use for Dr. Silverman's office Social Media (i.e. Facebook, Twitter, Instagram, etc.) and/or Dr. Silverman's office website, currently known as www.newbeginningsplasticsurgery.com.

I understand that any photographs, videotapes, and other images and likenesses of me will be and remain the property of Dr. Adam T. Silverman, M.D. and that I will not receive any compensation for them. I also understand that, although the photographs, videotapes, and other images and likenesses of me might be disclosed to and/or be seen by third-parties, my name and personal information shall not be disclosed by Dr. Adam T. Silverman, M.D. in connection with those photographs, videotapes, and other images and likenesses. I hereby waive any right that I might have to inspect and/or approve the finished product or the copy that may be used in connection therewith or the use to which it may be applied (other than as limited herein).

On behalf of myself, my heirs, representatives, executors, and assigns, I hereby release, discharge, and agree to release, indemnify, and hold harmless New Beginnings Plastic & Reconstructive Surgery, Dr. Adam T. Silverman, M.D. his employees, agents and staff members and from all claims, demands, and causes of action that I have or may have, whether intentional or unintentional, arising from the taking or use of photographs, videotapes, and other images and likenesses of me pursuant to this form.

_______________________________________ _____________________

Signature of Patient or Guardian of Patient, if Patient Is Under the Age of 18 Years of Age | Date

_______________________________________

Name of Patient (please print)

_______________________________________

Name of Guardian, if Patient is Under the Age of 18 Years of Age (please print)

# INSURANCE SUBMISSION & PATIENT RESPONSIBILITY

At New Beginnings Plastic and Reconstructive Surgery, we are happy to provide you with the courtesy of submitting all insurance information necessary to process your claim and to receive payment directly from your insurance company. In order for us to provide these services, you must agree to the following:

- **Provide us with current insurance cards and photo ID**
- **Forward any reimbursement checks and Explanation of Benefits from your insurance company. These items should be forwarded to Dr. Silverman upon receipt. Please endorse checks and print "make payable to Adam T. Silverman, MD" on the back.**
- **Pay any difference between the amount billed and the amount paid by the insurance company that we don't participate with.**

*Please note that all major surgery has a 90-day post-operative period. After this time, a claim will be sent to your insurance company for reimbursement towards any new care.*

New Beginnings Plastic and Reconstructive Surgery will estimate, to the best of our ability, the amount of benefit that your insurance company will provide. New Beginnings Plastic and Reconstructive Surgery are not responsible for any difference between the estimate and the amount that your insurance company actually pays. Each patient is personally responsible for the payment of his/her balance if the insurance benefit does not cover services rendered in-full.

Our office will submit all necessary forms and information required to process your claim, and in some cases, contact your insurance company in an attempt to obtain your rightful benefits under your policy. This office, however, is not responsible for negotiating with your insurance company in the event of a disputed claim. We can provide you with any information or advice necessary if you need to make an inquiry to your health insurance provider.

Please sign below to indicate you have READ, UNDERSTOOD and AGREE to the above policy.

Name (Please Print) ____________________________________________________

Signature _____________________________________ Date ___________________

Witnessed by __________________________________________________________

# CANCELLATION & NO-SHOW POLICY

If you do not show up for your appointment AND if you had not cancelled your appointment at least 48 hours (two full days) in advance, New Beginnings Surgery, PC will charge you a "no-show fee". The amount of the no-show fee will depend on the nature of your scheduled visit. For example, missed follow-up visits will result in a $50 no show fee and missed procedures and tests will result in a no-show fee of $100 or more. A no-show fee is a separate charge that will not be covered by your insurance plan.

**BEFORE CHARGING YOU A NO-SHOW FEE, NEW BEGINNINGS SURGERY, PC MAY CONSIDER AN EXTENUATING CIRCUMSTANCE ON A CASE-BY-CASE BASIS.**

You will need to pay the no-show fee in full before you schedule any future appointments.

**WHY WE CHARGE A NO-SHOW FEE:** A patient who does not show up for their appointment and who had not cancelled their appointment with at least 48-hours advance notice affects the care we provide our other patients and the cost of care. First of all, each no-show represents a missed opportunity for another New Beginnings Surgery, PC patient to see Dr. Silverman. Second, certain supplies and medications that we have ordered for you may be wasted if you do not show up. Every no show is inconsiderate and costs New Beginnings Surgery, PC time and money.

I understand the New Beginnings Surgery, PC no-show policy and agree to pay the New Beginnings Surgery, PC no-show fees stated above if I am a no-show and had not called the New Beginnings Surgery, PC office at least 48 hours in advance of my appointment to cancel.

Patients Name (PRINT) Patients Signature Date

____________________________________________________________

Responsible Person's Name (PRINT) Responsible Person's Signature Date

____________________________________________________________

# ADAM T. SILVERMAN, MD

# CONSENT FOR DISCLOSURE OF PATIENT INFORMATION

The Privacy Rule that is contained in HIPAA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment or health care operations purposes, except in emergency situations.

The following information must be included in a medical record release form used by the practice to be in compliance with HIPAA requirements.

I understand that by giving consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment; it may also be used for payment and operational purposes. I have the right to review Dr. Adam T. Silverman's "notice of privacy practices" before I sign this consent. The provider reserves the right to change the terms of the notice of privacy practice. Change in the privacy practices will be made available to me. I may request additional restrictions on access to this information for treatment, payment or health care operations purposes. I understand that the provider may not be able to comply with this request.

I request the following special restrictions:
_______________________________________________________________

I understand that from time to time my physician and his staff may inform me of new drugs, treatments or other services that may be appropriate for my condition and from time to time may inform me of new services that may be appropriate for a person in my situation (age, sex, etc.). I consent to the use of my identifiable patient information to notify me such new drugs, treatments or other services that may be necessary for the continuity of my care or which may benefit in maintaining or improving my health with the understanding that the provider will not provide such information to others for marketing, fund-raising or similar purposes without my consent.

I understand that I, or my representative, promptly upon request, may inspect, request correction of and obtain information from my medical record.

I may revoke this consent in writing at any time except to the extent that the provider has already acted in reliance on this consent.

Signature ____________________ Name ____________________ Date _____________

**STANDING CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY**

I, ________________________________________________, whose signature appears below, authorize New Beginnings Surgery PC and Dr Adam Silverman to view the external prescription history via the RxHub service for the patient listed below.

Accurate prescription history reduces medication errors and enhances patient safety. This access provides our staff with information about medications you are already taking to minimize the number of adverse drug events.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions issued back in time for several years.

_______________________________________________

Patient Name

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT I AUTHORIZE THE ACCESS TO MY PRESCRIPTION HISTORY.

____________________________________________________ ______________

Signature of Patient or Guardian Date

If Guardian, Relationship to Patient

__________________________________________________ ________________

Witness Signature

**OFFICE DIRECTIONS**
New Beginnings Plastic & Reconstructive Surgery
4 Liberty Street, Third Floor
Poughkeepsie, NY 12601

*(LOCATED OFF CANNON STREET - MUNICIPAL PARKING LOT IS BEHIND THE BARDAVON)*

From Points South: Take Route 9 North to the Route 44/55 East exit. Once on 44/55 east stay in left lane and take a left onto Market Street. Take your first right onto Cannon Street. The municipal parking lot is on your left and the office entrance is located under the awning (Four Liberty Elting) directly across from the entrance to the parking lot.

From Points North: Take Route 9 South to the Route 44/55 East exit. Once on 44/55 east stay in left lane and take a left onto Market Street. Take your first right onto Cannon Street. The municipal parking lot is on your left and the office entrance is located under the awning (Four Liberty Elting) directly across from the entrance to the parking lot.

From Points East: Take Route 44/55 West into the city of Poughkeepsie, turn left onto Catherine Street. Catherine becomes Academy once you cross over Main Street, the next light past Main Street is Cannon Street take a right. The municipal parking lot is on your right and the office entrance is located under the awning (Four Liberty Elting) directly across from the entrance to the parking lot.

From Points West: Take the Mid-Hudson Bridge, you are now on Route 44/55 east stay in left lane and take your third left onto Market Street. Take your first right onto Cannon Street. The municipal parking lot is on your left and the office entrance is located under the awning (Four Liberty Elting) directly across from the entrance to the parking lot.