ADAM T. SILVERMAN, MD

NAME (LAST)_____ (FIRST)_____

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

ADAM T. SILVERMAN, MD
4 Liberty Street, 3rd Floor
Poughkeepsie, NY 12601

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name _____ Date _____

☐ Check here if patient is a minor or unable to consent.
I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the photographs may be used in my medical record, for purposes of medical teaching or for publication in medical textbooks and journals as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs may determine if New Beginnings Plastic & Reconstructive Surgery and/or Adam T. Silverman, MD will provide medical care but will in no way affect the quality of medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact New Beginnings Plastic & Reconstructive Surgery and/or Adam T. Silverman, MD.

1) I consent for these photographs to be used in medical publications, including medical journals, textbooks and electronic publications. I understand that the photographs may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my photograph to be shown for teaching purposes and to be used for my medical record.

Signature _____ Date _____

2) I consent for my photograph to be shown for teaching purposes AND to be used in my medical record but **NOT FOR** medical publication.

Signature _____ Date _____

3) I consent to the use of my photograph for medical records **ONLY**.

Signature _____ Date _____

4) I consent for the use of my photograph on Social Media (ie. Facebook, Instagram, Twitter) and/or the Website for New Beginnings Plastic & Reconstructive Surgery at www.newbeginningsplasticsurgery.com.

Signature _____ Date _____

I understand that New Beginnings Plastic & Reconstructive Surgery and Adam T. Silverman, MD and those it may authorize shall not be responsible for unauthorized duplications and/or use by third parties on the Internet or otherwise. I hereby release New Beginnings Plastic & Reconstructive Surgery and Adam T. Silverman, MD, those it has authorized, and their respective successors and assigns, from any and all claims and/or damages that may arise regarding the use, reproduction, display and distribution of my photograph. I have read, understood and agree to the terms of this Consent Form.

Signature _____ Date _____

Witness _____

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

4 Liberty Street 3rd Floor
Poughkeepsie, NY 12601
845-454-6392

(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.