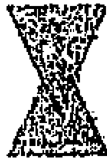

The safety of our staff and patients remain CRS overriding priority. As the coronavirus disease 2019 (COVID-19) outbreak continues to evolve and spreads globally, we are monitoring the situation closely and will periodically update company guidance based on current recommendations from the Centers for Disease Control and Prevention and the World Health Organization. To prevent the spread of COVID-19 and reduce the potential risk of exposure to our office and patients, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this building. Thank you for your time

Name: ______________________ Phone: ______________________

1	Have you tested positive for COVID-19? ☐ No ☐ Yes
2	Have you traveled outside the state of Florida within the last 14 days? ☐ No ☐ Yes (If YES) Where to:
3	To your knowledge, have you come in close contact or cared for someone diagnosed with COVID-19 within the last 3 weeks? ☐ No ☐ Yes
4	To your knowledge, have you come in contact with anyone who has traveled outside of Florida within the last 14 days? ☐ No ☐ Yes If answer is yes, where to:
5	Have you or anyone in your household experienced any flu-like symptoms witin the last 14 days? (Fever,cough,sore throat, repiratory distress) ☐ No ☐ Yes
6	Are you currently experiencing flu like symptoms: ☐ No ☐ Yes

By signing I attest that all information provided is true.

Signature: ______________________ Date: ______________________

906 NE 26th Avenue Fort Lauderdale, FL 33304 | Tel (954)533-8029 | Fax (954)533-6209
Christopher J. Low, M.D. | Michael C. Cheung, M.D.

Patient Information Form

Name: Last:__________ First:__________ M.I.:_____

DOB:________ Age:_____ SSN:________ Sex: ☐M ☐F

Address:__________ Apt/Unit#________

City:________ State:_____ Zip Code:________

Home Phone:________ Cell Phone:________

Email:__________

Occupation:________ Employer:________ Work Phone:________

Referred to office by:__________

Reason for today's visit:__________

Name of emergency contact:________ Phone Number:________

Relationship to patient:________

Appointment with ☐ Dr. Low ☐ Dr. Cheung

Primary Care Doctor Name:________ Phone:________

INSURANCE SELF/HEALTH/WORK COMP/AUTO/LOP:

☐ Self-Pay ☐ Health Insurance

Insurance company:________ Policy Number:________ Co-pay:_____

Patient's Relationship to subscriber:______ Subscriber's Name:________

Secondary Insurance Company:________ Policy Number:________

☐ **Worker's Comp:** Date of Accident:______ Employer:________

Name of Adjuster:________ Phone number:________ Claim#________

☐ **Auto Accident:** Car Insurance:______ Claim number:______ Date of Loss:______

Name of Adjuster:________ Phone number:________

☐ **LOP/ATTORNEY:** Attorney Name:________ Atty Phone:________

AUTHORIZATION OF RELEASE OF MEDICAL PHOTOGRAPHS

Medical photographs may be taken before, during or after surgical procedure or treatment. Consent is required to take such images. These images are used only for the education of other patients and physicians. Occasionally photos may be posted on social media outlets for the same purposes concealing any obvious identifying markers. Your signature below constitutes acknowledgement and consent. You may also choose decline signature and this will not affect your care in any way.

Patient/Guardian Signature:__________ Date:________

cosmetic and reconstructive specialists of florida

Confidential Patient History Form (Please Complete in Detail)

Last:______________________ First:______________________ Age:__________

Race:______________________ Ethnicity:______________________ ☐ I Decline to answer

Height:________ Weight:________

Preferred Pharmacy: ______________________
Pharmacy Phone: (   ) ________-________

Please list All Your Medical Conditions (i.e.: Diabetes, Thyroid, Asthma, Hypertension...):

______________________ ______________________
______________________ ______________________
______________________ ______________________

Have you had any surgeries? ☐ Yes ☐ No If YES Please List Below:

SURGERY:	YEAR:	SURGERY:	YEAR:

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING VITAMINS:

____
____
____

PLEASE LIST ALL ALLERGIES: ______________________ ☐ **NO KNOWN ALLERGIES**

____
____

Social History

Tobacco:

☐ Never smoked ☐ Quit smoking (Quit Date):____________

☐ Current smoker: Packs per day: ______________ Since Year: ______

Alcohol:

☐ Never drank ☐ Social drinking ☐ Daily Beer/Wine: How many per week? ________

Recreational Drugs(Including Marijuana):

☐ Yes ☐ No If yes, please list: ______________________________

Family History

Do you have family history of:

Diabetes: ☐ Yes ☐ No
Skin Cancer: ☐ Yes ☐ No
Breast Cancer: ☐ Yes ☐ No
Heart Disease: ☐ Yes ☐ No

The above information is accurate and complete to the best of my knowledge.

Patient/Guardian Signature:______________________ Date:______________

Reviewed By Signature (Office):______________________ Date Reviewed: ____________

Cosmetic and Reconstructive Specialists of Florida Office Policy

Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policy which we request you read and sign.

- All patients are required to complete our registration form, provide us with a valid medical insurance card and photo ID, as well as new insurance cards as they become available.
- **We accept assignment of insurance benefits as a courtesy to our patients; however, the balance is your responsibility. Deductibles applied by your insurance, not covered by any another insurance, will also be your responsibility. Please be aware that some services may not be covered and may not be considered medically necessary, under Medicare and other insurances. Patients will be responsible for payment in full at the time of visit, unless valid insurance is presented. All copayments are to be paid at the time services rendered.**
  Initials ______
- Some visits are performed by the nursing staff, without seeing a doctor, are still considered an office visit and fees will be charged accordingly where applicable. Initials ______
- **We ask 24-48 hours to process prescription requests and prescription refills. Initials ______**
- If you are calling to make an appointment from a referring physician and your insurance requires a referral to be seen, please allow at least 3 business days prior to appointment to assure we receive the authorization. If you choose to be seen without proper authorization, you will be given a waiver to sign stating you aware authorization has not been received and would like to be seen. You will be responsible for any charges your insurance denies because of un-authorized visit. Initials ______
- **There is a fee for copied medical records. We will notify you of the records fee and will require payment in full prior to the release of records. We require at least 5 business days to receive records and make copies. Initials:______**
- If you need any forms filled out, <u>the patient's portion is to be filled out prior to giving to a staff member</u>. We ask 3- 7 business days for forms to be completed. **Initials ______**
- **Should you arrive late to your appointment, you may be asked to reschedule, or you may have to wait to be seen between or after other patients who have arrived on time. Initials ______**

I,______________________________ have read, understand and agree to the office policy of Cosmetic and Reconstructive Specialists of Florida, PLLC.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Responsible Party Date

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Cosmetic Reconstructive Specialists of Florida, PLLC

Financial Responsibility

I have requested professional services from Cosmetic Reconstructive Specialist of Florida, PLLC ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and(3) allow a photocopy of my signature to be used to process insurance claims I understand that any information disclosed pursuant to this authorization may be disclosed by the recipient pursuant to my providers Notice of Privacy disclosure and may not be protected by the federal privacy regulation. I understand that I have a right to revoke this authorization at any time by providing written notice to my Provider and my health benefit plan (or its administrator) via electronic mail, U.S. mail or facsimile. I further understand that there are no exceptions to my rights to revoke this authorization.
Therefore, this authorization will remain in force and effect for claims with date of service within one year of the signature date, or until revoked by me in writing, or until my healthcare claims are adjudicated to my provider's satisfaction.

ERISA Authorization and Limited Power of Attorney

I hereby designate, authorize, and convey to CRS Plastic Surgery, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to sign any and all documents that require my signature, sent to or received from my health benefit plan (or its administrator) on my behalf, in the event that my health benefit plan (or its administrator) require additional information; (2) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan and assigned hereunder to Provider; and (3) the right and ability to act as my Authorized Representative to pursue any such claim, right, or cause of action in connection with said insurance policy and/or benefit plan including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines;
A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

____
Patient Name

______________________________ ______________________
Signature Date