



**Associates in Plastic & Aesthetic Surgery**  
**njplasticsurgerygroup.com**

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security No \_\_\_\_\_

Demographics  Male  Female  Single  Married  Divorced  Widowed

Reason for your Visit \_\_\_\_\_

Who referred you to this office  Doctor  Patient  Web Site  Other

Please elaborate (name and phone) \_\_\_\_\_

If your visit pertains to an injury, what was the date \_\_\_\_\_

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Preferred Language  English  Spanish  Other \_\_\_\_\_

Ethnicity  Hispanic/Latino  Not Hispanic/Latino

Race  American Indian/Alaskan  Asian  African American  Native Hawaiian/Pacific  Other  White

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**PERSONAL INFO**

Email \_\_\_\_\_ Cell # \_\_\_\_\_ Home # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**WORK INFO**

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFO**

Insurance (primary) \_\_\_\_\_ (secondary) \_\_\_\_\_

Guarantor (Primary Insured Name) \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_ Relationship to the Insured \_\_\_\_\_

Who is your primary medical doctor (name and phone no.) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Charles A. Loguda MD   Howard N. Tepper MD   Jerrold Zeitels MD   Richard Tepper MD

955 S. Springfield Ave   Suite 105   Springfield, NJ 07081   908.654.6540



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Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Please approximate your blood pressure (i.e. 120/80) \_\_\_\_\_

Any RECENT fever, chills or unintended weight loss? Yes No

Problems with your Heart (previous heart attack)? Yes No

Problems with your Breathing (asthma, shortness of breath)? Yes No

Do you have Obstructive Sleep Apnea? Yes No Do you use a CPAP machine? Yes No

Have you ever had a Blood Clot (DVT) in your legs? Yes No

Have you ever had excessive bleeding from surgery? Yes No

Have you ever had a complication from surgery? Yes No

Please explain \_\_\_\_\_

Have you ever had a complication from anesthesia (not including nausea / vomiting)? Yes No

Have you ever received a blood transfusion? Yes No

Did you have any metal implant? (where \_\_\_\_\_) Yes No

Do you smoke? Never Quit Few cigs/day ½ pack 1 pack > 1 pack/day

Do you drink Alcohol / Beer / Wine? No Yes (if yes, please select social few/week heavy)

**Current Medications** No Yes (if yes, list name and dosage) \_\_\_\_\_

**Allergies to Medicine (or latex)?** No Yes (what happens?) \_\_\_\_\_

**Do you take Blood Thinners?** No Baby Aspirin Full Aspirin Coumadin Eliquis

Pradaxa Savaysa Xarelto Lovenox Plavix

**Do you take supplements?** No Dong Quai Ginger Ginkgo Biloba Vitamin E Garlic

Ginseng Omega-3 fatty acid Feverfew Other (names / dosages) \_\_\_\_\_

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**Current Medical Conditions (check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> <b>NONE</b>                 | <input type="checkbox"/> COPD (emphysema)         | <input type="checkbox"/> Kidney Failure - Dialysis |
| <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Migraines                 |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Mitral Valve Prolapse     |
| <input type="checkbox"/> A-fib (atrial fibrillation) | <input type="checkbox"/> Heart Attack ("MI")      | <input type="checkbox"/> MRSA (Staph infection)    |
| <input type="checkbox"/> Bleeding Problems           | <input type="checkbox"/> Heart (coronary) Disease | <input type="checkbox"/> Rheumatoid Arthritis      |
| <input type="checkbox"/> Cancer (explain below)      | <input type="checkbox"/> Hepatitis or HIV         | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> CHF (heart failure)         | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Stroke (or TIA)           |
| <input type="checkbox"/> Cholesterol (high)          |   | <input type="checkbox"/> Thyroid (low)             |

**Other Medical**

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**Previous Surgery**     No    Yes (please explain)

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**Family History**     No     Yes (please explain)

- Cancer    Heart Disease    Bleeding Problems    Other \_\_\_\_\_

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**Have you recently experienced any of the following (you may underline or circle)?**

- Constitutional: Recent fevers or unexplained weight loss
- Head-Neck: Recent vision changes, dry eyes or irritation, nasal problems, or neck pain
- Heart: Recent chest pain, palpitations, need to take nitroglycerin under your tongue, or angina
- Lungs: Recent shortness of breath, cough, or difficulty breathing
- Hematology: Easy bruising, difficulty clotting, very heavy periods, or frequent and/or excessive nose bleeds
- GI: Recent stomach pains / nausea / vomiting / GI problems
- Skin: Unexplained rashes, difficulty healing, wounds that won't heal, or skin cancer concern
- Neuro: Recent headaches, dizziness, or poor balance
- Hand: Change in fingertip feeling, weakness, dropping things unexpectedly
- Musculoskeletal: Neuropathy, pain in calves when walking

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WELCOME TO THE PRACTICE

**FROM OUR PHYSICIANS:** Thank you for entrusting your care to us. We are all board-certified plastic surgeons who are licensed to practice medicine in the State of New Jersey. We are committed to providing safe, private and personalized care. Please note that when we are requesting your permission or consent, the forms used in this practice will make reference to your (or my) "provider(s)". "Provider(s)" refers to Dr. Charles Loguda, Dr. Howard Tepper, Dr. Jerrold Zeitels, and / or Dr. Richard Tepper.

**PRIVACY PRACTICES / MY RIGHTS ACKNOWLEDGEMENT:** I have received the Notice of Privacy Practices / My Rights and have been provided an opportunity to review it.

**WHAT IS EXPECTED OF YOU (the patient):** It is our goal to provide you with the highest quality of care, and to treat you with respect and dignity. In order to do so, it is imperative that we have your fullest attention and cooperation. By receiving care from our practice, you agree to follow all of our instructions and be compliant with all aspects of your care, both pre-operative (pre-treatment) and post-operative (post-treatment). You acknowledge that failing to do so may result in an increased risk of complications and/or a sub-optimal result.

**PLAY A PART IN YOUR CARE:** We encourage all patients to be involved in their care, so feel free to ask questions of anyone in this organization. Please speak the office manager about any concerns you may have (Diane Ballistreri). If you feel that concerns have not been addressed to your satisfaction, you may contact AAAASF at 888-545-5222 or by email at [info@aaaasf.org](mailto:info@aaaasf.org). You may also contact the office of the Medicare beneficiary Ombudsman James McCracken at 877.582.6995 or 609.943.4026, or at <http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>

**INFECTION CONTROL:** Staff members are educated about proper infection control techniques upon hire and annually thereafter. They follow CDC guidelines. We encourage staff to stay home when ill. We provide tissues, garbage cans and hand sanitizers throughout this facility. We request that everyone cover their mouth when coughing or sneezing, and then wash their hands. We value patient safety.

**PHOTOS, VIDEO OR DIGITAL IMAGES:** Your signature confirms that you understand that photos, videos or digital images (collectively referred to as "images") may be obtained during treatment and that any or all may be used to document care. By signing, you consent to such "images" being taken and understand that our practice retains all ownership rights to these "images". You will be allowed to view them or obtain copies if you request. These "images" will be secured in a manner consistent with our privacy policy and maintenance of medical records. Any "images" of you may reveal private or personal details and may further reveal your identity, and your signature acknowledges your approval of this. See "authorization to release information" regarding release of such "images" and electronic / print / advertising uses.

**HOW WE MAY USE YOUR INFORMATION**

Our practice collects information and stores this information in a certified EHR system. Annual reporting requirements by state or federal agencies may require release of this information. When your permission is required, you will be asked to sign the necessary release forms. Generally speaking, we are permitted to release your information when it pertains to your treatment, payment, and healthcare operations. We do not sell your personal information. But we do collect your email and may use it from time to time for the purpose of notifying you about general practice information or new procedures, cosmetic services, and specials. You may choose to unsubscribe if you prefer not to receive such emails. Your email will not be used to transmit

I have read the above paragraphs.....**Patient Initials** \_\_\_\_\_ **Date:** \_\_\_\_\_

Charles A. Loguda MD   Howard N. Tepper MD   Jerrold Zeitels MD   Richard Tepper MD   **(Sept 2018)**  
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personal information or HIPAA-protected information unless you specifically give us permission for such use. You may email us at your discretion. However, our office emails are NOT encrypted. Thus anything you send to us, and any reply to such, will not be encrypted. Use caution when sending sensitive information. Furthermore, do not rely on email to transmit any medical information of an urgent or emergency nature. If you have a medical emergency, you should dial 911 or go to the nearest emergency room. If your concern is less than urgent, you may reach us at 908.654.6540.

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize "my provider" or any "affiliate" to release any and all information regarding my treatment, including digital photos or "images", even if they reveal my identity or other private area on my body, to my insurance carrier(s), Workers' Compensation Carrier, Case manager, PIP representative or other health professional as necessary to obtain insurance pre-approval or payment, and to process my insurance claim(s) generated in the course of examination and /or treatment. "Affiliate" refers to any outside company we hire to assist with our business operations. A photocopy of my signature and agreement is to be considered as valid as the original. This order will remain in effect until revoked by me in writing.

**FINANCIAL POLICY regarding INSURANCE BENEFITS:** If your "provider(s)" participates with your insurance plan, he will submit claims for services rendered, but co-payments and deductibles are due at the time of your visit unless other arrangements have been made. If you require special arrangements regarding payment, please raise this concern prior to services being rendered. If a referral is required, it is your responsibility to obtain one. Otherwise, without such, you will be responsible for the full payment.

Please be advised that a list of the insurance plans with which each of our physicians participates is located on our website, www.NJPlasticSurgeryGroup.com. This information is also available from our office upon request. If your health plan is not listed on our website or communicated to you at the time of your appointment as a benefit plan with which your physician participates, such means that the doctor does not participate in that network of your healthcare plan. Out-of-network physicians are not contractually bound by your healthcare plan rates and are permitted to charge more. The estimated amount that will be billed to you is available upon request and our practice will do its best to convey your financial responsibility prior to any services being rendered. Unforeseen medical circumstances may arise when services are provided, and such may result in a higher fee.

Depending on your specific plan, you may have financial responsibility for services related to your out-of-network deductible, co-pay and /or co-insurance. Additionally, you may be responsible for the portion of our charges that are not covered by your insurance and we recommend that you contact your insurance carrier for further information regarding the costs under your specific plan. Our office will gladly review with you the specifics of your plan benefits.

As a courtesy to our patients, we will bill your insurance company directly for reimbursement for our services, unless other arrangements are made. Occasionally, the insurance company will either mail the check or deposit our reimbursement for surgical fees directly to you. In these circumstances, we kindly request that you mail us a copy of the explanation of benefits (EOB) with the check from your insurance company endorsed by you, or in the case of monies being directly deposited, a check from you in the exact amount stated in the EOB made payable to (physician / practice name). Failure to comply will force your account to become past due. This may result in the amount owed being turned over to a collection agency and this may adversely affect your credit. We thank you for your cooperation in this matter and we are happy to assist you in any way we can.

I have read the above paragraphs.....**Patient Initials** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Sept 2018)*

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Payment for cosmetic surgery must be made at least one week prior to the procedure. We do not submit insurance claims for cosmetic surgery. The price you pay for cosmetic surgery will state the surgeon's fee, anesthesia fee (if any) and facility fee on the specified procedural date. When applicable, we will collect fees for the hospital / surgery center and anesthesia group solely for your convenience, and send those fees to the respective people. Collecting fees in no way implies that we take any responsibility for any action taken by either anesthesia or the hospital / surgery center. If you choose, you may pay them directly. Hospital / Surgery center and anesthesia fees are based on an estimate of the time required for your procedure. You may receive a refund for unused time, but it is your responsibility to pursue such a refund. You may be billed for additional time if required. You are responsible for payment if extra time is needed. We are not responsible for that. We may elect, at our own discretion, to assist you with such, but you acknowledge that we bear no responsibility for those refund / additional charges and make no guarantees, implied or otherwise.

We include routine postoperative care for 90 days at no additional cost. Any and all additional treatments including, but not limited to, medications, garments, scar treatments, laser therapy, and/or revisions, that you may need and / or desire are not included in your cost for surgery unless otherwise clearly stated in writing. At our sole discretion and with no implied warranty or guarantee, we may choose to extend your care or provide additional services at no cost or a reduced cost. You should check with your insurance company prior to having cosmetic surgery as some companies have provisions regarding coverage for complications related to cosmetic surgery. If you experience an adverse event, such as an infection, poor wound healing, hematoma or bleeding, blood clot or other situation requiring treatment, whether as an outpatient or in the hospital, such treatments may result in additional charges to you and are not included in the price you pay for cosmetic surgery. We bear no responsibility for charges rendered by the hospital or anesthesia providers.

If you initiate a personal injury lawsuit against another person / entity for injuries sustained, and you received treatment by our practice for those injuries, you agree to notify us immediately when your lawsuit is filed and provide the name and contact information of your attorney. In the event you prevail in your legal proceeding, either by settlement or actual jury verdict, and receive a monetary award, you agree that the remainder of this paragraph will be in full force in the event that a subrogation action occurs. In such a case, your own health insurer will be reimbursed for care. This applies to private / commercial plans as well as Medicare and Medicaid plans. As such, we are not bound by their contracted fee schedules. Thus, our full and non-discounted fees will then apply. The balance owed on your account will then be calculated by subtracting what has already been paid from the total non-discounted amount. You agree to have your lawyer pay us the entire balance from the proceeds of your legal case before you or any other entity is paid.

If your insurance company denies a claim because it is considered medically unnecessary, you will be responsible for full payment. If pre-certification is required prior to surgery, we will obtain authorization on your behalf. If you provide inaccurate insurance information and such renders the authorization invalid, resulting in non-payment, you will be the responsibility for the entire balance. Balances remaining after 45 days will be subject to sixteen percent interest (annually). If payment of our fees is not made in what we consider to be a timely manner your account may be sent to collection, and may be subjected to additional charges and fees associated with such collection.

I have read the above paragraphs.....**Patient Initials** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**CANCELLATIONS:** Last minute cancellations are disruptive to the practice and result in unused time. We want patients to take the surgery time and date seriously, to avoid these last minute cancellations. We reserve the right to impose the following penalties for last minute cancellations: 25% of the full fee if within 72 hours of the procedure, 50% of the full fee if within 48 hours of the procedure, and forfeiture of the entire fee for cancellation within 24 hours of surgery

**SURGICAL REVISIONS:** From time to time, a patient may require or desire a surgical revision. Surgical revisions are not included in the price you pay for surgery, whether cosmetic or reconstructive, unless specifically stated in writing ahead of time. Cosmetic revisions are frequently offered at no charge, especially if we can perform such in our office, but this decision lies with each doctor individually and no guarantee whatsoever is made that you will receive free or discounted care. In the event that you require / desire a revision following a procedure that your insurance company initially covered, such doesn't mean that your insurance company will approve the revision. If not approved, you may have the option of proceeding with a cosmetic revision, and the cost will be discussed with you prior to the procedure. Patient non-compliance can have detrimental effects and lead to increased complications and even poor outcomes, whether intentional or not. In such cases, any additional care you receive, whether required or simply desired, may incur additional charges. From time to time, an executive decision can be made to refund or eliminate patient balances as the cost of business and not a reflection on quality or outcome.

**Please provide the names of people with whom we can discuss your personal information and sensitive medical information.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I acknowledge that I have read the information in this registration packet. I have initialed the preceding 3 pages and have signed this page, acknowledging my acceptance and understanding of the provisions within. I am aware of "my provider(s)" participation status with regard to my insurance company, meaning whether he is an in-network provider or an out-of-network provider, and have had my questions answered to my satisfaction. I elect to obtain services from "my provider(s)". I understand that it is my responsibility to remit any funds rendered to me by my insurance carrier as payment for medical services provided to me by "my provider(s)". Failure to do so may expose me to any applicable civil or criminal penalties. I hereby authorize "my provider(s)" and Associates in Plastic & Aesthetic Surgery to appeal and pursue all other legal rights for any and all unpaid claims on my behalf with my insurance company. I also acknowledge that I have read the above information regarding fee disclosures.

\_\_\_\_\_  
**Patient Signature (or authorized person)**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

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**ASSIGNMENT OF BENEFITS & LIMITED POWER OF ATTORNEY**

I, the undersigned, irrevocably assign to Dr. Charles Loguda, Dr. Howard Tepper, Dr. Jerrold Zeitels, and / or Dr. Richard Tepper (known as "my provider"), all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me including, but not limited to, all of my rights and benefits under the **Employee Retirement Income Security Act** ("ERISA") and/or other applicable federal and state laws, applicable to the medical services at issue. This is regardless of the "my provider's" managed care network participation status. I irrevocably authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan/ other responsible party, for any and all rights and benefits under ERISA or applicable federal and / or state statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan documents and other equitable relief. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, "my provider". I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to ERISA. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize "my provider" to release all medical information necessary to pre-certify a service and / or process my claims under HIPAA, including the release of office records, outside testing or consultation, and digital images obtained during the course of treatment. This information may contain private and/or personally identifiable information.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney-in-fact. I further grant limited power of attorney to you as "my provider" to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my medical condition. **I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

In the event that I receive direct payment (i.e. "a check") from my insurance company in any amount for services already rendered by "my provider", I agree to forward immediately to "my provider" such checks, made payable to "my provider" (enter the actual physician name). I agree to include the Explanation of Benefits (EOB) in my possession, and will further keep a photocopy of the check and EOB for my records. I understand that such an insurance check, even if made payable to me, isn't mine and represents the property of "my provider". I understand that failure to release such check may result in a criminal penalty. If you, "my provider", initiate a collection proceeding against me, whether through litigation, arbitration or otherwise, in connection with any and all claims unreimbursed and/or under-reimbursed by my insurance carrier, I agree to pay any and all of "my provider's" attorneys' fees and court fees in connection with that proceeding.

I acknowledge that I been given ample opportunity to read this agreement, ask questions about it, and am in full agreement with it. A photocopy of this assignment is to be considered as valid as the original.

\_\_\_\_\_  
**Patient Signature (or authorized person)**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

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