Cross Hudson Plastic Surgery
Boris Mordkovich, M.D.
Cosmetic ♦ Reconstructive ♦ Hand & Microsurgery
Phone (201)751-9490 Fax (201)751-9491
Website: *www.crosshudsonmd.com* ***E-mail:*** *info@crosshudsonmd.com*

General Policy

- Patients are seen by appointment only.
- **As a courtesy**, our office will submit a bill to your insurance company on your behalf but it in no way relieves you, the patient/guardian, of responsibility for all and/or any balance remaining on your account.
- Your insurance coverage plan is a contract **BETWEEN YOU AND YOUR INSURANCE COMPANY, NOT BETWEEN THE DOCTOR AND THE INSURANCE COMPANY**. It is designed to pay the doctor or reimburse you, the patient, for all or part of the doctor's fee, however, ultimately you, the patient/guardian are responsible for satisfying all fees for rendered services.
- Your insurance coverage plan is not a guarantee of payment or specific amount of payment.
- As there are multiple different coverage plans, we cannot guarantee that your insurance policy will cover all or any specific amount of the fees for rendered services. The amount covered will depend upon your individual coverage outlined by your insurance plan. **Any checks you receive from your insurance carrier are to be sent to our office immediately.**
- The charges billed are reasonable and customary for the geographic area. We **DO NOT** participate in any managed care programs and are therefore not bound by their reimbursement rates.

Financial Policy

- COSMETIC CONSULTATIONS are free. All other consultations are payable at the time of the office visit.
- COSMETIC & ELECTIVE SURGERY fees must be paid **7 days** prior to the surgery/procedure.
- EMERGENCY ROOM SURGERY AND FOLLOW-UP TREATMENT is payable within **60 days** of the date of service. If not paid in full, you, the patient/guardian will be responsible for the outstanding balance.
- WORKER'S COMPENSATION injuries and MOTOR VEHICLE accidents covered either through Worker's Compensation or No Fault insurance and are billed through their respective carriers. It is YOUR responsibility to report the injury to your No Fault insurance carrier or Employer, as well as provide us with the **INSURANCE COMPANY NAME, ADDRESS, PHONE NUMBER, and CLAIM NUMBER**
- If you fail to provide us with the necessary billing information, the bill will be sent to **YOU** directly for full payment.
- Interest of 1%/month (12% APR) is charged on **ALL DELINQUENT ACCOUNTS UNPAID IN 60 DAYS**. In the event that it becomes necessary to institute collection proceeding for the payment of your bill, you will be responsible for all collection and/or legal fees and all court costs, including but not limited to reasonable attorney fees. Also, all credit card charges are subject to a 3% processing fee.

Patient Signature:_____ Date: _____

Print Name: _____

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PATIENT INTAKE FORM

Last Name: _____ First Name: _____ Middle Initial: ____ DOB: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Cell Carrier:_____

May we contact your cell phone? □ Yes □ No May we send you text messages? □ Yes □ No

May we contact you at home? □ Yes □ No If yes, can we leave a message? □ Yes □ No

May we contact you via email? □ Yes □ No May we contact you at work? □ Yes □ No

□ I am interested in learning about special events and exclusive offers

Gender: □ Female □ Male Social Security # _____ E-mail: _____

Employer Name:_____ Occupation: _____

Employer address:_____Phone:_____

How did you hear about us? □ Advertisement □ Our website □ Living Social □ Zwivel □ Real Self

□ Patient referral Who? _____ □ Web search engine Which? _____

□ Physician Referral Who? _____ □ Hospital: Which? _____

Emergency Contact and/or Guardian information

Name: _____ Relationship: □ Spouse □ Parent/ Guardian □ Other _____

Cell Phone: _____ Work Phone: _____ Same address as above? □ Y □ N

If no, please provide address: _____

Can we discuss your medical information with him/her? □ Yes □ No

Primary Insurance

Name: _____Subscriber ID#:_____ Group#: _____

Claim's Address (back of card) _____Phone: _____

What type? □ Commercial □ Self-Pay □ Worker's Compensation □ Motor Vehicle INS

Date of Accident/Incident? _____ Date seen in hospital? _____

Secondary Insurance

Name: _____Subscriber ID#:_____ Group#: _____

Claim's Address (back of card) _____Phone: _____

Specific Medical History

1. Are you pregnant? □ Yes □ No Height: _____ Weight: _____

Have you ever been diagnosed and/or currently have: (Check all that apply)

□ Cancer □ Bleeding tendency □ Leukemia □ Heart disease □ High Blood Pressure □ Infections diseases

□ Blood disorders □ Chronic lung disease □ Tuberculosis □ Asthma □ Serve Allergies □ Kidney disease

□ Migraines/Headaches □ Diabetes □ Gout □ Thyroid issues □ Epilepsy/Seizures □ Stroke □ Obesity

If any checked, please describe? _____

□ Others not listed: _____

Have you been advised to or had any psychiatric care? □ Yes □ No If so, diagnoses? _____

Surgical & Anesthesia History

Have you ever had any kind of surgery? □ Yes (Please describe) □ No

_____

Do you have a blood relative who had anesthesia complications of any kind? □ Yes (Please describe) □ No

_____

Social History

Do you smoke? □ No □ Yes How much? _____ Do you Drink? □ No □ Yes How much?_____

Have you ever used or currently using recreational drugs? □ Yes □ No (Please describe) _____

Family History

Have any blood relatives had any of the following? (Check all that apply)

□ Cancer □ Bleeding tendency □ Leukemia □ Heart disease □ High Blood Pressure □ Infections diseases

□ Blood disorders □ Chronic lung disease □ Tuberculosis □ Asthma □ Allergies □ Kidney disease

□ Migraines/Headaches □ Diabetes □ Gout □ Thyroid issues □ Epilepsy/Seizures □ Stroke □ Obesity

□ Mental Illness If any checked, please describe? _____

Medications/Allergies/ Sensitivities

SAFE and SECURE MEDICINE DISPOSAL

Unused medications that remain in your medicine cabinet are susceptible to theft and misuse. To prevent medications from getting into the wrong hands, New Jersey's Office of the Attorney General and Division of Consumer Affairs urge you to properly dispose of your expired and unwanted prescription medicine at a nearby Project Medicine Drop location. DROP OFF IS SIMPLE, ANONYMOUS AND AVAILABLE 24 HOURS A DAY – 365 DAYS A YEAR, NO QUESTIONS ASKED. Simply bring in your prescription and over-the-counter medications and discard them in an environmentally safe manner. Always scratch out the identifying information on any medicine container you are discarding. For a list of Project Medicine Drop locations, please visit www.NJConsumerAffairs.gov/meddrop.

Are you taking any medications, vitamins or herbal supplement? □ Yes (Please describe) □ No

_____

Are you allergic to any medications or local anesthesia? □ Yes (Please describe) □ No

_____

Woman's section only

Periods □ Normal or □ Irregular Started what age? _____ Menopause □ Yes □ No Age?____

# of Pregnancies: _____ # of Miscarriages _____ # of Abortions _____ # of Children _____

Birth control □ Yes □ No Method:_____ Date of last mammogram: _____

Any history of breast cancer? □ Yes □ No Family member? □ Yes □ No Who? _____

Other procedure that I am interested in (please check all that apply)

□ Breast Reconstruction	□ Breast Augmentation	□ Breast Lift	□ Ultherapy
□ Fat Grafting	□ Tummy Tuck	□ Breast Reduction	□ Brow Lift
□ Buttocks Lift	□ Arm Lift	□ Body Lift	□ Face Lift
□ Liposuction	□ Botox Injections	□ Collagen Injection	□ Hair Removal
□ Eyelid Surgery	□ Nose Surgery	□ Deeper Lesions	□ Scar Revisions
□ Acne Laser Treatment	□ Vascular Lesions (Rosacea)	□ Pigmented Lesions (Age Spots/Freckles)	

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient signature: _____ Date: _____

Guardian signature: _____ Relationship: _____

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HIPAA Information and Consent Form

Patient Name:_____DOB:_____/_____/_____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov
We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice *and/or* as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

By signing below I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information and any subsequent changes in office policy. I understand that this consent shall remain in force from this day forward

_____ _____/_____/_____

Authorized Signature Date

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GENERAL CONSENT/AUTHORIZATION

1. CONSENT TO TREATMENT/ADMISSION

I assign and hereby consent to treatment by BORIS MORDKOVICH M.D. and authorize the physician, practitioners, health care professionals, employees and members of the Medical Staff to render medical care. I understand that the medical care that I receive from Cross Hudson Plastic Surgery may include, but may not be limited to, laboratory tests, diagnostic procedures, examinations and administration of medications, etc. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I understand and acknowledge that no guarantees have been made to me about the outcome of my care.

2. RELEASE OF INFORMATION

I hereby authorize Cross Hudson Plastic Surgery/ Boris Mordkovich, MD to release part or all of my medical record (as necessary to either determine eligibility for health benefits or verify, collect or pursue my account) to any person, corporation, agency or entity that is either responsible for payment for the cost of care provided to me, or involved in the collection, processing, verification, or payment of my account., regardless of whether I am eligible for reimbursement by a third-party payer. My consent to the release of this information is subject to revocation at any time, except to the extent the party which is to make the disclosure has already relied upon my consent. I hereby agree to all the Pre-Certification requirements as stated in my health insurance policy. **I authorize BORIS MORDKOVICH M.D. to release information to outside healthcare institutions, agencies, or physicians as necessary to maintain continuity of care post discharge. I acknowledge that any questions I had were answered to my satisfaction.**

3. AUTHORIZATION TO PAY PHYSICIAN AND/OR SURGEON & ASSIGNMENT OF BENEFITS

I authorize & assign payment directly to BORIS MORDKOVICH M.D. for services rendered to me, my spouse, or dependents for all hospital/office services. This assignment of benefits includes payments from Medicare, commercial insurance, worker's compensation, auto insurance, etc.

4. FINANCIAL AGREEMENT/PAYMENT POLICY

For and in consideration of care and treatment provided, I hereby guarantee payment of all charges not covered or paid by my insurance benefits including Medicare, commercial insurance, workers compensation, auto-insurance, etc. I understand that Cross Hudson Plastic Surgery/Boris Mordkovich, MD **does not participate with any HMO/POS/PPO, commercial or private insurance carriers. However,** we will accept the payments from such carriers on the "out-of-network benefits" basis. I grant Cross Hudson Plastic Surgery/Boris Mordkovich, MD to file a claim with any and all applicable insurance company/entity on my behalf. I understand that Cross Hudson Plastic Surgery/Boris Mordkovich, MD will forward my claim to my insurance carrier as a courtesy, however ultimately payment of the entire outstanding balance noted on the bill is my responsibility. I will be responsible for co-payments, co-insurance, deductibles & payment of your bill if my insurance does not pay within **60 days** from the date of service. All visit co-pays & valid referrals, if applicable, are my responsibility & are due at the time of my office visit. If I do not have my co-pay or referral, my appointment will be rescheduled. I hereby agree to all precertification requirements as stated in my health insurance policy**. I understand that if the insurance company pays me directly for services provided by Cross Hudson Plastic Surgery/Boris Mordkovich, MD, it is my responsibility to endorse the payment to BORIS MORDKOVICH M.D. and forward payment. I understand that if I do not pay those amounts which are my responsibility to pay, I will also be responsible for any additional fees incurred during the collection process, including the collection agency fee and legal fees up to 40%. I also understand that all credit card charges are subject to a 3% processing fee.**

ACKNOWLEDGEMENT

I hereby acknowledge that I have read (or have had it read to me) and understand this form and any questions I had were answered to my satisfaction. I hereby agree and accept the terms and conditions stated on this form.

PATIENT OR PERSON SIGNING ON PATIENT'S BEHALF _____ RELATIONSHIP _____

WITNESS TO BOTH ACKNOWLEDGEMENT SIGNATURES _____ DATE _____

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Hyaluronic Acid Injectable Filler Consent Form

Name: _____ DOB: ____/_____/_____

Allergies: _____

(Women Only) Are you Pregnant or Lactating? _____

I authorize Dr. Boris Mordkovich to perform a cosmetic treatment upon me by injecting cosmetic filler containing Cross Linked Hyaluronic Acid beneath the skin of my face to remove unsightly wrinkles, scars, or surface depressions. I understand that this material has been used in humans for many years safely. _____ ***Initials***

I understand that this is an elective procedure and the indication is my request for the elimination of facial wrinkles or depressions in my skin, and is being performed for the improvement of my appearance. I understand that follow up treatments may be required for optimal results and that insurance will not cover the cost of the procedure(s). _____***Initials***

I have been told that minor side effects are common and include temporary bruising, redness and pain, which may last for a few days. Other potential risks include under correction or over correction of the problem being treated, facial asymmetry or the development of antibodies. Serious or long lasting effects are very rare. I also understand that the results of treatment are temporary and will wear off within 4 to 8 months and that my appearance will return to what it was before treatment was stared. **_____** ***Initials***

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected. _____ ***Initials***

Pre-treatment and post-treatment instructions have been given to me and the potential advantages and disadvantages have been discussed with me. _____***Initials***

I agree that this constitutes full disclosure, and that this Consent supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions. I have had all of my questions answered and I freely consent to this Cross Linked Hyaluronic Acid Cosmetic treatment today and for all subsequent treatments. I accept the risks and complications of the procedure.

Patient's Signature: _____ Date: _____

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Patient Consent Form BOTOX® Cosmetic or DYSPORT

Name: _____ DOB _____/_____/_____

I authorize Dr. Boris Mordkovich to perform a cosmetic treatment upon me by injecting Botox/Dysport beneath the skin of my face and/or neck. _____ ***Initials***

I understand that Botox/Dysport, *Botulinum Toxin Type A,* is produced by the Allergan Inc./Ipsen Pharm and has been used for more than a decade to improve spasm of the muscles around the eye, to correct double vision due to muscle imbalance as well as numerous other neurological uses. Botox® Cosmetic/Dysport is now approved by the FDA to improve the appearance of the vertical lines between the brows. A few tiny injections of Botox® Cosmetic/Dysport relax overactive muscles and soften those vertical lines. Injections in other areas to improve appearance of facial lines have been reported in the literature, but the FDA has not approved those uses. The results of Botox® Cosmetic/Dysport are usually dramatic; however, no guarantees can be or have been made concerning expected results. _____ ***Initials***

I understand that this is an elective cosmetic procedure and request that the practitioner attempts to improve my facial lines with Botox® Cosmetic/Dysport. I understand that follow up treatments may be required for optimal results and that insurance will not cover the cost of the procedure. _____ ***Initials***

The Botox® Cosmetic/Dysport solution is injected with a tiny needle into the muscle; the benefits of the procedure should be seen over the next two to seven days. A decreased appearance of frowning or creasing of other lines will be the result of this treatment. _____ ***Initials***

I have been told that the most common side effects are headache, flu-like syndrome, temporary eyelid droop, and nausea, which may last for a few days. Other potential risks include under correction or over correction of the problem being treated, facial asymmetry or/and muscle weakness or development of antibodies to Botox/Dysport. Additionally, slight temporary bruising may occur at the injection site. I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all. _____ ***Initials***

I consent to photographs being taken during the course of my treatment to evaluate the effectiveness of my treatment. _____ ***Initials (Clinical purposes only)***

I understand that the results are temporary and will wear off within 3-6 months and that my appearance will return to what it was before treatment was started. _____ ***Initials***

I acknowledge that pre-treatment and post-treatment instructions have been given to me and the potential advantages and disadvantages have been discussed with me. I have had the opportunity to look over the brochure on Botox/Dysport treatment published by the Allergan Company/Medicis. _____ ***Initials***

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions. I have had all of my questions answered and I freely consent to this Botox® Cosmetic/Dysport treatment today and for all subsequent treatments.

Patient's Signature: _____Date: _____