ONG INSTITUTE for Plastic Surgery and Health
9377 E Bell Road Suite 363 Scottsdale, AZ 85260
T: 480-771-7771 | E: concierge@onginstitute.com

Patient Registration Form

Patient Information

Name
____

Address
____
Street

____
City State Zip Code

Cell Phone w/area code ____________________ Home________________ Work ____________________

DOB ____________ SS #__________________Email Address ______________________________________

Sex: Male Female **Marital Status:** Single Married Divorced Separated Widowed

Race: American Indian or Alaska Native Asian Black or African American White Hispanic or Latino Native Hawaiian or Other Pacific Islander Multi-racial Other

Preferred Language:_______________________

Ethnicity: Hispanic or Latino Not Hispanic or Latino

If married, spouses name ___________________________DOB: ______________Phone #________________

Emergency Contact ____ DOB: __________________ Relationship _____________________ Phone #___________________

Primary Care Physician ____________________________

Address____Phone_______________

Referring Physician ____________________________

Address____Phone________________

Employer _____________________________________ Occupation __________________________________

Employer address ____

Employer Phone ______________________

Person responsible for bill, if other than patient ___________________________ DOB _____________

Address ____ Phone _________________________

SS# ____________________ Relationship ______________________

Name: DOB:

ONG INSTITUTE for Plastic Surgery and Health
9377 E Bell Road Suite 363 Scottsdale, AZ 85260
T: 480-771-7771 | E: concierge@onginstitute.com

Insurance Information

Primary Insurance ___________________________ Policy # _________________ Group # _________________

Policy Holder ______________________________ SS # ___________________________ DOB _____________

Secondary Insurance _______________________ Policy # __________________ Group # _______________

Policy Holder ______________________________ SS # ___________________________ DOB _____________

Secondary Insurance ___________________________Policy # ________________ Group # _______________

Policy Holder ______________________________ SS # __________________________ DOB _____________

All Patients Please Complete and Sign This Release of Medical Records and Assignment of Benefits

I hereby authorize Ong Plastic Surgery, PLLC to release to or request from my insurance company, other physicians or hospitals, any information including the diagnosis and records of any treatment or examination rendered to me during surgical care, that may be necessary to process my health insurance claim and that the information may be faxed. I also authorize and request my insurance companies to pay directly to the above named corporation the amount due me in my pending claim for medical and/or surgical treatment or service. I also understand that if it becomes necessary to refer my account for collection, I will be liable for the reasonable collection fees and court costs expended therein.

Patient's Signature:____Date:___________________________

(Parent or guardian if minor)

Payment Policy

Patients with Insurance: Insurance cards must be presented at the time of check in prior to your visit. As our participation with insurances can change, it is your responsibility to call your insurance company before each appointment to verify we still are participating providers for your insurance plan. Your health insurance is a contract between you and your insurance company.

Private Pay and Patients without Insurance: Typically at the time that we scheduled your appointment we would have let you know that you need to pay a certain amount at the time of the visit in order to be seen. This amount will be used as a deposit for care rendered on that day. If there is a balance over the amount we collected from you, you will be billed for that balance.

Co-Payments: We are required to collect your co-payment at the time of service. We accept cash, check and most credit cards. If you are unable to pay your co-payment at the time of service your appointment may need to be rescheduled.

Returned Checks: If your check gets returned to us for non-sufficient funds, you will be assessed a $25 charge.

Forms Completion/Medical Records: There may be a charge for forms, letters or copies of medical records. The type of service requested by the patient will determine the charge. For example, disability forms will be assessed a $20 processing fee for each form. There will not be a charge for medical records sent to any physician for continuing care but we do require a signed medical records release form signed by the patient. Please be aware that we do retain the right to charge patients who are requesting copies of their medical records for personal use. All patients will be required to sign a medical records release before any information can be given to them.

Name: DOB

ONG INSTITUTE for Plastic Surgery and Health
9377 E Bell Road Suite 363 Scottsdale, AZ 85260
T: 480-771-7771 | E: concierge@onginstitute.com

PATIENT IS RESPONSIBLE FOR ADVISING OUR OFFICE OF ANY CHANGES TO THEIR ADDRESS, PHONE NUMBER, INSURANCE PLAN, PAYOR OR COVERAGE.

Statement of Financial Responsibility
I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor and as a courtesy, Dr. Ong will bill my insurance. I hereby authorize Dr.Ong to bill my insurance company or other third parties responsible for my medical charge. I also authorize Dr. Ong to release any medical information that may be requested by my insurance company to help with the process of my claims. I authorize and request be made directly to Dr. Ong for all medical and surgical services. I understand that I am responsible for any balance not covered by my insurance company.
I also understand that if I choose to finance my payment through a third party company, any agreement(s) made are solely between the patient/ guardian and that company.

I have read and agree to this Payment Policy.

Printed Patients Name	DOB	Patient or Guardian's signature	Date

Preferred Pharmacy Selection

Please indicate your preferred pharmacy (ies) for any medications we may prescribe:

Pharmacy Name	
Address and/or Cross Streets	
Phone Number	

Pharmacy Name	
Address and/or Cross Streets	
Phone Number	

Consent to Obtain Medication History
Our medical practice has adopted an electronic medical record system to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record. This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for Cheri Ong, MD to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Name: DOB

ONG INSTITUTE for Plastic Surgery and Health
9377 E Bell Road Suite 363 Scottsdale, AZ 85260
T:480-771-7771 | E: concierge@onginstitute.com

Patient Name (Print) ______________________ **Date of birth** ______________

Patient or Parent/Guardian Signature ______________________ **Date** ______________

Notice of Privacy Practices Acknowledgement.

I understand that under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or had the opportunity to review the Notice of Privacy Practices from Ong Institute for Plastic Surgery & Health (OPS) which contains a more complete description of the uses and disclosures of my health information. I understand that OPS has the right to change its Notice of Privacy Practices from time to time and that I may contact OPS at any time to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that OPS restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand OPS is not required to agree to my requested restrictions, but if OPS does agree then OPS is bound to abide by such restrictions.

Signature: ______________________

Patient Name: ______________________

Relationship to Patient: ______________________

Date: ______________________

Please inform us if there is any person(s) to whom we may inform about your medical condition, diagnosis and/or your financial account:

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

OPS OFFICE USE ONLY:
I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: ______________ Employee Name/Initials: ______________
Reason: ______________________

Name DOB

ONG INSTITUTE for Plastic Surgery and Health 9377 E Bell Road Suite 363 Scottsdale, AZ 85260
T:480-771-7771 | E: concierge@onginstitute.com

PHOTOGRAPHY AND VIDEO CONSENTS

SURGICAL DOCUMENTATION

____I have given Dr. Ong and her Staff full consent to take photographs or videos of my surgical procedure. This includes Pre-Op, Intra-Op, and Post-Op time periods. I understand that the photographs are strictly for documenting the surgery and evaluating the results of surgery. I understand that the digital photographs will be stored securely on secured computers or in my electronic medical record .

EDUCATIONAL AND MARKETING USES

____I give Dr. Ong full consent to use my photographs or videos for educational and marketing purposes (various media outlets such as print, CD/DVD, social media or internet) in an anonymous manner and with complete confidentiality. There will be no identifying marks seen or portrayed unless approved by me.

____I decline to have my photographs or videos used for educational or marketing purposes.

____
Patient Signature Name Date

____
Witness Signature Name Date

PATIENT CONSENT FOR USE OF CREDIT CARDS, DEBIT CARD, AND FINANCING - DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment

Services that are performed and are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Dr. Ong to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment.

____ I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

____ I agree that this non credit card challenge agreement is irrevocable.

____
Patient Signature Name Date

____
Witness Signature Name Date

Name: DOB