KRYGER INSTITUTE OF PLASTIC SURGERY

Patient Information as of _____/_____/ 2011

(Please Print Legibly & Fill In/Correct **All** Fields)

Patient Name: _____ Birthdate: _____ SS#:_____

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

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Email Address: _____ Restrictions for Contacting You: ☐ No ☐ Yes: _____

_____

Gender: ☐ Male ☐ Female Drivers License #: _____

Marital Status: ☐ Single ☐ Seperated ☐ Married to: _____ ☐ Other: _____

Patient's Employer: _____ Occupation: _____

Work Phone: _____ Ext: _____ May we call you at work: ☐ Yes ☐ No

Address: _____

Emergency Contact (*not* in your household) - Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Address: _____

Refferal Source: ☐ Insurance Company ☐ ER ☐ Dr. _____ ☐ Patient: _____
☐ Newspaper ☐ Magazine Website: ☐ DrKryger.com ☐ LoveYourLook.com ☐ Search Engine Result
☐ Other: _____

*** INSURANCE PATIENTS ***

Health Insurance Info: ☐PPO ☐POS ☐HMO ☐Workers Comp ☐None ☐Other

Primary Insurance: _____ ID#: _____ Group #: _____

Insured Party (if not self) – Name: _____ Birthdate: _____ SS#: _____

Relationship To Insured: ☐ Spouse ☐ Child ☐ Other _____ Copay: ☐ No ☐ Yes (Amount $_____)

Primary Care Physician Name (if HMO): _____ and Phone Number: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Insured Party (if not self) – Name: _____ Birthdate: _____ SS#: _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Kryger to bill my insurance company, however I understand that not all fees may be covered by my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Kryger and myself.

Signature: _____ **Date:** _____

Kryger Institute of Plastic Surgery

New Patient (Child) Health History

Name:_____ **DOB:** _____ **Date:** _____

SOCIAL:

Age: _____ School Grade: _____ # of Siblings: _____ Sibling Ages: _____

MEDICATIONS:

Prescription Drugs:	Dose:	Treatment for:	Non-Prescription (Vitamins, Herbs, etc.):
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: Y o N o *List drug(s) and type of reaction:* _____

_____

PERSONAL MEDICAL HISTORY: *Please list all medical problems for which you are being treated:*

_____

_____

_____

Immunizations up-to-date? Y o N o

Previous Operations or Hospitalizations:

_____

_____

_____

FAMILY HISTORY: *Have any **blood relatives** of the child ever had the following problems:*

Abnormal Bleeding: Y o N o Blood Clots: Y o N o

Major Medical Problems: Y o N o Anesthetic Problems: Y o N o

Please describe questions with a "Yes" answer:

_____

_____

PEDIATRICIAN: _____ Phone Number: _____

Who referred you to us? _____

REVIEW OF SYSTEMS (check if positive):

[ ] Headache [ ] Vision problems [ ] Cough [ ] Fever/chills [ ] Diarrhea [ ] Constipation [ ] Seizures
[ ] Difficulty breathing [ ] Seasonal Allergies

_____ **M.D.**

Kryger Institute
of Plastic Surgery

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Reconstructive Surgery
Microsurgery
Post-mastectomy
Abdominal wall
Lower extremity
Facial fractures
Skin cancer
Wounds
Pediatric

Hand Surgery
Fractures
Wrist injuries
Nerve compression

Aesthetic Surgery
Face
Breast
Body contouring
Non-surgical procedures

- I hereby give my consent for The Kryger Institute of Plastic Surgery, AMC to use and disclose protected health information about me to carry out treatment, payment and healthcare operations (TPO). The Kryger Institute's Notice of Privacy Practices provides a more complete description of such uses and disclosures.
- I have the right to review the Notice of Privacy Practices prior to signing this consent. The Kryger Institute reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Kryger Institute of Plastic Surgery.
- With this consent, The Kryger Institute of Plastic Surgery, AMC and staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carry out TPO such as appointment reminders, insurance items and any calls pertaining to my clinical care.
- With this consent, The Kryger Institute and Staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.
- With this consent, The Kryger Institute and Staff may e-mail to my home or other alternative location any items that the practice in carrying out TPO, such as appointment reminder cards, patient statements.
- With this consent physician peers may review my office and operating room charts for operative consent and completeness of chart.
- I have the right to request that The Kryger Institute restrict how it uses or discloses my information to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.
- By signing this form, I have consented to The Kryger Institute of Plastic Surgery, AMC's use and disclosure of my protected information to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The Kryger Institute may decline to provide treatment to me.

Patient Signature (or person authorized):_____

Printed Name of Patient: _____ Date: _____

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Thousand Oaks, CA. 91361

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Fax: (805) 777-4822
www.drkryger.com

7325 Medical Center Dri
Suite 2
West Hills, CA. 913

Kryger Institute
of Plastic Surgery

Our Financial Policy

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policy as an essential element of your care and treatment. If you have questions about this policy, contact our Insurance Biller at (805)777-3877.

Please have available, at every visit, the following documents:

- Your Insurance Identification Card
- Your Driver's License

Reconstructive Surgery
Microsurgery
Post-mastectomy
Abdominal wall
Lower extremity
Facial fractures
Skin cancer
Wounds
Pediatric

Hand Surgery
Fractures
Wrist injuries
Nerve compression

Aesthetic Surgery
Face
Breast
Body contouring
Non-surgical procedures

Payment Policy:

- Payment in full is expected at the time service is rendered. For your convenience, we accept cash, checks and credit/debit cards. Any refunds made to a credit/debit card will result in a 3% deduction from the total refund amount. Bounced checks will be subject to a $35 fee.

- In the event of non-payment, we will submit the charge to an outside collections agency and the expenses will be added to your account balance. By signing here, you understand that this will adversely affect your credit rating.

- **Self-Pay Patients:** If you do not have a valid insurance plan to cover the cost of our services, you will be required to make a full payment at the time of your visit.

- **Insurance Plans:**
  1. We bill those insurance companies with which we contract (a full list of insurance plans may be obtained from the office), however, the patient or guarantor is responsible for the co-payment, co-insurance, or deductible at the time of the visit.
  2. In many cases, you will be responsible for a portion of your bill. This amount will be determined by your agreement with your insurance plan. In some cases, you will be responsible for the entire fee (e.g. if you have not met your deductible).
  3. In the event that your health plan determines a service to be "non-covered", we will bill you, and your payment is due upon receipt of that statement. Any amount not covered by your insurance company within 30 days will be billed to you.
  4. If your insurance plan is with a company with which we do not have an agreement, payment is expected in full at the time of service. As a courtesy, we will submit a claim on your behalf to your insurance company.

I have read the above policy and I understand and agree to it.

Patient Signature (or person authorized): _____

Printed Name of Patient: _____ **Date:** _____

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