RESTORATION HAND & PLASTIC SURGERY, P.C./MITCHELL A. FREMLING, M.D., F.A.C.S.
12207 N. Pecos St., Suite 300 Westminster, CO 80234
Phone: 303-466-3261 / Fax: 303-466-3674 / email: appointments@restorationplasticsurgery.com

Name: ______________________________ Date: ______________
Address: ______________________________
City: ______________________ State: _________ Zip Code: ____________
Patient's SS#: ________-________-________ Driver's License#: ______________
Date of Birth: _____/_____/_____ Married ____ Single ____ Divorced ____ Widowed ____
Gender: Male ____ Female ____ Other _____ Sex at birth: Male ____ Female ____
Home Phone: ________-________-________ Cell Phone: ________-________-________
Email Address: ______________________________

Employer's Name: ______________________________
Address: ______________________________
City: ______________________ State: _________ Zip Code: ____________
Work Phone: ________-________-________

Emergency contact name ______________________ Number _______-_________-__________

Name of your Primary Care Physician: ______________________________
Name of Referring Physician if different from Primary Care Physician: ______________________
Policyholder/Responsible Party Information (if different than patient)
Name: ______________________________ Date of Birth: _____/_____/_____
Relationship to Patient: ______________________ SS#: ________-________-________
Address: ______________________________
City: ______________________ State: _________ Zip Code: ____________
Phone#: ________-________-________
Employer: ______________________________

Primary Insurance Company: ______________________________
Name of Policyholder: ______________________________
Policyholder's Member ID#: ______________________ Group#: ______________________
HMO___ PPO___ Other___

Secondary Insurance Company: ______________________________
Name of Policyholder: ______________________________
Policyholder's Member ID#: ______________________ Group#: ______________________
HMO___ PPO___ Other___

Workman's Comp Information: Date of Injury: _____/_____/_____ Claim#: ______________________
Insurance Company: ______________________________
Adjuster's Name: ______________________ Phone#: ________-________-________

Required by Government Please Choose The Appropriate Boxes:

Language:
- ☐ English
- ☐ Spanish
- ☐ Other ________________________________

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Choose Not To Answer

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Native Hawaiian
- ☐ More Than One Race
- ☐ Other
- ☐ Other Pacific Islander
- ☐ White
- ☐ Choose Not To Answer

Release of Information

I authorize Restoration Plastic Surgery, P.C. to release my medical information to my insurance company to accomplish the task of billing for my medical care. I also authorize the transfer of my medical information between Restoration Plastic Surgery, P.C. and hospitals, surgery centers, x-ray facilities, laboratories, therapists, other physicians, and other medically related sites to assist in my medical care. I understand the transmission of this information may take the form of written communication, verbal communication, US mail, fax, and electronic communication.

Additionally, I authorize Restoration Plastic Surgery, P.C. to discuss my medical care with the following individual(s): ____

I give permission for Restoration Plastic Surgery, P.C. to leave voicemails which include my medical information at the home and cell phone numbers I have listed above. ***Circle one***: Yes or No

I give permission for Restoration Plastic Surgery, P.C. to use photographs and x-rays taken of me in which my identity is not revealed (e.g. photos of extremities, close-ups of lesions, or photos otherwise modified as needed to preclude identification) to help educate patients on the management and outcome of treatment for various conditions. ***Circle one***: Yes or No

I give permission for Restoration Plastic Surgery, P.C. to use photographs taken of me in which my identity may be ascertained (i.e. full unmodified facial photos) to help educate patients on the management and outcome of treatment for various conditions. ***Circle one***: Yes or No

Patient or Responsible Party Name if Patient is a Minor: ____(print)

Signature: ____ Date: _______________

Financial Policy

Assignment of Benefits: (**this is required if you wish for us to bill your insurance carrier directly*) I hereby assign all medical and surgical benefits to which I am entitled to Restoration Plastic Surgery, P.C. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment for services rendered directly to Restoration Plastic Surgery, P.C. I understand that I am responsible for any amount not covered by insurance.

Billing and Collection Practices: I hereby agree to the following billing policies: Restoration Plastic Surgery, P.C. will bill the patient/responsible party's insurance company for services rendered. Restoration Plastic Surgery, P.C. may also collect any co-payments, co-insurance, and/or deductibles at the time of service. The patient/responsible party will be responsible for any charges not covered by insurance, including co-payments, co-insurance, deductibles or denied claims. All balances are due within 30 days. There will be a $7.00 processing fee added to the amount due for each subsequent monthly billing cycle if full payment has not been received. Additionally, the patient/responsible party will be billed for services rendered in full should the insurance company deny coverage due to lack of referral, lack of proper reporting of incident/accident, lack of individual coverage, or for any other reason. There is a $75 fee for missed office visits not cancelled 48 hours prior to the scheduled time. There is a $350 fee for missed surgery appointments not cancelled 72 hours prior to the scheduled time. These missed appointment fees are not covered by insurance. Any account balance that is not paid within 90 days of the date of service may be forwarded to an outside agency for collection. Any account balance that remains unpaid after this transfer may be eligible for reporting to a credit bureau. Should this be necessary, the patient/responsible party agrees to pay all costs of collection including, but not limited to, collection fees, attorney fees, interest, and court costs.

Patient or Responsible Party Name if Patient is a Minor: ____(print)

Signature: ____ Date: _______________

HIPAA

Receipt Acknowledgement for the Notice of Privacy Practices

I have been given the opportunity to review the updated Notice of Privacy Practices for Restoration Plastic Surgery, P.C. I understand that this notice states how Restoration Plastic Surgery, P.C. may use and disclose my Protected Health Information (PHI). I understand that a copy of this notice is available upon request and is available online.

Patient or Responsible Party Name if Patient is a Minor: ____(print)

Signature: ____ Date: _______________

*****REQUIRED*** Pharmacy Information-** Please provide us with your preferred pharmacy information in the event that we should need to call/fax a prescription in for you:

Pharmacy Name: ____

Address: ____

City: ____ State: _________ Zip Code: ________________

Phone Number: __________-__________-_____________ Fax Number: __________-__________-_____________