Barry S. Handler, M.D.

PATIENT PERSONAL INFORMATION

Patient's Full Name_____ Age_____

Birth Date_____ SSN_____-_____-_____ Marital Status _____

Address_____ City_____ Zip_____

Home Telephone_____ Cell Phone_____

Email_____ ☐ ☐ Male or Female

PATIENT EMPLOYMENT INFORMATION

Employer_____ Occupation_____

Address_____ Phone Number_____

PRIMARY PHYSICIAN INFORMATION

Family Physician_____ Referred By_____

EMERGENCY CONTACT INFORMATION

Emergency Contact_____ Relation to Patient_____

Contact's Employer_____ Emergency Telephone_____

INSURANCE INFORMATION

Insurance Company _____

Group Number_____ ID Number_____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I authorize Dr. Handler to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment to those individuals who in Dr. Handler's sole determination, are required to receive such information for the purpose of medical quality assurance and peer review.

I authorize the release of any medical information necessary to process my insurance claim. I further consent to the taking of any photographs in the course of surgery or treatment for the purpose of confidential medical records. These photographs will remain in the property of Dr. Handler, unless authorized by me.

Patient Signature_____ Date_____

Witness_____

Barry S. Handler, M.D.

Statement of Financial Policy

New Patients: Payment for your first office visit is expected at the time of your appointment. If you have any questions, please feel free to speak with the front office personnel. If your insurance carrier requires prior authorization for your office visit or possible surgery, it is your responsibility to obtain your referral. It is also your responsibility to confirm which laboratory your insurance carrier contracts with. Please let the front office staff know this information prior to surgery.

Office Surgery: The total fees for your operative procedure includes: the professional fee, anesthesia fees and the operating room charges (supplies, surgical medications, etc.). For most cosmetic procedures the fee discussed includes both the professional fee and the operating room charge. Non-cosmetic procedures involving insurance billing are itemized. The deductible amount and your percentage of the charges or co-pay will be paid in advance of surgery. Please feel free to ask if you have any questions.

Hospital/ Surgery Center Surgery: The total fee for cosmetic operations performed in a hospital or surgery center will include the following: the professional fee paid to Dr. Handler, the operating room charge, and the anesthesiologist fee. The fee is due in full during the Pre-Operation visit prior to the surgery. Dr. Handler accepts cash, check, cashier's check, and money order, Visa, MasterCard or American Express.

Surgery Scheduling: For cosmetic procedures a deposit of $250 is required to reserve a specific surgery date. This deposit is **non-refundable.** Dr. Handler accepts cash, check, cashier's check, and money orders, Visa, MasterCard or American Express.

Insurance Billing: Dr. Handler does accept some insurance plans for non-cosmetic procedures. It must be recognized that the patient is ultimately responsible for all the fees incurred for an operation. The office will assist with insurance billing, but this is primarily the patient's responsibility. Should the insurance company decide not to pay the anticipated amount, the patient will be responsible for the amount due.

Post-Operative Revision: Occasionally during the normal healing period (twelve months after surgery) secondary procedures such as scar revision, evacuation of hematoma, scar capsule release, treatment of infection, etc. may be necessary. For these procedures, no additional surgical fee will be charged. The patient would be responsible for the cost of the operating room, medical supplies, labs and anesthesia.

Cancellation Policy: Fees will be refunded in full **(minus the deposit)** if surgery is cancelled or rescheduled more than two weeks before surgery. If notice is given less than two weeks, a 10% cancellation fee will be charged. If cancellation is less than one week prior to surgery, a 20% cancellation fee will be charged. If less than 24 hours prior to surgery, 50% cancellation fee will be charged.

_____ _____

Patient **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, read and understand the Notice of Privacy Practices that are implemented in the office of Barry S. Handler, M.D..
I understand that the above physicians will make reasonable efforts to protect my privacy and keep my patient information confidential and secure.

Notice to Consumers
Medical doctors are licensed and regulated by the Medical Board of California (MBC).
Contact information for MBC
800-633-2322
www.mbc.ca.gov

Notice
This office is under 24 hour video surveillance in all high traffic areas excluding the exam rooms.

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

Medical History

Date_____

Patient_____ Height_____ Weight_____

Reason for seeing Dr. Handler_____

Have you been treated for this in the past?_____

What do you expect surgery to do for you?_____

What **allergies** to medications do you have?_____

What **medications** do you take (include dosages)?_____

_____

Have you used Aspirin, Excedrin, Bufferin, Anacin, Ibuprofen, Motrin, Advil, Orudis or Ketoprofen in the past two weeks?_____

How many cigarettes do you smoke per day?_____ How many years?_____

Have you ever been hospitalized?_____ When?_____

_____

List **all** operations you've had_____

_____

Have you or anyone in your family had any anesthetic complications?_____

What serious medical illnesses have you had?_____

_____

Have you had a blood transfusion, if so when?_____

Have you ever had radiation (x-ray) treatments?_____

Have you had herpes infections or frequent cold sores?_____

Have you had any inflammatory disease (rheumatoid arthritis, lupus, systemic sclerosis)?_____

Women:

Could you possibly be pregnant now?_____

Date of last menses_____

Do you have any diseases or problems of the following organ systems?

Neurologic (seizure, paralysis)_____

Heart or blood pressure_____

Kidneys or urine_____

Lungs or breathing (emphysema, asthma)_____

Digestive tract (stomach, bowels)_____

Liver (jaundice, cirrhosis)_____

Bone and joint (arthritis)_____

Muscular (weakness, degeneration)_____

Skin (poor wound healing, keloids)_____

Blood Low Blood, easy bleeding, diabetes)_____

Are you presently under any abnormal psychological stress (divorce, death in the family, financial, etc.)?

_____