PRINCETON PLASTIC SURGEONS

106 Stanhope Street
Princeton, NJ 08540
609-301-0760

PATIENT INFORMATION

Date: _____ ☐ Male ☐ Female

Last Name: _____ First Name: _____ Middle Initial: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Age: _____ DOB: _____

Home Address: _____ SS# _____

City, State, Zip: _____

Home Phone #: _____ Mobile Phone #: _____ Work Phone #: _____

Email Address: _____

Referred by: ☐ DR. _____ ☐ Hospital ☐ Google ☐ RealSelf ☐ Internet

☐ Friend _____ ☐ Family _____ ☐ Other _____

Occupation: _____ Employer: _____

Employer's Phone: _____ _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Home Phone# _____ Mobile Phone #: _____ Work Phone #: _____

PERSONAL HEALTH HISTORY

Reason for visit today: _____

Have you seen other plastic surgeons for the same reason? _____

Height:_____ Weight: _____

Previous Surgery/Hospitalizations

Year	Reason	Facility

Medications: Please list both prescribed and over-the-counter, including inhalers, eye drops, vitamins, and herbs.

Drug	Strength	Frequency Taken

Do you take aspirin? ☐ Yes ☐ No

Do you take Ibuprofen (Advil, Motrin, Nuprin)? ☐ Yes ☐ No

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ALLERGIES/SENSITIVITIES

Previous reaction to anesthesia? ☐ Yes ☐ No

If yes, Describe: _____

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No

Drug:	Reaction:

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____

Do you currently smoke? ☐ Yes ☐ No If yes, how often? _____

Have you smoked in the past? ☐ Yes ☐ No If yes, when did you quit? _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, please specify _____

FAMILY HISTORY

	Age(s)	Significant Health Problems
Father		
Mother		
Siblings		
Children		

Has anyone in the family had any problems with anesthesia? ☐ Yes ☐ No

Has anyone in the family had unusual bleeding with surgery? ☐ Yes ☐ No

PRIMARY CARE PHYSICIAN:

Name: _____ Address: _____

Telephone: _____

PERFERRED PHARMACY:

Pharmacy Name: _____ Address: _____

Telephone: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature:

Date: _____

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REVIEW OF SYSTEMS

Have you or do you have any of the following?

	Yes	No	Description
Respiratory			
♦ Asthma	☐	☐	
♦ Emphysema	☐	☐	
♦ Bronchitis/Pneumonia	☐	☐	
Cardiovascular			
♦ High or Low Blood Pressure	☐	☐	
♦ Heart Disease	☐	☐	
Gastrointestinal			
♦ Hepatitis/Liver Disease	☐	☐	
♦ Reflux, Constipation, Irritable Bowel	☐	☐	Specify:
♦ GI Bleeding	☐	☐	
Genitourinary			
♦ Kidney/Bladder Disease	☐	☐	
Endocrine			
♦ Diabetes	☐	☐	
Neurological			
♦ Epilepsy/Seizures	☐	☐	
♦ Stroke	☐	☐	
Integumentary			
♦ Problem Scarring	☐	☐	
♦ Skin Cancer	☐	☐	
♦ Breast Cancer	☐	☐	
Psychiatric			
♦ Have you ever been advised to seek psychiatric care?	☐	☐	
Hematologic			
♦ Bleeding Tendencies	☐	☐	
♦ Blood Clots	☐	☐	
Infectious Disease			
♦ MRSA, Staph Infections	☐	☐	
♦ HIV/Hepatitis	☐	☐	
Women			
♦ Are you pregnant?	☐	☐	
♦ Date of last mammogram?	_____		Results: _____

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FINANCIAL POLICIES:

- Elective cosmetic procedures are not covered by insurance.
- There is a fee for insurance consultations. A bill for the consultation will be submitted to your insurance company.
- If we submit your surgery to insurance, you are responsible for your deductible & co pays (payable to our office).
- Payment of non-surgical treatments are due at the time of service by cash or credit card: we do not accept personal checks for non-surgical treatments or consultation fee's. Please note, our office does charge a $100 consultation fee **48 hours before** your appointment and a $50.00 no-show fee for follow up appointments.
- Consultation fee can be used ast credit applied towards a procedure performed by the doctor. The procedure must be booked within 30 days for credit to apply.

SCHEDULING SURGERY:

A $1,000 scheduling fee is required to secure a surgery date. This fee is refundable up until 3 weeks prior to your surgery date. Within 3 weeks of your surgery if the patient cancels surgery for **any reason**, this fee is **non-refundable.**

- The balance is due in full 2 weeks prior to the date of surgery.
- We provide a number of payment options, which may be useful individually, or combined (Cash, Checks, Visa, MC, Amex and Financing Plans). Checks must be received at least 2 weeks prior to your surgery date.
- Prior to scheduling reconstructive procedures, our office will work as to assist you through the precertification process to determine the terms of your insurance coverage.
- All co-pays or deductible are your responsibility and is paid at the time of service.
- The balance of any payment not covered by insurance is the responsibility of the patient is required in full at the time of service.

CANCELLATION/RESCHEDULING POLICY:

- We understand that a situation may arise that could force you to postpone your surgery. Please understand that such changes affect not only your surgeon but other patients as well. The surgeon's time as well as that of the operating room staff, is valuable and we request your courtesy and concern.
- If you cancel surgery within 14 days prior to surgery, the $1000.00 deposit is nonrefundable. We will refund any additional payments that have been paid.
- Should you need to reschedule your surgery again, there will be an additional $500.00 Fee.

OTHER CHARGES:

- Some surgeries are performed in the hospital or outpatient surgery centers. Please be aware that the hospital and anesthesia fees are separate expenses. You will be responsible for making payments separately for these fees. If you are having a cosmetic procedure, these fees are due on the day of surgery. You may also be billed after the procedure by hospital or surgery center for the time and services incurred.
- If you require a revisionary procedure, the operating room fee and anesthesia fee would be your responsibility. There may be an additional fee for the surgeon depending on the revision that is necessary.

In the event your account becomes delinquent and is therefore in default of payment, you will be responsible for the principal amount owed and all reasonable costs associated with the collection of this debt, including: collection service fees, attorney's fees, court fees, and additional legal expenses associated with the recovery of the debt.

AGREEMENT:

I have read thoroughly, understand and agree to the above policies and conditions.

Signature: _____ **Date:** _____

CHILDREN POLICY:

Please note: Although we love children, we ask if you are having any treatments or minor procedures in our office, that you do not bring young children. It is not only distracting to the patient, but also the physician and staff.

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MEDICAL PHOTOGRAPHY

Photographs or video tapes of myself or parts of my body may be required in connection with any/or all plastic surgery procedure(s) to be performed. This will become a part of your confidencial medical records.

PHOTOGRAPIC AUTHORIZATION

I understand that such photographs, videotapes or case histories may be published by Dr. Adam Hawawy and/or any party acting under his license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the rights to revoke the authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke the authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign the authorization and such refusal will have no effect on the medical treatment I receive from Dr. Adam Hamawy.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

I release and discharge Dr. Adam Hamawy and all parties acting under his license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claims for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Patient Signature	**Date**	**Physician /Witness Signature**

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Patient, Guardian or Guardian Signature	**Date**	**Physician /Witness Signature**

Safe Medicine Disposal Disclaimer:

I hereby acknowledge that I have received the Safe and Secure Medicine Disposal disclaimer for review.

Patient Signature	**Date**	**Physician /Witness Signature**

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PATIENT PARTNERSHIP PLAN

Dear Patient,

We hope to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health:, we ask you to participate in your care in the following ways:

I Will Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

I Will Call the Office When I do NOT Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

I Will Inform My Doctor if I Decide NOT to Follow His Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious effects on my health. I will let my doctor know whenever I decide not to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank You for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, seek an explanation, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

_____ _____

Patient Signature Date

HIPAA-ACKNOWLEDEMENT OF RECEIPT

Notice of Privacy Practices

_____

Printed Patient Name

We are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

I hereby acknowledge that I have received the HIPPA Notice of Privacy document for review.

_____ _____

Patient Signature **Date**

PRINCETON
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APPOINTMENT CANCELLATION POLICY

Welcome to Princeton Plastic Surgeons. Our mission is to provide you with the best care and have you look and feel your best. We promise to provide you with excellent care and respect.

We feel that his important that your time in the office is not rushed and that you are given our full attention during your visit. You're scheduled time is valuable and when you cancel at the last minute or do not show up that is a loss opportunity for someone else.

That's why we ask the favor that if you are unable to make future appointments that you notify us 24 hours before your appointment to avoid a cancellation fee.

Cancellation less than 24 hours or No Show Fee:	
Dr. Hamawy	$75
Skin Care Specialist	$25

Don't worry; you can avoid the above-mentioned fees! If you need to cancel your appointment, simply notify our office 24 hours before your appointment time.

INSURANCE COPAYS/ DEDUCTABLES/ BALANCE

If your visit or procedure is covered by insurance you will still be responsible for any co-pays and deductibles. As a courtesy, we will help file your claim. It is your responsibility to notify us of any changes to your insurance coverage. This is your insurance policy and we ask that you know your benefits and deductibles. Please note that any information requested by your insurance company regarding the treatment done will be provided by us as it is requested. **Any payments or checks from your insurance company should be forwarded directly to our office** and will be applied to your account. You are responsible and will be charged for any balance that is not paid.

We need your credit card on file, where we will keep it safe in case we need to charge any of the above:

PAYMENT INFORMATION				
Mastercard	Visa	American Express	Discover	CareCredit
Name as it appears on card:				
Credit Card Number:		Exp Date :	CVV:	
Billing Address:				

I have read and fully understand these policies. I acknowledged full responsibility for services rendered.

____Yes! I would like to receive my courtesy appointment reminders via email and/or text messaging.

Signature:_____Date:_____

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PLEASE READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____.

"Physician" shall be understood to mean Adam Hamawy, MD. I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Society of Plastic Surgeons.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Society of Plastic Surgeons and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____	_____
Physician	Patient/Guardian
_____	_____
Effective from Date of Treatment:	Date of Signature