PLASTIC SURGERY
OF WESTCHESTER

Patient Demographics Date_____

Last Name_____ First Name_____ MI_____

SSN_____ Date of Birth_____ Age _____Gender F M

Address _____Apt. #_____ City_____ State_____ Zip_____

Home Phone_____ Cell _____E-mail_____

Marital Status O Single O Married O Divorced O Separated O Windowed O Minor O Partnered

Employer_____Occupation_____

How did you hear about us?_____

Emergency Contact _____ Phone_____

Primary Insurance

Person Responsible Account_____

Relation_____ DOB_____SSN_____

Address (if different from patient's)_____Phone_____

City_____ State_____ Zip_____

Insurance Company_____ Phone_____

Subscriber ID #_____ Group #_____

Primary Care Doctor Information

Primary Care Physician Name _____Phone_____

Practice Name_____

Address_____ City_____ State_____ Zip_____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature:_____Print Name:_____Date:_____

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COVID-19 RISK INFORMED CONSENT

I _____ understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Nicole Nemeth and Dr. Vadim Pisarenko and all the staff at Plastic Surgery of Westchester are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Nicole Nemeth and Dr. Vadim Pisarenko and all the staff at Plastic Surgery of Westchester to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

_____

Patient or Person Authorized to Sign for Patient Date/Time

Witness _____Date/Time_____

I have been offered a copy of this consent form (patient's initials) _____

PLASTIC SURGERY
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ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Westchester Plastic Surgery and Dr. Nicole Nemeth, Dr. Ross Rainer, Dr. Vadim Pisarenko (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to Westchester Plastic Surgery and Dr. Nicole Nemeth, Dr. Ross Rainer, Dr. Vadim Pisarenko for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate' (including Howard Healthcare Group) under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.

The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.

The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.

The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.

The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name:_____ Date:_____

Patient Signature: _____

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General Patient Information

Date:_____

Patient Name: Last_____**First**_____**MI**_____

Age: _____

Health History

1. Do you have any medical problems? _____
2. Please list any medications you take:_____

   _____

3. Are you allergic to any medications? _____
4. Are you allergic to latex, iodine, contrast dye or shellfish? _____
5. Height:_____ Weight:_____

6. Do you have or had the following illnesses? (check all that apply)

a.	Arthritis:	_____	High Blood Pressure:	_____
b.	Blood Clots:	_____	Kidney Disease:	_____
c.	Diabetes:	_____	Lung Disease:	_____
d.	Heart Disease	_____	Stroke:	_____
e.	Cancer (type):	_____	Other:	_____

Previous Surgeries/Major Illnesses

	Year	Reason	Outcome
Hospitalizations			
Serious Illness or injuries			
Pregnancy			
Operations			
Broken Bones			

Social History

Do you smoke? Yes No
How much? _____
Did you used to smoke? Yes No
How much? _____

Do you drink alcohol? Yes No
How much? _____
Do you use any drugs? Yes No
Please List:_____

Women Only

(Check all conditions you have or had)

Breast Lump: _____
Breast Pain: _____

Menstrual Problems: _____
Menopausal Symptoms:_____

Vaginal Infection _____
Nipple Discharge_____

Date of last mammogram: _____
Date of last Pap Smear:_____
Do you do regular breast self-examinations? Yes No
Could you be pregnant now? Yes No
# of pregnancies: _____
# of deliveries:_____
# of abortions: _____
# of miscarriages:_____

Is there any personal or family history of breast cancer? Yes No

Reason for Today's Visit

What are your major concern(s)? (Circle all that apply)

Face	Skin	Breasts	Thighs	Back
Eyes	Feet	Waist	Abdomen	Legs
Lips	Body	Buttock	Forehead	Neck

Please further describe your concern:
_____
_____
_____

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____
Signature of patient or parent/guardian if a minor Date

Patient Name: _____

Date of Birth: _____

Pharmacy Information

Name of Pharmacy: _____

Address: _____

City and State: _____

Telephone No: _____

Allergies: _____

_____

Medications: _____

_____

PLASTIC SURGERY
OF WESTCHESTER

Authorization for and release of Medical Photographs/ Slides/ And / Or Video Footage

VIDEOTAPE AND PHOTOGRAPHS
RELEASE AND AUTHORIZATION

I hereby irrevocably consent to and authorize the use and reproduction by the Plastic Surgery of Westchester (PSW) and it affiliates, or anyone by any of them, of any and all photographs, electronic images or video footage of me taken by PSW, or that PSW had in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession or the general public about plastic surgery or plastic surgery procedures and techniques without compensation to me. Such use shall include, but not limited to, distributing the images via print, visual and electronic media, specifically in including the PSW website and social media sites such as You Tube, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of PSW. PSW also shall have the right to use my name in connection therewith if it so chooses.

I hereby waive any right to inspect or approve the finished product, photograph, and video, DVD, CD-ROM or matter that may be used in conjunction therewith or the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless PSW and its affiliates and their respective representatives, assigns, and employees and any person acting under their permission or authority, from and against any claims whatsoever in connection with use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over eighteen years of age, and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Date:_____ Printed Name:_____

I have read the above Release and Authorization. I am the parent, guardian or conservatory of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization in the interest of public education.

Date:_____ Printed Name:_____

Signature: _____

Nicole L. Nemeth, M.D | Vadim Pisarenko, M.D | Ross Ratner, M.D.
500 Mamaroneck Avenue St. 211 | Harrison, NY 10528

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speck with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

PrintName:_____Signature:_____Date:_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENT

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.