DOFT

Plastic Surgery

PATIENT INFORMATION

Name:_____ **Age:**_____ **DOB**:_____ **Sex:** ◯ Male ◯ Female

Home Address:_____ **Apt:**_____

City:_____ **State:**_____ **Zip Code:**_____

Home Telephone:_____ **Cell Telephone:**_____

Email Address:_____

You may contact me by: ☐ **Cell** ☐ **Home Phone** ☐ **Mail** ☐ **Email**
Do we have Permission to leave a message on your phone or voicemail: ◯ **YES** ◯ **NO**

Person to contact in case of emergency:

Name:_____ **Telephone #:**_____ **Relationship:**_____

Referred by:_____

Pediatrician:

Name:_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Telephone Number:_____

INSURANCE INFORMATION

On occasion newborn babies may be added as dependents to both parents' polices or have automatic coverage under the mother's insurance for the first 30 days. We will need the information for all insurance providers to determine your child's benefits.

Please note that if there are any changes to the coordination of benefits after services are rendered, you will need to inform the office as soon as possible. Failure to do so may result in the insurance not paying for the claim and financial obligation transferring to the person financially responsible.

Primary Insurance

Primary Insurance:_____

Members ID Number:_____ **Group Name:**_____

Subscriber's Name:_____ **DOB:**_____

Secondary Insurance

Secondary Insurance:_____

Members ID Number: _____ **Group Name:**_____

Subscribers Name:_____ **DOB:**_____

Person Financially Responsible for Patient

Name:_____ **DOB**:_____

Address:_____ **Apt:**_____

Home Telephone:_____ **Email Address:**_____

I, the undersigned, herby consent to care and treatment now and in the future. In the event that my insurance company is billed, I authorize payment of medical benefits to the physician(s) or supplier of rendered services. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay the claim in full, I understand that I am responsible for payment of charges for services rendered. I authorize the release of any medical information necessary to process my claim.

Patient or Guardian Signature:_____

DOFT PLASTIC SURGERY

NOTICE OF YOUR LEGAL RIGHTS TO MEDICAL INFORMATION AND PRIVACY

Your medical information in this office is used only in specific instances governed by law. Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), patients have certain legal rights to privacy regarding their healthcare information.

Understand that this information is limited to:

- Communication with other medical providers to conduct plan, and participate in the treatment of your healthcare directly or indirectly in emergency and non-emergency situations.
- Conduct normal healthcare operations from insurance companies.

Your medical information will **not** be used for any other purpose unless this office receives written permission from you.

I have read and understand my Notice of Privacy Rights to Medical Information privacy.

Patient's Name:_____

Relationship to patient: Self or other:_____

Signature:_____ Date:_____

DOFT PLASTIC SURGERY

EAR MOLDING – INFORMED CONSENT

- I hereby authorize Dr. Melissa Doft M.D, and assistant(s) as designated by her to treat the condition or conditions that appear indicated below.
- I consent to the procedure **EAR MOLDING** for my child.
- The procedure is to be performed on: ☐ **Right Ear** ☐ **Left Ear** ☐ **Bilateral Ears**
- I have had the opportunity to ask Dr. Melissa Doft questions about the operation/procedure, all of which has been answered to my satisfaction.
- I have been made aware of the potential benefits, certain risks, side effects, hazards, complications and consequences that are associated with the above procedure; as well as the reasonable alternatives and the risks, benefits, side effects of those alternative; potential problems related to recuperation; the likelihood of achieving treatment goals; and the possible results of not undergoing the proposed treatment.
- The practice of medicine is not an exact science and the procedure may not result in the intended benefits.
- It has been explained to me that during the course of a procedure unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) of different procedure(s) than those set forth in paragraph 2. I therefore authorize and request that the above named surgeon, her associates and/or assistant perform such surgical procedures as are necessary and desirable in the exercise of their professional judgment. The authority granted under this paragraph shall extend to treating all conditions that require treatment and are not known to the above physician at the time the procedure commenced.
- I also consent to the admittance of observers (including manufacturer representatives) to the procedure room and to the photographing or televising of the procedure to be performed, including appropriate portions of the patient's body, for the purpose of advancing medical education and for other medical or scientific purposes, providing the patients identity is not revealed by either the pictures or the descriptive texts accompanying them.

I have read all of the above and have had the opportunity to discuss these issues to my satisfaction

Patient Name X_____

Parent / Guardian Signature X_____ **DATE:**_____

Witness X _____

I have explained to the above patient (or authorized to consent for the above patient), the nature of the condition(s) which appear indicated by diagnostic study, and have described in layman's terms the operation or procedure(s) necessary for treatment. I have explained in layman's terms the risks and side effects, including potential problems related to recuperation, the likelihood of achieving treatment goals, the reasonable alternatives to the proposed treatment including the risks, benefits and side effects of such alternatives and the consequences of not receiving the proposed treatment.

Physician Signature X_____ **DATE**:_____