HALL/WRYE

PLASTIC SURGEONS / HAIR RESTORATION
AESTHETIC TREATMENT CENTERS

Wesley W. Hall Jr, M.D.
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Reno, NV 89511

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Reno, NV 89523

775-284-8296 Office
775-332-6583 Fax

Patient Personal Information

Date: _____

Patient Name: Last_____First _____Middle Initial _____

Address:_____ City: _____ State: _____ Zip: _____

DOB: ____/____/_____ Age: _____ ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Other: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____ Social Security: _____-_____-_____

Emergency Contact: _____ Relation: _____ Phone: (_____) _____

HOW DID YOU HEAR ABOUT US? (PLEASE SELECT FROM OPTIONS BELOW)

My Physician, list name: _____ AD (TV, Magazine, online):_____

Friend/ family member, list name: _____ Internet, list site: _____

Other, list: _____

COMPLETE ONLY FOR RECONSTRUCTIVE OR MEDICAL PATIENTS

Primary Insurance, if medical: _____ ID #: _____

Subscriber:_____Subscriber DOB: _____ /_____ /_____ Relationship to Patient:_____

Secondary Insurance, if medical:_____ID #:_____

Subscriber:_____Subscriber DOB: _____/_____/_____ Relationship to Patient:_____

COMPLETE ONLY IF A MINOR

Mothers Name: _____ Social Security:_____-_____-_____DOB:_____/_____/_____

Mothers Address:_____ Phone:(_____) _____

Mothers Employer & Address:_____ Phone:(_____) _____

Fathers Name: _____ Social Security:_____-_____-_____DOB:_____/_____/_____

Fathers Address:_____ Phone:(_____) _____

Fathers Employer & Address:_____ Phone:(_____) _____

PATIENT RESPONSIBILTY, FOR MEDICAL PATIENTS

I understand that regardless of valid insurance coverage or any 3rd party liability, I am ultimately responsible for any balance due.

ORIGINIAL ASSIGNMENT OF BENEFITS, FOR MEDICAL PATIENTS

I hereby authorize payment directly to providers of services related to this hospitalization/ medical treatment from any hospital/medical insurance benefits, or benefits payable from any other entity payable to me. This authorized payment shall not exceed the balance due to the provider's regular charges for this period of hospitalization/ medical services. I understand that I am financially responsible to the providers for charges not covered by this authorization.

INITIATION OF APPEAL, FOR MEDICAL PATIENTS

In the event that insurance benefits are denied due to but not limited to non-medical necessity, out-of-provider network services or unusual and customary rates, I agree that it is my responsibility to contact and appeal to my insurance company, and if necessary, The Insurance Commission for the State of Nevada.

FINANCIAL POLICY & CANCELATION POLICY, FOR ALL PATIENTS

For medically billed patients, we will bill your insurance although we may not be contracted with them.

You are responsible for: j

1.) Annual deductibles
2.) Co-Payments
3.) Charges for non-covered or cosmetic services

For all patients scheduling appointments with Hall & Wrye Plastic Surgeons & Med Spa, cancelation policy is applicable.

Medically billed patients who cancel their appointments within 24 hours of their scheduled appointment time or are not present at their scheduled appointment time will be billed for their appointments through their insurance.

Elective surgery and medical spa patients require a deposit and/or credit card placed on file prior to making their appointments. If an appointment is canceled or rescheduled within 24 hours of the scheduled appointment time or the patient is not present during scheduled appointment time, the deposit will be used towards their cancelation/ no show fee and will not be subject to a refund. If credit card was placed on file and cancelation within 24 hours or a no-show occurs, the credit card will be billed for the no-show charge based off their visit. If the patient makes their appointment or reschedules their appointment with more than 24 hour notice, their deposit will be used towards their treatment or surgery

If the patient has two or more infractions of not attending their designated appointment without proper cancelation notice they will be considered for termination as a patient from our practice.

If HALL & WRYE PLASTIC SURGEONS, LTD has to take legal, adverse action (collections) against your account, you will be responsible for the following:

1.) $25.00 administration fee, regardless of the amount on the outstanding balance.
2.) The collection agency's commission of the 40% of the total balance.
3.) A $25.00 returned check fee.

_____ _____

Patient or Guardian Signature **Date**

I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to HALL AND WRYE PLASTIC SURGEONS for any services furnished to me that my party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorized any holder of medical or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries/ carrier or any other insurance company needed for this or a related Medicare/Other Insurance Company claim. I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim.

_____ _____

Patient or Guardian Signature **Date**

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PATIENT CONSENT OF NOTICE OF PRIVACY PRACTICES: PF-2000

HALL AND WRYE PLASTIC SURGEONS

We reserve the right to modify the privacy practices outlined in the notice.

I, _____ understand that as part of my healthcare, Hall and Wrye Plastic Surgeons uses and discloses paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care of treatment. I understand that this information serves as a basis of planning care and treatment, communication among the many health professionals who contribute to my care, a source of information for applying my diagnoses and surgical information to my bill, by which and third-party-payer can verify such as assessing quality and reviewing the competence of health care professionals. I understand that I have been provided with a ***Notice of Information Practices*** that provided a more complete explanation of information uses and disclosers. I understand that as part of this organization treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax. Should Hall and Wrye Plastic Surgeons change their notice, I will be sent a copy of any revised notice to the addressed I've provided (whether U.S. mail or, if I agree, E-mail) see ***Section 164.520*** of the ***Code of Federal Regulations***.

I wish to have the following restrictions to the use of disclosure of my health information:
I understand that Hall and Wrye Plastic Surgeons is not required to agree to the restrictions requested and that I may revoke this consent in writing, except to the extent that the organization has already taken action in the reliance thereon. I understand that by refusing to sign this consent can result in refusal of treatment, see ***Section 164.506*** of the ***Code of Regulations***.

I fully understand the terms of this consent.

X_____ _____
Patient Signature or Representative **Date**

I acknowledge that Hall and Wrye Plastic Surgeons has given me a copy of the Notice of Privacy Practices (HIPPA).

X_____
Patient Initials

For Office Use Only

- ☐ Consent was given on _____ and taken by_____
- ☐ Consent refused by patient, and treatment refused as permitted
- ☐ Consent added to the patient's medical records on _____

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PHOTO CONSENT

Date: _____

Name: _____

Before and after photographs are important proofs as to the success of your operation and treatments. Doctors Hall and Wrye do not use these photographs for any purpose unless they have your permission. However, many patients who are considering cosmetic surgery or medical spa treatments find looking at before and after photographs very useful. In order to have any treatment within our office we require photo consent. Photos will not be shared unless approved by patient.

I have read the above statement and allow Hall and Wrye Plastic Surgeons to obtain photos of me for purpose indicated above.

Patient Signature

By signing the line below, I allow Hall and Wrye Plastic Surgeons to use photographs and other audio-visual and graphic materials before, during, and after the course of my therapy. These may to be used for medical, marketing, and education purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, images and video may be taken if consent is granted.

I have read the above statement and allow Hall and Wrye Plastic Surgeons to obtain photos of me for purpose indicated above.

Patient Signature

Witness: _____

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Appointment Cancellation & No Show Policy

Should you have to cancel or reschedule your appointment, our office policy requires a 24 hour notice prior to your scheduled appointment.

Appointment time is allotted for each patient for their scheduled time. When less than 24 hours' notice is given, it becomes very difficult to bring another patient in on such short notice to fill this vacancy.

Unfortunately, due to patients not giving 24 hour notice or not showing up for their appointments, it has become necessary to impose a cancellation charge to those patients who do not give 24 hour notice of cancellation, or do not show for their scheduled appointment. If you are a patient being seen for medical purposes, your insurance will not be billed for this charge. This charge is billed directly to the patient. If a deposit was taken for your appointment your deposit will be used for a "No-Show Fee", if applicable.

Hall & Wrye Plastic Surgeons

Patient Signature_____ Date_____

Printed Name: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone_____

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ Okay to mail to my home address
- ☐ Okay to mail to my work/office address
- ☐ Okay to fax to this number _____

☐ Work Telephone _____

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____

_____ _____

Patient Signature Date

_____ _____

Patient Name (Printed) Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of disclosures of Protected Health Information:

Below, please list whom (if any) we may disclose your requested information to:

Name	Relationship to Patient	Restrictions applicable to the disclosure of information	How may we disclose information? (Fax, Phone, Email, Mail, Other)

Patient Name_____ Date: _____

Other than the services we have already provided for you, what else would you like to learn about? Please select all that apply:

☐ Botox/ Dysport	☐ Facial Veins
☐ Facial Filler	☐ Lip Fullness
☐ Latisse- Eyelash Growth Solution	☐ Facial Redness
☐ Submental fullness reduction (Double chin)	☐ Body Contouring & Tightening
☐ Skin Care Products	☐ Cellulite Reduction
☐ Facial Lines/ Wrinkles	☐ Mole Removal
☐ Brown Spots/ Age Spots/ Freckles	☐ Scar Revision
☐ Unwanted Hair	☐ Breast Size
☐ Facial fullness/ Drooping/ Sagging	☐ Abdominal Area
☐ Age-related volume loss in cheeks	☐ Facial Contouring
☐ Chemical Peel & Facials	☐ Other:_____

FOR OFFICE USE ONLY:

Patient has been examined and approved for the following procedures and prescriptions: (Check all that apply)

____ Neuromodulators	____ Sculptra	____ Hydroquinone
____ Dermal Fillers	____ Kybella	_____ Valtrex or Acyclovir
____ Retinol	____ Cellutone	____ Microlaser
____ Chemical Peel	____ Protégé	____ LaseMD
____ Topical/ Oral/ Pronox/ Injectable Anesthetic	____ Profractional	____ Pelleve
____ Vanquish	____ BBL	____ Latisse
____ Other		

Additional Notes or Exclusions: _____

_____

_____

Physician Name/ Provider Name: _____ Signature: _____

Date: _____/_____/_____