# Gregg M. Anigian, M.D., P.A., FACS

## Plastic Surgery

Dear Patient:

We are pleased that you have chosen the office of Dr. Gregg Anigian for a consultation and we look forward to meeting you. Enclosed is your patient information packet. Please review sign and date all forms and bring with you to your appointment along with driver's license and insurance card.

**LOCATION:**
We are located in Presbyterian Professional Bldg. II, on the east side of the Presbyterian Hospital of Dallas complex, which is located east of 75 Central Expressway and south of 635 LBJ Freeway. The entrance to our building is on Walnut Hill Lane near the intersection of Greenville Avenue.

Parking is located in the front, the side and rear of our building and requires payment to exit the lot (complimentary first 15 minutes, fees apply after 15 minutes). Validation for parking is not available through our office. Please allow ample time to reach our office, especially during inclement weather.

**MEDICAL INFORMATION:**
Your first office visit is only for a consultation. If surgery is required, the specifics will be discussed during the consultation.

Please bring with you any medical reports that concern this visit, such as previous biopsy reports, x-ray reports and films, mammogram or sonogram reports and films.

**MEDICAL INSURANCE:**
PLEASE BRING YOUR INSURANCE CARD WITH YOU. We require 2 forms of identification; therefore insurance cards are required for all consultations. If you do not have your insurance card, we will be happy to keep your appointment but we will not be able to file a claim for your visit. If we are not a participating provider with your insurance plan, or you do not have your insurance card, full payment is expected at the time service is rendered and our office will not file a claim. Please inform our office of any insurance changes.

If you are covered by a HMO/PPO plan, please make sure Dr. Gregg Anigian is a listed provider. It is also your responsibility to obtain an authorization/referral number from your primary care physician (PCP), prior to your visit if your plan requires one.

**COSMETIC/ PRIVATE PAY CONSULTATIONS:**
Cosmetic consultations are $125.

**PAYMENT METHODS:**
Acceptable means of payments are cash, check or credit card. We accept Visa, America Express, MasterCard or Discover.
Again, we look forward to meeting you and establishing a long-term relationship. If you have any questions please do not hesitate to call our office.

Best regards,
Dr. Gregg Anigian's office

Members of the American Society for Aesthetic Plastic Surgery

Certified, American Board of Plastic Surgery
Fellow of the American College of Surgeons
8220 Walnut Hill Lane • Suite 108 • Dallas, Texas 75231
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American Society of Plastic Surgeons

**Gregg M. Anigian M.D., P.A.**
**8220 Walnut Hill Lane, Suite 108**
**Dallas, Texas 75231**
**214-369-0006**

## OFFICE POLICIES

**PLEASE READ AND REVIEW CAREFULLY, THEN SIGN AND DATE**

**ALL APPOINTMENTS** require a copy of a valid drivers license and insurance card. Insurance cards are not required for cosmetic/private pay consultations.

**APPOINTMENT CANCELLATIONS**: Please notify our office of any appointment cancellations at least 24 hours in advance by calling our office or 24 hour answering service. We reserve the right to charge you (not your insurance company) for a missed appointment. This is a $35 fee (subject to change without prior notice). The purpose for this charge is because the appointment time with the doctor was reserved for you. Out of consideration for another patient who may have needed that time, and in respect for the doctor who designated the time for you, this charge may be imposed.

**COPIES OF MEDICAL RECORDS**: We will be happy to copy your medical records for you and forward them to a physician of your choice. The American Medical Association has recommended the following schedule for copies of medical records: $25.00 for the first 20 sheets copied, then $.50 per sheet over 20.

**FORMS FEE**: There is a $25.00 fee (per employer) for processing forms that require more than the physician's signature. This is billable directly to you (not your insurance company) and should be paid prior to the completion of the forms.

**PRESCRIPTION PRIOR AUTHORIZATIONS**: Performing a prescription prior authorization (PA) is routinely required by your insurance plan. Our financial policy regarding prescription PA services is as follows: First PA is at no cost; thereafter there will be a $25 fee for each additional request. This fee must be paid prior to completion of the PA.

**COSMETIC/PRIVATE PAY CONSULTATIONS**: Our office does not file with insurance for any cosmetic/private pay consultations or procedures. Consultation fees are $75-$100.

I have read the above and agree to accept responsibility as described.

Signature:_____ Date: _____
Patient or Guardian

**PLASTIC & RECONSTRUCTIVE SURGERY**
Gregg M. Anigian, M.D., P.A.

# PATIENT INFORMATION

**Referred by:** _____ **Phone #:** _____

Name: (First) _____ (MI)_____(Last)_____
Date of Birth: _____ Age: ____ Gender: M F Martial Status: S M W D
Address: (Street) _____
(City, Sate, Zip) _____
Home # _____ Cell #: _____
Employer: _____ Work#: _____
Social Security#: _____ Driver License#: _____
Email: _____ Permission to communicate via email: ☐yes ☐no
Pharmacy Name: _____ Pharmacy #: _____

Spouse Name: _____ Date of Birth: _____
Work#: _____ Cell#: _____

Emergency Contact: _____ Telephone: _____
Parent/Guardian (If patient is a minor) _____

Internist or Family Physician: _____
Telephone#: _____

# INSURANCE INFORMATION

***(Must be filled out even if copy of insurance card has been made)***

Insurance Co: _____ ID #: _____
Primary Insured (if you are not the primary insured this information must be filled out so that a claim can be submitted to your insurance company): _____
Subscriber's Employer: _____ Subscriber's DOB: _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plans, to Dr. Gregg M. Anigian. I transfer my title of reimbursement from my insurance company to Dr. Gregg M. Anigian. I hereby agree to pay any and all charges that are not covered by insurance (and any deductible and co-insurance). I also agree to pay any charges incurred during a grace period if I have insurance purchased thru the marketplace. I hereby authorize said assignee to release all information necessary to secure payment. I understand that I am financially responsible for any and all charges whether or not they are covered by insurance. I understand that if I have a secondary insurance plan, Dr. Anigian's office will NOT file with the secondary insurance. I agree to pay a $25.00 fee (per employer) for any forms completed for leave of absence or insurance purposes. If my insurance requires a referral, I understand it is my responsibility to obtain and my appointment will be cancelled without a valid referral.

I authorize Dr. Gregg M. Anigian's office to disclose my protected health information (PHI) concerning his medical findings and treatment from the initial office visit until the date of conclusion of such treatment to those individuals, who, in Dr. Gregg M. Anigian's sole determination, are required to receive such information. Release of my PHI could include the following entities, but are not limited to: another physician for purpose of medical treatment, scheduling a procedure with a facility or anesthesia, peer review, outside billing services, ordering supplies, filing insurance claims via electronic filing, fax or mail or for any purpose Dr. Anigian or his staff deem necessary. This assignment/agreement will remain in effect until revoked by me in writing. A photocopy of this assignment/agreement is to be considered valid as an original.

Patient's Signature: _____ Date: _____

(See back of page)

PLASTIC & RECONSTRUCTIVE SURGERY
Gregg M. Anigian, M.D., P.A.

# FINANCIAL POLICY

Thank you for choosing Dr. Gregg M. Anigian as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

**All patients must read and sign this form prior to receiving services.**

Payments for services are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Discover, American Express, MasterCard and Visa.

**COSMETIC**: There is a fee for cosmetic consultations and payment is due the day of the visit. Payment in full is required two weeks in advance for patients who undergo cosmetic procedures.

**INSURANCE**: Plan provisions require patients present a current insurance card at time of service otherwise, payment is due in full, and no adjustment will be made later. If we are not a contracted provider with your insurance plan, full payment is expected at the time service is rendered.

It is your responsibility to provide us with your most current insurance information. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

* Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is your responsibility to know and understand the level of services covered by your insurance company.

* Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary, and reasonable.This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of cost and care in this area.

* Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. In the event your insurance carrier does not cover your service, you will be responsible for payment of that service and will be billed accordingly or payment may be collected prior to your surgery.

* Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe and collect 2 – 3 weeks prior to your procedure based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

* If payment from your insurance company is not received within 45 days from the date of service you will be responsible for payment in full.

We must emphasize that, as a medical care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date of service is rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I have read the above and as the patient or his duly authorized representative understand and accept these terms.

**SIGNATURE:** _____ **DATE:** _____

**PLASTIC & RECONSTRUCTIVE SURGERY**
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# MEDICAL HISTORY

Name: _____ Date: _____

Reason for Consultation: _____

Allergies (drug): _____
_____

Age: _____ Height: _____ Weight: _____

Do you smoke: yes/no How Much? _____
Do you drink: yes/no How Much? Never _____ Occasionally _____ Regularly _____

Medications currently taking: (prescription, over the counter, herbal)
_____ _____
_____ _____

***Operations:*** Date: Complications with surgery/anesthesia?
_____
_____
_____

***Family History***: Is there a history of any of the following in your blood relatives?
Diabetes: _____ Prolonged Bleeding: _____
Hepatitis: _____ Cancer (type): _____
Heart Attack/Stroke: _____ High Blood Pressure: _____

Have you ever had a blood transfusion? _____
Date of last physical exam: _____
If female, Date of last mammogram and results: _____
Have you ever taken any aspirin-containing drugs in the last two weeks? _____
If female, Date of your last menstrual period: _____

***Medical History***: (*please mark the appropriate answer if you have a history of:*)

| | | | |
|---|---|---|---|
| Shortness of breath | yes___ no___ | Irregular Pulse | yes___ no___ |
| Visual Problems | yes___ no___ | Anemia | yes___ no___ |
| Heart Disease | yes___ no___ | Murmurs | yes___ no___ |
| Kidney Problems | yes___ no___ | Joint Pains | yes___ no___ |
| Stomach Problems | yes___ no___ | Hepatitis | yes___ no___ |
| High Blood Pressure | yes___ no___ | Diabetes | yes___ no___ |
| Prolonged Bleeding | yes___ no___ | Cancer | yes___ no___ |
| Fainting or Black out spells | yes___ no___ | if yes, what type? _____ | |
| Autoimmune Disease | yes___ no___ | _____ | |
| Viral Diseases | yes___ no___ | | |
| Herpes (Cold Sores) | yes___ no___ | | |
| Any type of implant | yes___ no___ | Location _____ | |

**Gregg M. Anigian, M.D., P.A.**
**8220 Walnut Hill Lane, Suite 108, Dallas TX 75231**
**Phone: 214-369-0006 Fax: 214-369-0190**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

**Please Circle your response to the following:**

May we leave messages on your cell phone? YES NO N/A

May we leave messages on your voice mail at home? YES NO N/A

May we leave messages on your voice mail at work? YES NO N/A

May we leave messages concerning your appointments with co-workers, receptionist or secretary that regularly answers your calls? YES NO N/A

**May we correspond with you via email regarding your personal health information, appointments, office specials & events?** YES NO N/A

**Your Email Address:** _____@_____

May we discuss your appointment, treatment, or financial issues with your spouse?
YES NO N/A

Please list the names of your spouse/family member/caretaker or friend that we may discuss your appointments, treatments, or financial issues with:

1.
2.

If you are over the age 18 and living at home, may we discuss your appointments, treatments or financial issue with your parent(s)/Guardian name:
_____ YES NO N/A

You must inform our office, in writing, of any changes in your directives. This consent takes effect on the date indicated below. Please sign and acknowledge that you have received a copy of our Notice of Privacy Practice.

Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____