Eric P. Bachelor, M.D., F.A.C.S.
Certified by the American Board of Plastic Surgery

PATIENT INFORMATION

DATE: _____ *NEW PATIENT* ____ *UPDATE:* ____

(PLEASE COMPLETE THE FOLLOWING INFORMATION AND PRESENT YOUR INSURANCE CARD AT THE FRONT DESK)

WHICH OFFICE WOULD YOU PREFER TO BE SEEN AT ON A REGULAR BASIS? PLEASANTON _____ DANVILLE _____

WHAT WOULD YOU LIKE TO DISCUSS WITH DR. BACHELOR:
_____

WHO REFERRED YOU TO DR. BACHELOR:
_____

PATIENT NAME: _____
(LAST) (FIRST) (MIDDLE) (MAIDEN)

ADDRESS: _____
(STREET NUMBER) (CITY) (STATE) (ZIP)

MAILINGS ADDRESS IF DIFFERENT FROM ABOVE:
_____

BIRTHDATE: _____/_____/_____ **AGE:** _____ **BIRTHPLACE:** _____

SEX: MALE / FEMALE **MARITAL STATUS: M S D W** **SPOUSE'S NAME:** _____

RACE/ETHNIC ORIGIN: _____ **E-MAIL ADDRESS:** _____

HOME PHONE: (**)** _____ **WORK PHONE (** **)** _____ **CELL PHONE: (** **)**
_____

DRIVER'S LIC. #: _____ **SS#:** _____ / _____ / _____

EMERGENCY CONTACT: _____ **PHONE #: (** **)** _____ **RELATIONSHIP:** _____
_____

EMPLOYMENT INFORMATION:

PATIENT'S EMPLOYER: _____ **SPOUSE'S EMPLOYER:** _____

ADDRESS: _____ **ADDRESS:** _____

_____ _____
(CITY) (STATE) (ZIP) **(CITY) (STATE) (ZIP)**

PATIENT WORK #: (**)** _____ **SPOUSE'S WORK #: (** **)** _____

PATIENT'S OCCUPATION: _____ **SPOUSE'S OCCUPATION:** _____

IF PATIENT IS A MINOR:

PARENT NAME: _____ **PARENT SS #:** _____ / _____/ _____

1387 Santa Rita Road, Pleasanton, CA 94566
919 San Ramon Valley Blvd., Ste. 150, Danville, CA 94526
Phone: 925-462-3700 Fax: 925-462-4681
www.ericpbachelormd.com

FATHER / MOTHER **PARENT WORK #: ( ) _____**

FINANCIAL RESPONSIBILTY

PRIVATE INSURANCE: _____ ***PERSONAL PAY:*** _____ ***MEDICARE:*** _____

WORKERS COMPENSATION: _____ **THIRD PARTY PAY / ATTORNEY:** _____

INSURANCE INFORMATION / RESPONSIBLE PARTY / POLICY HOLDER

PERSON RESPONSIBLE: _____ **R E L A T I O N S H I P T O P A T I E N T :** _____

ADDRESS (IF DIFFERENT FROM PATIENT): _____
(CITY) (STATE) (ZIP)

DAYTIME PHONE #: ( ) _____ **W O R K P H O N E # : ( )** _____

BIRTHDATE: _____ / _____ / _____ **S S # :** _ _ _ _ _ _ _ _ _ _ _ _ _ _ / _ _ _ _ _ _ _ _ _ _ _ _ _ _ / _____

EMPLOYER: _____ **ADDRESS:** _____

_____

PRIMARY INSURANCE CARRIER

INSURANCE NAME: _____ **P H O N E # : ( )** _____

ID #: _____ **GROUP #:** _____ **PLAN #:** _____

CO-PAY: $_____ **EFFECTIVE DATE:** _____

SECONDARY INSURANCE

INSURANCE NAME: _____ **P H O N E # : ( )** _____

ID #: _____ **GROUP #:** _____ **PLAN #:** _____

CO-PAY: $_____ **EFFECTIVE DATE:** _____

ATTORNEY INFORMATION:

NAME: _____ **P H O N E # : ( )** _____

ADDRESS: _____
(CITY) (STATE) (ZIP)

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OFFICE PAYMENT POLICY

I HEREBY ACKNOWLEDGE RESPONSIBILITY FOR ANY AND ALL MEDICAL AND OR SURGICAL CHARGES BILLED TO ME FOR SERVICES RENDERED TO MYSELF AND/OR MY MINOR CHILD. PAYMENT IN FULL IS DUE AT TIME OF SERVICE/TREATMENT & SURGERIES ARE DUE WITHIN THIRTY (30) DAYS OF THE DATE OF SERVICE UNLESS ARRANGEMENTS ARE MADE WITH ONE OF DR. BACHELOR'S STAFF MEMBERS.

Dr. Bachelor's staff will bill my insurance as a courtesy. In order to accommodate the needs and requests of our patients, we have enrolled in several managed care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult to keep track of the individual requirements of all plans. Each insurance company offers many different insurance plans. Each plan has different policies regarding the frequency of treatments, covered services and where services may be rendered. I understand that it is my responsibility to ensure that Dr. Bachelor is a provider for my insurance company and that benefit coverage is available at the time of service. I also understand that it is my responsibility to follow-up with my insurance company.

Providing quality medical care to our patients is our primary concern. We are more than willing to provide that care within your insurance company guidelines if you let us know exactly what those guidelines are. Unfortunately, if you do not inform us of any special requirements within your insurance plan and we order outside services, such as lab, pathology or hospitalization at a non-contracting facility (not part of your plan) they will have no choice but to seek payment directly from you.

I, the undersigned, hereby authorize any health insurance company (ies) insuring me and or my family members to pay Dr. Bachelor for medical and or surgical services rendered. Eric P. Bachelor, M.D. has my permission to release to my health insurance company (ies) information required to satisfy my claims for medical and or surgical services and supplies.

If revision procedures (noninsurance) are necessary within the first year, there may not be a surgeon's fee; however, the cost of the operating room, supplies and anesthesia would be my responsibility.

Interest will accrue at a rate of 1.50% per month on all accounts over $500.00 that remain unpaid after 45 days from the date of service. Accounts under $500.00 will be charged a $5.00 a month rebilling fee after 45 days. There will be a $35.00 service charge for all returned checks.

If my account is assigned to a collection agency or an attorney, I shall be responsible for the payment of collection costs, reasonable attorney fees and court costs. I hereby authorize this office to obtain a Credit Report as deemed necessary to collect an unpaid debt.

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ _____

Signature **Date**

_____ _____

Witness **Date**

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DEPOSIT/CANCELLATION POLICY

I UNDERSTAND THAT MY CONSULTATION AND PLANNED SURGERY WITH ERIC P. BACHELOR, M.D., IS CONSIDERED COSMETIC IN NATURE. DUE TO THE FACT THAT THIS IS A "NON-COVERED SERVICE", THE CHARGES WILL NOT BE SUBMITTED TO MY INSURANCE CARRIER.

I also understand that my consultation fee is payable at the time of my visit. If I schedule my procedure within six (6) months of the consultation, this fee will be deducted from the quoted surgical fee. (This excludes; Hypertonic Saline Injections for Treatment of Spider Veins, Ear Piercing, Removal of Moles/Lesions and Scar Revisions).

A $1000.00 deposit is required to reserve/schedule a surgery date. If I cancel surgery, I must directly notify Dr. Bachelor's Surgery Coordinator or Dr. Bachelor at least 14-days prior to the surgery date for a full refund of the deposit. This cancellation can NOT be left as a message. If cancellation occurs less than 14-days prior to the surgery date, the deposit will NOT be refundable. If a credit card refund is requested for any reason there will be a processing fee of 3.5% of the total amount charged.

The fee for surgery is payable in full at the time of the pre-operative appointment, including the facility fee payable to The Plastic & Reconstructive Surgery Center. Non-payment may result in the cancellation of my reserved surgery time. If revision surgery is required within the first year of surgery, there may be charges for the facility fees, supplies and materials.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND I AGREE TO COMPLY WITH THIS THE ABOVE POLICY.

_____	_____
PRINT NAME	**DATE**
_____	_____
SIGN NAME	**DATE**
_____	_____
WITNESS	**DATE**

DISCLOSURE OF OWNERSHIP / DO NOT RESUSITATE POLICY

Eric P. Bachelor, M.D., F.A.C.S.
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The Plastic and Reconstructive Surgery Center (PRSC) is privately owned by Dr. Bachelor. The American Board of Plastic Surgery certifies him, and he is a member of the American Society of Aesthetic Plastic Surgery, the American Society of Plastic Surgeons and the California Society of Plastic Surgeons.

The surgery center is Medicare Certified # 55C0001004 and also accredited by The American Association of Accreditation of Ambulatory Surgery Facilities Inc., AAAASF #1465.

The PRSC has been designed to provide you with a safe environment, excellent care and comfort during and after your surgical procedure.

The PRSC has a policy that does not recognize a "Do Not Resuscitate" order. A patient with Medicare may request to sign a DNR form if they wish to do so.

Medical doctors are licensed and regulated by the Medical Board of California.
If you ever have a need to contact the Board you may do so by calling them at (800) 633-2322 or e-mail www.mbc.ca.gov .

Your signature is not a permit for surgery, but rather an indication that you have read and understand the contents of the above statements.

_____ _____
Signature Date

_____ _____
Witness Date

This form will be placed in the patients' permanent medical record.

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HEREBY GIVE MY CONSENT FOR DR. ERIC P. BACHELOR, M.D. TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO). ERIC P. BACHELOR, MD'S NOTICE OF PRIVACY PRACTICES PROVIDES A MORE COMPLETE DESCRIPTION OF SUCH USES AND DISCLOSURES.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Eric P. Bachelor, MD reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Eric P. Bachelor's Privacy Officer at 1387 Santa Rita Road, Pleasanton, CA 94566.

With this consent, Eric P. Bachelor, MD and staff may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent physician peers may review my office and operating room charts for operative consent and the completeness of your chart.

With this consent, Eric P. Bachelor, MD and staff may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With this consent, Eric P. Bachelor, MD and staff may e-mail to my home or other alternative locations any items that the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Eric P. Bachelor, MD restrict how it uses or discloses my PHI to carry out TPO. However, the practice and surgery center is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I have consented to Eric P. Bachelor, MD and The Plastic and Reconstructive Surgery Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, or later revoke it, Eric P. Bachelor, MD may decline to provide treatment to me.

_____	_____
Print Patient Name	**Date**
_____	_____
Sign Patient Name / Authorized Representative	**Date**

PHI = Protected Health Information
TPO = Treatment, Payment and Operations

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