

Steven L. Brown, M.D.

Certified American Board of Plastic Surgery | Certified American Board of Surgery
Hand Surgery | Cosmetic Surgery | Reconstructive Surgery

NEW PATIENT REGISTRATION

Patient's Name: _____ Date: _____

Date of Birth: _____ Sex: _____

Street Address: _____

City / State / ZIP: _____

Cell Phone: _____ Home Phone: _____

Email: _____ Marital Status: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Family Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

HOW DID YOU HEAR ABOUT US?

☐ Walk-in ☐ Google ☐ Social Media ☐ Referral ☐ Other: _____

INSURANCE INFORMATION

Insurance Company: _____ Medicare: Yes / No _____

Member ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Insurance Address (if different): _____

WORKERS' COMPENSATION — COMPLETE ONLY IF APPLICABLE

Was this injury sustained at work? ☐ Yes ☐ No Date of Injury: _____

Injury / Details: _____

Workers' Compensation Company / Address: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

SIGNATURE

Patient / Responsible Party Signature: _____ Date: _____

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MEDICAL INFORMATION

TODAY'S CONSULTATION

Reason for consultation: _____

Current symptoms or concerns: _____

How long have you had these symptoms/concerns? _____

Previous evaluation or treatment for this condition: _____

MEDICAL & SURGICAL HISTORY

Past medical conditions: _____

Previous surgeries / procedures: _____

HEALTH HISTORY — CHECK YES OR NO FOR EACH CONDITION

Mental health condition	☐ Yes	☐ No
Neurological / nervous system condition	☐ Yes	☐ No
Heart disease or heart condition	☐ Yes	☐ No
Lung disease or breathing condition	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Medication, drug, or local anesthetic reaction	☐ Yes	☐ No
History of MRSA	☐ Yes	☐ No
Easy bruising, unusual bleeding, or bleeding disorder	☐ Yes	☐ No

CURRENT MEDICATIONS

Include prescriptions, over-the-counter medications, vitamins, and supplements.

Medication	Dose	Reason / Prescribed By
_____	_____	_____
_____	_____	_____

ADDITIONAL HEALTH INFORMATION

Height: _____ Weight: _____

Relevant family medical history: _____

Social history (tobacco, alcohol, or other information): _____

QUESTIONS OR ADDITIONAL INFORMATION

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FINANCIAL POLICY

Insurance & Managed Care Plans

Our practice participates with a number of insurance and managed care plans. Because benefits, networks, and plan requirements can change, patients are responsible for confirming coverage directly with their insurance carrier. Our office is happy to assist with insurance-related questions; however, your insurance carrier is the final source for information about coverage, deductibles, copayments, coinsurance, and authorization requirements.

Referrals & Surgical Authorizations

If your insurance plan requires a referral to our office, it is the patient's responsibility to contact and follow up with their referring or primary care provider to make sure the referral is sent to our office. If prior authorization is required for surgery, our office will obtain and manage the surgical authorization with your insurance carrier. Surgical prior authorization is not the patient's responsibility.

Insurance Procedures & Out-of-Pocket Costs

For procedures billed through insurance, our office cannot guarantee your final out-of-pocket cost before the claim is processed. Your deductible, copayment, coinsurance, medical necessity determination, and other plan provisions may affect what you owe. For questions about benefits or anticipated costs, please contact your insurance carrier directly. Eligibility checks and prior authorizations do not guarantee payment or establish your final responsibility. In some cases, even the insurance carrier may not provide a final amount in advance. Your actual responsibility is determined after the claim is submitted and processed.

Self-Pay Cosmetic & Aesthetic Services

Self-pay cosmetic and aesthetic consultations have a \$150 consultation fee. All self-pay in-office cosmetic or aesthetic procedures and surgical procedures must be paid in full no later than two weeks before the scheduled procedure date.

Payment for Services

Payment is expected at the time of service for amounts known to be the patient's responsibility. A 3% processing fee applies to payments made with major credit cards. Debit cards and HSA cards are not subject to the 3% processing fee. Personal checks and cash are also accepted. Returned checks may be subject to applicable bank or processing fees.

Insurance Assignment & Patient Responsibility

I authorize payment of insurance benefits directly to Steven L. Brown, M.D., for services rendered. Insurance billing is provided as a courtesy. I understand that I am ultimately responsible for charges not paid or covered by my insurance plan.

Past-Due Balances

Patient balances are due upon receipt unless other arrangements have been made with our office. Balances that remain unpaid may be subject to applicable late fees or finance charges as permitted by law. Delinquent accounts may be referred to a collection agency or attorney for further collection. The patient may be responsible for reasonable collection costs, court costs, and attorney fees where permitted by law.

Cancellation / No-Show Fees

Appointments canceled with less than 24 hours' notice may be subject to a \$50 cancellation fee. A missed appointment without notice may be subject to a \$100 no-show fee. Special unavoidable circumstances may be considered for waiver with management approval.

Release of Information

I authorize Steven L. Brown, M.D. and/or authorized representatives to release information necessary to process insurance claims, obtain payment, and communicate with hospitals, physicians, insurance carriers, or other parties as reasonably necessary for services rendered.

PATIENT ACKNOWLEDGMENT

I have read and understand this Financial Policy and agree to the terms above.

Patient / Responsible Party Signature: _____

Date: _____

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CANCELLATION / NO-SHOW POLICY & PHOTO RELEASE

1. CANCELLATION & NO-SHOW POLICY

Your appointment time is reserved specifically for you. If you need to cancel or reschedule, please provide more than 24 hours' notice whenever possible. This allows us the opportunity to offer the appointment to another patient.

MORE THAN 24 HOURS' NOTICE

No cancellation fee.

LESS THAN 24 HOURS' NOTICE

May be subject to a \$50 cancellation fee.

NO-SHOW

May be subject to a \$100 no-show fee.

We understand that unavoidable circumstances can occur. Cancellation or no-show fees may be waived when appropriate with management approval.

Patient / Responsible Party Signature: _____ Date: _____

2. PATIENT PHOTO RELEASE

Photographs may be taken as part of your clinical documentation. The authorization below applies specifically to the use of photographs or images for educational, promotional, advertising, social media, website, or other marketing purposes.

PLEASE SELECT ONE:

☐ YES — I authorize the practice to use my photographs/images for the purposes listed above.

☐ NO — I do not authorize the practice to use my photographs/images for these purposes.

Your decision regarding this optional photo release will not affect your medical care.

Patient / Responsible Party Signature: _____ Date: _____

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AUTHORIZATION TO DISCUSS HEALTH INFORMATION

Optional form — complete only if you want us to speak with another person about your care.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone: _____

WHO MAY WE SPEAK WITH?

Name: _____

Relationship to Patient: _____

Phone Number: _____

WHAT MAY WE DISCUSS?

☐ Medical care / treatment

☐ Appointments / scheduling

☐ Insurance / authorizations

☐ Billing / account information

☐ Surgical planning / instructions

☐ All of the above

HOW LONG SHOULD THIS AUTHORIZATION REMAIN ACTIVE?

☐ Until I revoke it in writing

☐ Until this date: _____

YOUR AUTHORIZATION

I authorize Steven L. Brown, M.D. and authorized office staff to discuss the categories of information selected above with the person named on this form. I understand that this authorization is voluntary and that I may revoke it in writing at any time. Revocation will not apply to information already disclosed before the office received my written revocation.

Patient Signature: _____

Date: _____

Witness / Staff Signature: _____

Date: _____

You do not need to complete this form if you do not want the office to discuss your information with anyone other than you, except as otherwise permitted or required by law.

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PATIENT AESTHETIC & WELLNESS INTEREST QUESTIONNAIRE

Help us understand your goals so we can discuss options that may fit you best.

Patient Name: _____

DOB: _____

1. WHAT WOULD YOU MOST LIKE TO IMPROVE?

- | | |
|--|---|
| ☐ Fine lines / wrinkles | ☐ Forehead lines |
| ☐ Frown lines | ☐ Crow's feet |
| ☐ Lips | ☐ Cheeks / volume loss |
| ☐ Under-eye area | ☐ Jawline / chin |
| ☐ Neck / skin laxity | ☐ Brown spots / sun damage |
| ☐ Redness / visible vessels | ☐ Acne / acne scarring |
| ☐ Pores / skin texture | ☐ Unwanted hair |
| ☐ Body contouring | ☐ Cellulite |
| ☐ Hair thinning / restoration | ☐ Intimate wellness |

2. WRINKLE RELAXERS — ARE YOU INTERESTED IN ANY OF THESE?

- | | |
|---|---|
| ☐ BOTOX® Cosmetic | ☐ Dysport® |
| ☐ Not sure — I would like a recommendation | ☐ Not interested |

3. DERMAL FILLERS / BIOSTIMULATORS — WHAT INTERESTS YOU?

- | | |
|--|---|
| ☐ Restylane® | ☐ JUVÉDERM® |
| ☐ RHA® Collection | ☐ Sculptra® |
| ☐ Radiesse® | ☐ Not sure which product — I would like a recommendation |
| ☐ Not interested | |

AREAS YOU MAY WANT TREATED:

- | | |
|---|---|
| ☐ Lips | ☐ Cheeks |
| ☐ Chin | ☐ Jawline |
| ☐ Smile lines / lower face | ☐ Under-eye area |
| ☐ Other: _____ | |

4. SKIN, LASER & WELLNESS TREATMENTS

- | | |
|---|--|
| ☐ Skin resurfacing | ☐ Pigmentation / brown spots |
| ☐ Redness / visible vessels | ☐ Skin tightening |
| ☐ Acne / scarring | ☐ Laser hair removal |
| ☐ Facial rejuvenation | ☐ Body contouring |
| ☐ Intimate wellness | ☐ Hair restoration |
| ☐ Preventative / anti-aging treatments | ☐ Not sure — I would like recommendations |

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AESTHETIC & WELLNESS INTEREST QUESTIONNAIRE — CONTINUED

5. COSMETIC PROCEDURES — WHAT ARE YOU INTERESTED IN?

- | | |
|--|---|
| ☐ Breast augmentation | ☐ Breast lift |
| ☐ Breast reduction | ☐ Tummy tuck / abdominoplasty |
| ☐ Liposuction | ☐ Body contouring |
| ☐ Upper eyelid surgery / blepharoplasty | ☐ Lower eyelid rejuvenation |
| ☐ Face / neck rejuvenation | ☐ Earlobe repair |
| ☐ Combination procedures | ☐ Curious about surgery, but not ready yet |
| ☐ Other: _____ | |

6. WHAT MATTERS MOST TO YOU?

- | | |
|--|--|
| ☐ Natural-looking results | ☐ Minimal downtime |
| ☐ Fast / convenient treatment | ☐ Long-lasting results |
| ☐ Non-surgical options | ☐ Comfortable with some downtime |
| ☐ Open to surgical options | ☐ I would like Dr. Brown's recommendation |

7. APPROXIMATE BUDGET / INVESTMENT RANGE

This helps us discuss options that are realistic for your goals and comfort level.

- | | |
|--|--|
| ☐ Under \$500 | ☐ \$500 – \$1,000 |
| ☐ \$1,000 – \$2,500 | ☐ \$2,500 – \$5,000 |
| ☐ \$5,000 – \$10,000 | ☐ \$10,000+ |
| ☐ I would like to discuss treatment options and pricing first | |

Would financing or payment options make you more likely to move forward? ☐ Yes ☐ No ☐ Maybe

8. WHEN ARE YOU HOPING TO START?

- | | |
|---|---|
| ☐ As soon as possible | ☐ Within 1–3 months |
| ☐ Within 3–6 months | ☐ Within 6–12 months |
| ☐ Just researching right now | |

9. IF YOU COULD IMPROVE ONE THING, WHAT WOULD IT BE?

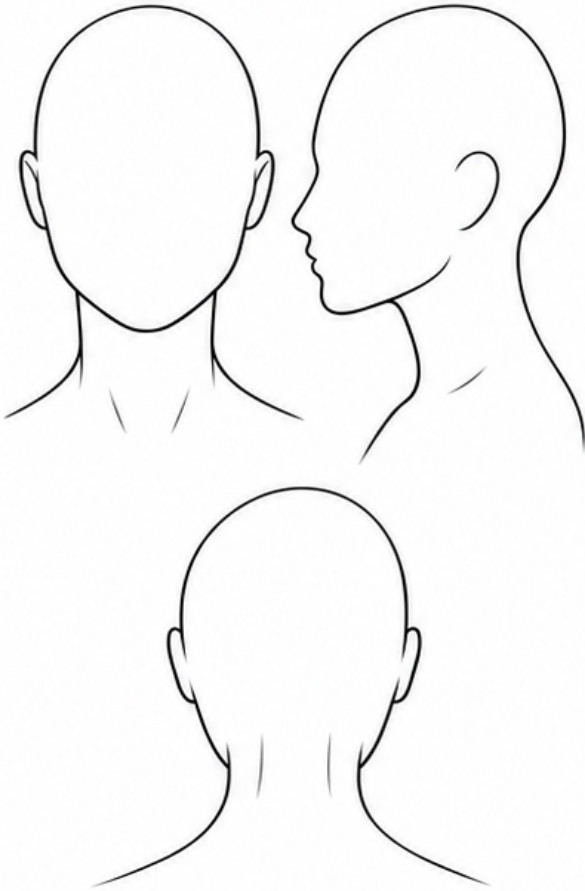
COSMETIC AND AESTHETICS INTEREST DIAGRAM

Please shade or circle the areas of your face and/or body that you are interested in improving.

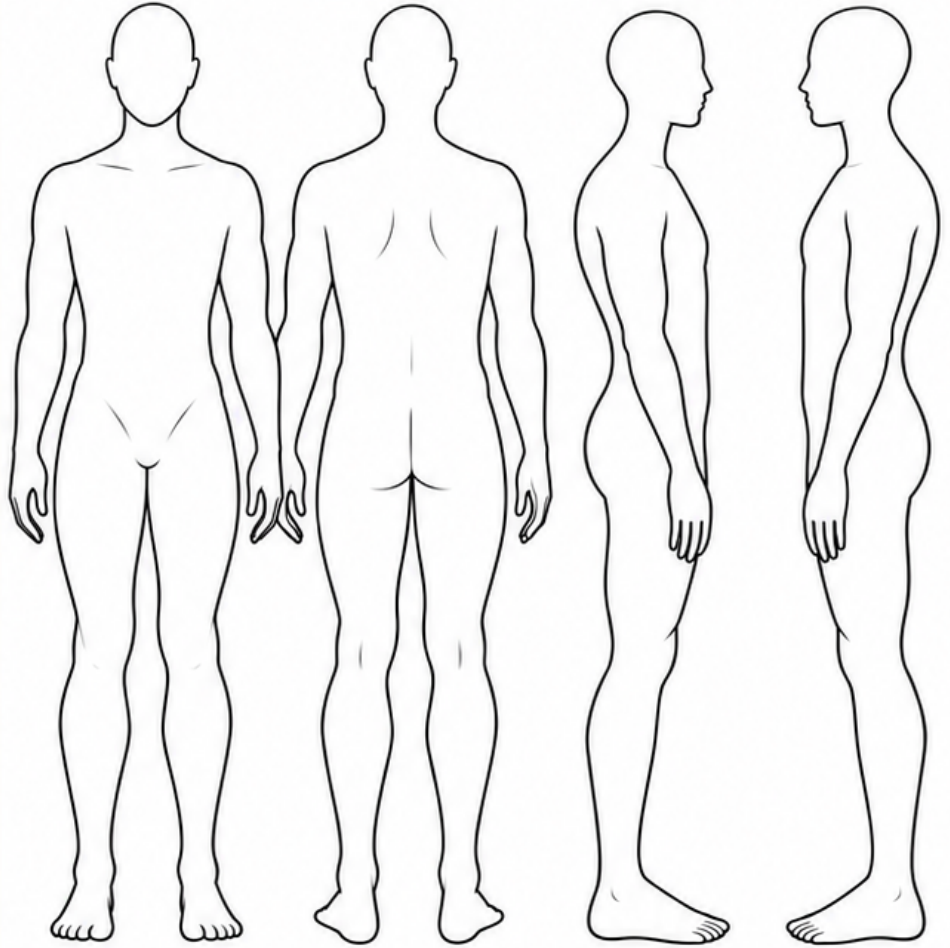
Patient Name: _____

DOB: _____

FACE



BODY



ADDITIONAL NOTES

Please let us know any specific concerns, areas of interest, or goals you would like to discuss.
