

# David E. Halpern MD REGISTRATION FORM

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Email Address:	May we contact you by: (please circle one) Email Phone or Both			Birth date:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: (     ) Cell Phone No: (     )		
P.O. box:		City:			State:	ZIP Code:	
Occupation:		Employer:			Employer phone no.: (     )		
Whom may we thank for this referral?		<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Internet Search	<input type="checkbox"/> Other		<input type="checkbox"/> Family		
Primary Care or Referring MD's Name							

**Reason for Office Visit:**

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.:	
		/ /				(     )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer phone no.:	
						(     )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Medicare		<input type="checkbox"/> BCBS		<input type="checkbox"/> Humana	
<input type="checkbox"/> Amerigroup		<input type="checkbox"/> Cigna		<input type="checkbox"/> United Health Care		<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:	
			/ /			\$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

### IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work /Cell phone no.:
			(     )	(     )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Tampa Bay Plastic Surgery/ David E. Halpern MD. or insurance company to release any information required to process my claims.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date

**David E. Halpern MD**  
Tampa Bay Plastic Surgery Inc.

Reason for Consultation:

Please circle one or more of the areas that most concern you:

Face	Breast	Body	Skin
Face	Augmentation	Abdomen	Botox
Eyes	Lift	Hips	Fillers
Brow	Lift & Implant	Thighs	Chemical Peel
Neck	Reduction	Arms	Lesion/Moles
Nose	Reconstruction	Knees	Scar Revision
Chin		Calves	
Lips		Buttocks	
Ears		Back	

How long has been a concern?

What have you done to address this concern in the past?

Describe the treatments (including dates for surgeries):

Are there any other areas of concern that you would like to discuss?

**MEDICAL HISTORY:**

Reason for Consultation:

\_\_\_\_\_

Have you ever been seen by Dr. David E Halpern - if so, where?

\_\_\_\_\_ Office \_\_\_\_\_ Hospital \_\_\_\_\_ Wound Care Center

If so, which Hospital/Wound Care Center \_\_\_\_\_

List names of Medications you are taking? (Including Aspirin/Vitamins)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any Past or Present Medical Illnesses:

\_\_\_\_\_

List any Past or Present Cosmetic/Medical Surgeries (include dates) you have had:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any known Allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, Please list:

\_\_\_\_\_

Do you smoke? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, How many packs per day? \_\_\_\_\_

Family History of : Cancer? \_\_\_\_\_, Cardiac Disease? \_\_\_\_\_, Diabetes? \_\_\_\_\_

Personal History of : (Please Circle)

High Blood Pressure / Diabetes / Bleeding Problems / HIV / Pregnancy or currently pregnant / HCV

Other \_\_\_\_\_

Females: # of Pregnancy (s) \_\_\_\_\_

## BENEFITS AGREEMENT

Payment policies of Tampa Bay Plastic Surgery Inc. have been explained to me and I hereby acknowledge and accept responsibility for payment of all charges incurred. This responsibility extends to the total charges without regards to possible insurance benefits. Any insurance benefits, which may be provided, will be considered part of my financial resources only and will in no way waive my responsibility.

I/We agree to be financially responsible for the cost of all medical and adjunctive care and services rendered to the patient by Tampa Bay Plastic Surgery Inc. I/We also hereby authorize the release of medical records to any company insuring the above listed patient and assign all benefits to Tampa Bay Plastic Surgery Inc. for providing the professional services.

If payment for these services is not made when agreed upon, I/We agree to pay, in addition to the physician's fees, all costs of collecting the amount due, with interest from the due date, which costs include attorneys fees, and or collection agency fees, which may be up to 50% of the amount due, and all court costs expended in the collection of this medical bill.

### \*\*\*PLEASE NOTE THE FOLLOWING\*\*\*

#### MEDICAL PATIENTS

THERE IS A CANCELLATION FEE OF \$25.00, IF YOU FAIL TO CANCEL AN APPOINTMENT WITHIN 24 HOURS OF YOUR APPOINTMENT TIME.

#### COSMETIC PATIENTS

THERE IS A CANCELLATION FEE OF \$50.00, IF YOU FAIL TO CANCEL AN APPOINTMENT WITHIN 24 HOURS OF YOUR APPOINTMENT TIME.

I understand that if I am being seen as a cosmetic patient and that my insurance WILL NOT be billed for any and all visits that are cosmetic related.

**By my/our signature(s), I/we acknowledge that I/we have read and understand the terms of this agreement and that the information provided to Tampa Bay Plastic Surgery Inc. is as accurate and complete as possible.**

**By my/our signature(s), I/we acknowledge that I/we have been made aware of my rights and protection under the HIPAA guidelines.**

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**Patient Signature**

**Guarantor Signature**

**Witness**

**Date**

## PHOTOGRAPH AUTHORIZATION

In connection with the medical services, which I am receiving from Dr. David E Halpern I consent, that photographs may be taken of me or parts of my body under the following conditions:

1. The photos may be taken only with the consent of my physician and under such conditions and times as may be approved by him.
2. The photos shall be used for medical records only, unless in the judgement of my physician, medical research, education or science will benefit by their use. In that event, I agree that they may be used for such purposes providing that my identity is not revealed by the photos or by descriptive texts accompanying them.

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Signature:

Date:



DAVID E. HALPERN, M.D., FACS  
**TAMPA BAY PLASTIC SURGERY, INC.**  
120 South Fremont Avenue  
Tampa, Florida 33606

\* PLEASE READ THIS LEGALLY-BINDING DOCUMENT CAREFULLY \*

## DOCTOR/PATIENT ARBITRATION AGREEMENT

This Doctor/Patient Arbitration Agreement (the "Agreement") is made between David E. Halpern, M.D., FACS, doing business through Tampa Bay Plastic Surgery, Inc., on behalf of the company and its officers, directors, principals, agents, and employees, all collectively referred to hereinafter as "Doctor" and \_\_\_\_\_ referred to hereinafter as "you" or "the Patient." It is the intention of the parties to this Agreement that it binds themselves, and also their heirs, personal representatives, guardians, children, spouses or any person deriving their claims through or on behalf of the Patient.

It is understood by you, the Patient, that you are not required to use the professional services of David E. Halpern, M.D., FACS, or any of Dr. Halpern's staff or those referred to in this Agreement as "Doctor" for the performance of general surgery, hand surgery, plastic surgery, reconstructive surgery and/or related medical procedures and services. It is also acknowledged by you, the Patient, that there are numerous other physicians in the Tampa Bay area who are qualified to perform general surgery, hand surgery, plastic surgery, reconstructive surgery, cosmetic surgery and/or related medical procedures and services.

For and in consideration of the mutual benefits flowing between the parties pursuant to this Agreement, it is understood and agreed that in the event of any controversy, dispute or claim which might arise between Doctor and you the Patient, in connection with medical procedures or services performed by Doctor for you the Patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, the dispute shall be resolved by arbitration as provided in the Florida Arbitration Code, Chapter 682, Laws of Florida. **IT IS UNDERSTOOD THAT THIS ARBITRATION SHALL BE IN LIEU OF ANY INSTEAD OF ANY TRIAL BY JUDGE OR JURY.** Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. All the arbitrators shall be licensed physicians who are members in good standing of the American Society of Plastic Surgeons, certified by the American Board of Plastic Surgery, and actively engaged in the practice of plastic and reconstructive surgery in the State of Florida. The panel of arbitrators shall hear and decide all aspects of any controversy, dispute or claim between the parties to this Agreement, and their decision shall be binding on all parties.

It is further understood and agreed by Doctor and you the Patient that the arbitration of any controversy, dispute or claim pursuant to this Agreement shall be commenced within the time prescribed by the applicable Florida Statute of Limitations. An action pursuant to this Agreement shall be deemed to commence upon the receipt of a written claim notifying the Doctor or Patient, whichever the case may be, of the nature of the controversy, dispute or claim, and demanding that the parties proceed with arbitration in accordance with the terms of this Agreement.

In the event of a final arbitration decision based on you the Patient's failure to pay for medical services rendered by Doctor, you the Patient expressly agree that any arbitration award in favor of Doctor shall include pre-award interest calculated at the rate of one and one-half percent (1.5%) per month of the total principal amount awarded for each month unpaid from the date of initial invoice until the date of the arbitration award, regardless of any differential between the invoice and award amounts. The parties further agree that any final judgment may be submitted for enforcement to a state or federal court of competent jurisdiction located in Tampa, Florida, and to that end both Doctor and you the Patient expressly consent to the personal jurisdiction of said court for such purposes.

In witness whereof, we have signed in agreement below on this \_\_\_\_ day of \_\_\_\_\_, 201\_\_.

**"Doctor"**

**"Patient"**

By: \_\_\_\_\_  
Authorized Agent

By: \_\_\_\_\_  
Patient

Witness: \_\_\_\_\_

Witness: \_\_\_\_\_