CNY FACIAL SURGERY GROUP, PC
4939 Brittonfield Parkway
Bldg-B
Suite-210A Medical Suite 210B Cosmetic
East Syracuse, New York 13057
TEL: (315) 471-8404 FAX: (315) 471-6803
SANG W. KIM, MD

APPOINTMENT POLICIES AND PROCEDURES

You will receive a reminder call approximately 2 days in advance of your appointment

The office of CNY Facial Surgery Group, PC, respects your privacy, therefore, if you wish to not receive reminder calls or reminder emails, please advise us at least 5 days prior to your appointment.

Please bring the following information with you to your appointment:

- Please complete and bring with you this New Patient packet
- Please ***hand deliver to our front desk team on arrival.***
- Please fill-in **all** information.
- Please sign and date all forms that request signatures and dates.
- Bring your insurance card(s) with you to your appointment. *If you do not have your insurance card with you, payment will be expected at the time of your visit.*
- Bring your Driver License. We need to identify you and be sure that it matches the insurance information.
- *CT Scans, X-rays, MRI films with reports.*
- *Any related medical records that will assist us in your treatment.*

- No-Fault and Workers Compensation Cases You Must have the following at the time of your appointment or we will have to reschedule you.
    - The date of injury/accident.
    - Name of insurance carrier w/address & phone number.
    - Case number and/or Reference number.
    - Any other relevant information regarding your case.

Co-Pays and Self Pay Fees

Any copays and self-pay fees are due at time of visit.
We accept cash, check, debit cards, American Express, Visa, MasterCard, Discover and Care Credit.

Referrals

Referrals are required. If an insurance referral is required, please be sure you obtain one prior to your visit or we will have to reschedule you.

Cancellations / Rescheduled Appointments:

Please understand that we have a No-Show fee of $50. that will be billed in the event you do not call or email us within 24 hours. We understand that emergencies and unpredictable circumstances arise and are a part of life. If you must make a short notice change, please call our main office directly and respect the time we have dedicated to you. Please note that if you arrive more than 15 minutes late, you will need to be rescheduled.

I have carefully read the above office policy, as well as understanding and agreeing to the terms and conditions.

Signature: _____ **Date:** _____
Rev 4/2024

CNY FACIAL SURGERY GROUP, PC
SANG W. KIM MD
please Print

NAME _____
FIRST MIDDLE INITIAL LAST

DATE OF BIRTH _____AGE_____ SEX (CIRCLE) M F MARITAL STATUS (CIRCLE): S M D W

ADDRESS _____

CITY _____ STATE _____ ZIP CODE_____

EMAIL ADDRESS _____

HOME PHONE#_____ CELL# _____WORK#_____EXT_____
[indicate area code if other than (315)]

EMERGENCY CONTACT: NAME/ RELATIONSHIP _____ PHONE#_____

PHARMACY NAME/ADDRESS/PHONE _____

NAME OF YOUR PRIMARY CARE PHYSICIAN _____PHONE# _____

NAME OF REFERRING PHYSICIAN _____PHONE# _____

EMPLOYED BY: _____PHONE# _____

NAME OF SPOUSE: _____ SPOUSE DOB: _____

HOW DID YOU HEAR ABOUT US? (CHECK/NAME ALL THAT APPLY)
Friend/Colleague-Please indicate name if appropriate_____
Internet Search ____Website ____ Magazine____ Real-Self____ Business/Salon/Spa_____

IF PATIENT IS UNDER 21, PLEASE INDICATE THE FOLLOWING: STUDENT(circle): **FT PT N/A**

NAME OF FATHER_____ DOB_____

EMPLOYER_____ WORK#_____

NAME OF MOTHER_____ _____ DOB_____

EMPLOYER_____ WORK#_____

IF DIFFERENT ADDRESS THAN ABOVE, PLEASE INDICATE _____

INSURANCE

PLEASE FILL-IN ALL INSURANCE INFORMATION
IF YOUR CLAIMS ARE NO FAULT/WORKERS COMPENSATION (PLEASE LET US KNOW AND ASK FOR ADDITIONAL PAPERWORK)

NAME OF PRIMARY INSURANCE
SUBSCRIBER_____ID#_____

SECONDARY INSURANCE
SUBSCRIBER_____ID#_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO CNY FACIAL SURGERY GROUP, PC.

SIGNATURE _____ **DATE** _____

Rev 01/2019

Patient Authorization & Consent Form for
HIPAA LAW 164.506 AND 164.508
(Health Insurance Portability and Accountability Act)

In order to maintain your Patient Rights under the HIPAA LAW 164.506 and 164.508, we need to inform you of the following ways that your personal information can be used in order to render your care. If for any reason you do not want us to use your information in any of the manners listed below, please place a single line through that entry and write "refused" at the end of the particular entry.

I _____ understand and give consent to *CNY Facial Surgery Group, PC* to receive payment from my insurance carrier and to obtain all necessary information to render care to me including: Transmission of my treatment and care rendered by this practice to my insurance carrier via electronic or paper claims submission for billing purposes.

Notification of my health care needs to my primary care or other involved physicians, through written documentation that may be faxed, e-mailed or sent through the US Postal service.

I also understand that *CNY Facial Surgery Group, PC* may also be receiving information from my various physicians in the same manner through, facsimiles, e-mail and the US Postal Service.

I also understand that if testing is required and specimens are collected and sent out to various laboratories and pathology sites, pertinent information about myself such as name address, date of birth, social security number, pertinent diagnosis and insurance information may be sent along with such specimens for the purpose of processing.

I also understand that if surgery of any type is required and a medical clearance is needed, my primary care physician's office may be contacted and the appropriate appointments and arrangements may be made by the staff of *CNY Facial Surgery Group, PC*. These appointments may include blood work, physicals and other testing procedures. The outcome of these appointments may be received by facsimile and/or e-mail and then shared with the designated surgery center and the anesthesiologist who will be involved in my care.

I also understand that billing information will be shared with any entity involved in my care, for the purpose of payment of services only.
I also understand that in order for the office of *CNY Facial Surgery Group, PC* to maintain patient flow, I will be required to verbally check-in for my appointment with a receptionist.
I also understand that my name will be called aloud when the technical staff is ready for me in the exam area, or when any other staff member is in need of my personal attention at their station.

I also understand that in the event of an emergency *CNY Facial Surgery Group, PC* tries to obtain my consent as soon as reasonably practical after the delivery of treatment. If he is unable to obtain my consent, he may still use or disclose my health information.

I also understand if *CNY Facial Surgery Group, PC* tries to obtain consent but is unable to do so due to substantial communication barriers and *CNY Facial Surgery Group, PC* determines, using professional judgement that you intend to consent to use or disclose under the circumstances.

We may disclose your private health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls, to make repairs or replacements.
By acknowledgment of this information, I authorize *CNY Facial Surgery Group, PC* to bill my insurance carrier(s) and I understand that any information pertinent to the findings of my exam can be released to my insurance carrier(s). I have the right to refuse billing to my carrier and understand that I am financially responsible for all visits here whether deemed self pay or non-covered service determined by my insurance carrier to be the responsibility of the insured. This includes, co-payments, co-insurance payments, deductibles, and not medically necessary treatments.

SIGNATURE_____ DATE_____
REV 04/2016

CNY FACIAL SURGERY GROUP, PC FINANCIAL POLICY

Thank you for choosing our practice to provide your care. We value you as a patient and wish to make you aware of our financial policies. We require that you read and sign this document prior to seeing the provider.

Cancelled Appointments: If you are unable to keep your scheduled appointment, please kindly call our office within 24 hours to reschedule. This will allow us to provide this time slot to another patient. In the event of a 'no-show', you will be charged a $50.00 'no-show' fee.

No Insurance: Payment will be due at time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our front desk or billing manager.

Insurance: Please bring your insurance card with you at each appointment. It is your responsibility to provide our office with your current insurance as well as updating us of any changes in insurance. With insurance plans where we have agreed to participate as a network provider, carriers require that all copay's be paid prior to services being rendered. The copay cannot be waived, as it is a requirement placed on you by your insurance carrier. For your convenience, we accept cash, check, credit card, Care Credit and HCS.
You are responsible for any copays, co-insurance, deductible or non-covered services not paid by your insurance. You will receive a statement from our office indicating what your insurance has paid and what the amount of your responsibility is. The payment will be due upon receipt.

Non-Covered Services: Some services we provide may not be deemed medically necessary by your insurance carrier or may be a non-covered service benefit by your specific policy and therefore not paid by your insurance carrier. Most cosmetic procedures are not covered i.e. Skin Tag Removal. We cannot bill your insurance for any cosmetic procedures.

Laboratory services: Some services such as biopsies and other specimens will be sent to an outside lab for evaluation. In those circumstances, the patient will receive a separate bill from the lab where the specimen was sent to.

Returned Check Policy: A $25.00 fee will be charged for each check that is returned for insufficient funds

ABN: In certain situations, we may ask you to sign an ABN. An Advance Beneficiary Notice (ABN), also known as a waiver of liability, is a notice a provider should give you before you receive a service if your provider has reason to believe your insurance may not pay for the service or does not provide preauthorization.

Sublingual Allergy Drops: Please be advised that these drops are still considered investigational and experimental and therefore are not covered by any insurance companies at this time.

Vial for Allergy Injections: Please be advised that once we have verbal/ written consent from the patient to move forward with this treatment, the vials will be mixed in office prior to each appointment, and sometimes several weeks in advance. Your insurance company (or you, if you are self pay) will be billed for the total number of doses made. Billing is NOT based off of when the patient receives the vial. This charge is billed ONLY WHEN VIALS ARE PREPARED. It is separate from the charge for each injection.

ASSIGNMENT AND RELEASE
I, the undersigned, assign directly to CNY Facial Surgery Group all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.
I further authorize CNY Facial Surgery Group, PC to disclose information in my medical records, including current and previous medical records, to other physicians and health care providers to whom the physician refers me for my treatment.

FINANCIAL AGREEMENT
I acknowledge that payment is due at time of treatment and I agree that Parents/Guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges not covered by insurance.

Signature_____ Date_____
Rev 09/2024

CNY Facial Surgery Group Medical History Form

Name:_____ Date of Birth_____

Age_____ Height_____Weight_____

Reason for visit _____ PCP_____

Medical History

Please check box if applicable		DVT/ PE/ Blood Clots	
Heart Attack		HIV/ Aids	
Mitral Valve Prolapse		Cancer Type?	
Heart Murmur		Hepatitis Type?	
Pacemaker/AICD		MRSA	
Aneurysm		Limited Neck Mobility	
A Fib		Fibromyalgia	
Irregular Heart Beat		Restless Leg Syndrome	
High Blood Pressure		Broken Nose When?	
High Cholesterol		Chronic Mouth Breathing	
Stroke/TIA		Heavy Snoring	
COPD/ Emphysema		Sleep Apnea CPAP or BiPAP?	
Asthma		Anxiety	
Shortness of Breath		Depression	
Kidney Disease		Problems with Anesthesia?	
Liver Disease		Other (Please specify below)	
Diabetes (Type?)			
Thyroid Disease			
Autoimmune Disease Type ?			
Bleeding Disorder			

Surgical History

Surgery	Year

Medications

(include prescriptions, vitamins and supplements)

Medication	Dose

Rev (7/2024)

CNY Facial Surgery Group Medical History Form

Name:_____ Date of Birth_____

Age_____ Height_____Weight_____

Reason for visit _____ PCP_____

Allergies

O Latex O Shellfish O Iodine

Allergy	Reaction

Social History

Occupation	Retired
Marital Status	Single Married Divorced Widowed
Live Alone	Yes No
Pets (Specify Type)	
Tobacco Use	Smoke Cigarettes? Yes No (If you never smoked, please move to alcohol/drug use) Other Tobacco Product use? Please specify
Alcohol Use	Yes No # of Drinks per Week Beer / Liquor / Wine
Drug Use	Marijuana use? CBD? THC?
	Other Recreational Drug Use? (Please specify)

Family History

	Mother	Father	Sibling	Other
Diabetes				
Heart Disease				
Bleeding Disorder				
Cancer (Specify Type)				
Stroke				
Other Condition				