Constance M. Chen, MD, MPH

Perforator Flap Breast Reconstruction
Diplomate of the American Board of Plastic Surgery

875 Park Avenue
New York, NY 10075
(212) 792-6378 Tel
(212) 504-9511 Fax
www.constancechenmd.org

Welcome

Welcome to the office of Constance M Chen, MD, PC. We look forward to meeting you at your appointment on

We are located at 875 Park Avenue, at the corner of East 78th Street, on the Upper East Side. Parking is available on 77th or 78th between Lexington and Third Avenues. Please visit our website at www.constancechenmd.org to learn more about our office. Icon Parking is a website that lists discounted lots near our office; go to www.iconparking.com for more information. Parking and hotel accommodations can also be found on our website. Our office is available to assist with any questions you may have on parking or hotel recommendations; please do not hesitate to call.

Please see attached documentation and complete prior to your visit with Dr. Chen. Feel free to contact the office if you have any questions.

Sincerely,

Andrea Smith
Office Coordinator
andrea@constancechenmd.org

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New York, New York 10075
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Plastic & Reconstructive Surgery
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Patient Information | Demographics

Date: ________________ Social Security #: ______-______-_____ Sex: ☐ Male ☐ Female

Patient's Name: ______________________________________ Date of Birth: ____________________

Street: ____ Apartment # ____________________

City: __________________ State: _______ Zip: ________ Marital Status: ☐ S ☐ M ☐ D ☐ W

Employer: ____ Email: ___________________________

Home #: ___________________ Work # ____________________ Cell # ___________________

Preferred method of contact: ____

Patient/Guardian Name (if patient is a minor): _____________________ Phone: ___________________

Emergency Contact: ____ Phone: ___________________

Primary Physician: ____ Phone: ___________________

PCP Address: ____

Referring Physician: ____ Phone: ___________________

Referring Address: ____

Pharmacy: ____ Phone: ___________________

PRIMARY INSURANCE

Policy #: ________________________________ Group#: _______________________________

Insurance Company: _________________________ Insured (if other than patient): _______________

Address: ________________________________ Relationship to Patient: ____________________

City: ______________State: ______Zip: _________ Phone: _________________________________

SECONDARY INSURANCE

Policy #: ________________________________ Group#: _______________________________

Insurance Company: _________________________ Insured (if other than patient): _______________

Address: ________________________________ Relationship to Patient: ____________________

City: ______________State: ______Zip: _________ Phone: _________________________________

I consent to treatment by Constance M. Chen, M.D., P.C. and to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I have been given a copy of this office's notice of privacy practices and understand that I may revoke this consent at any time with written notification. I authorize payment of all medical benefits from all insurance carriers directly to Constance M. Chen, M.D., P.C. I understand that I am responsible for any part of the charges that are not covered by third party payors.

Signed: ____________________________________ Date: ___________________________________
(Parent or Guardian if patient is a minor)

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Breast Reconstruction | Patient History Form

Today's Date: ___________________

Patient Name: ____ Date of Birth: _____________ Age: ___

Height: ______ Weight: _________ BMI: ________ Current Breast Size: _________ Previous Bra Size: _______

Primary Care Doctor: ____ Phone Number: ___________________

Referring Doctor: ____ Phone Number: ___________________

Oncologist: ______________________________Last Visit: ________________ Phone: ___________________

General Surgeon: _________________________Last Visit: _________________ Phone: __________________

HISTORY OF PRESENT ILLNESS:

When did the condition first occur? ____

How was it diagnosed: ☐Self ☐Mammogram ☐ Physician

BRCA Positive? ☐Yes ☐No

What side is/was the tumor on? ☐Right ☐Left ☐Both

What was the size of the tumor? ________________ Number of Lymph Nodes Removed: __________

Number of lymph nodes positive: _______________

What type of tumor (if known)? ☐DCIS ☐ Invasive Ductal ☐ Lobular

Date of Mastectomy (if applicable) _______________ Surgeon: ___________________________________

Date of Lumpectomy (if applicable) ______________ Surgeon: ___________________________________

Describe any other treatment you have had so far (including reconstruction, if any):

____

____

Radiation Therapy: Duration: from________________________ to ________________________

Quantity: ____

Chemotherapy: Duration: from________________________ to ________________________

Quantity: ____

PAST MEDICAL HISTORY: *Have you ever had the following?*

	NO	YES		NO	YES		NO	YES
Heart Disease	☐	☐	Blood Clots	☐	☐	Stomach Ulcer	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐	Kidney Disease	☐	☐
Rheumatic Fever	☐	☐	Asthma	☐	☐	Thyroid Disease	☐	☐
Anemia	☐	☐	AIDS or HIV	☐	☐	Bleeding Tendency	☐	☐
Tuberculosis	☐	☐	Stroke	☐	☐	Mitral Valve Prolapse	☐	☐
Diabetes	☐	☐	Hepatitis	☐	☐	High Blood Pressure	☐	☐

PAST MEDICAL HISTORY: *List any major illnesses and dates:*

Date	Illness

PAST SURGICAL HISTORY: *List all of your previous surgeries and dates:*

Date	Illness

DRUG ALLERGIES: *List any drug allergies and drug reactions:*

____

CURRENT MEDICATIONS: *Please include aspirin, ibuprofen, birth control pills, or any herbs/supplements*

Medication	Dosage

FAMILY HISTORY: *Please include types of cancer, or any other major medical disease for blood relatives*

Type	Relationship

BLEEDING DISORDERS: *Have you or any of your relatives had problems with blood clots or bleeding?*

____

Have you ever had a liposuction procedure? __________ If so where? ______________________

SOCIAL HISTORY:

Smoking (type & amt. per day)? ____________________ If former smoker, date quit: __________

Alcohol (type & amt. per week) ____

Occupation: ________________________________ Marital Status: ____________________

Spouse Occupation: ______________________________ Number of Children: ______________

PHYSICAL ACTIVITY LEVEL: How often do you exercise? ____________________________

What type of activities do you enjoy? ____

Does your work require any physical activity? ☐ No ☐ Yes | Do you have back pain? ☐ No ☐ Yes

REVIEW OF SYSTEMS: *Do you have now or have you had within the past year:*

	NO	YES		NO	YES		NO	YES
Weight Change	☐	☐	Swollen Feet/Ankle	☐	☐	Seizures	☐	☐
Dry Eyes	☐	☐	Skin Rash	☐	☐	Joint or Muscle Pain	☐	☐
Chronic Cough	☐	☐	Chronic Diarrhea	☐	☐	Swollen Lymph Nodes	☐	☐
Chest Pain	☐	☐	Jaundice	☐	☐	Easy Bleeding	☐	☐
Rapid Heart Beat	☐	☐	Depression	☐	☐	Easy Bruising	☐	☐
Abdominal Pain	☐	☐	Heartburn Reflux	☐	☐	Urinary Symptoms	☐	☐

Age period began: ____________________ Number of pregnancies: _____________

Date of last mammogram: ______________ Do you breast feed? ☐ No ☐ Yes

Do you do regular breast self-examinations? ☐ No ☐ Yes Breast lump or discharge? ☐ No ☐ Yes

I verify that the above information is true and accurate to the best of my knowledge.

______________________________ ____________ ______________________________

Signature of patient or parent if minor **Date** **Signature of Physician**

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OUT OF NETWORK AGREEMENT

Patient Name: ____ **DOB: ____________**

Please read the document below pertaining to out of network services with Dr. Chen:

Dr. Chen is out of network with all insurance companies. These companies forward their payment/check with Explanation of Benefit (EOB) for services of non-contracted providers directly to the patient/subscriber. The patient/subscriber is responsible for forwarding any payment to Dr. Chen along with the Explanation of Benefits (EOB) that accompanies the check.

My signature on this document signifies that I understand that any payment from an insurance company, **along with patient deposit,** will be applied to Dr. Chen's **billed charges**. If the patient deposit and insurance payment exceeds the billed charges the patient will get a refund in the exceeded amount. I further understand that failure to comply with this requirement will make the entire billed amount the patient's responsibility and will void any special terms, conditions or arrangements.

Checks from insurance companies are to be endorsed by the subscriber and made payable to Constance M. Chen, M.D. and mailed to our office. Again, please be sure to include Explanation of Benefits (EOB) for proper crediting to your account.

I agree and authorize Dr. Chen to further endorse such checks and deposit and negotiate such checks through her bank as may be appropriate for him to have full use of those funds as though paid to him directly.

If you have any questions, please contact our office at 212-792-6378.

___________________________________ ___________________________
Signature (or Signature of Patient Representative) Date

___________________________________ ___________________________
Signature of Witness Date

RELEASE OF MEDICAL RECORDS

1. I AUTHORIZE:

____
Name

____
Street Address

____
City State Zip Code

2. TO RELEASE TO:

Dr. Constance M. Chen
166 Fifth Avenue | Second Floor
New York, New York 10010

3. INFORMATION TO BE RELEASED

☐ All Information
☐ Diagnostic Tests/Labs
☐ All Progress Notes
☐ Allergy Records
☐ Photographs
☐ Operative Reports
☐ Radiology Results
☐ Other: ____________

SPECIAL AUTHORIATION: *Check applicable purpose*
By signing below, I am authorizing the office to release any end and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ STD ☐ HIV ☐ AIDS

Note: If this release pertains o alcohol, drug or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: ______________________________ **Date:** ____________

4. RECORDS FROM THE TIME PERIOD: **From** ____________ **through** ____________

5. PURPOSE OF DISCLOSURE: *Check applicable purpose*

☐ Continued Medical Care
☐ Personal
☐ Payment of Insurance Claim
☐ Worker's Compensation Claim
☐ Legal
☐ Other: ____________

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

______________________________ ____________ ____________
Patient Signature Date of Birth Date

______________________________ ____________ ____________
Medical Record # Date Staff Initials

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PATIENT PRIVACY and CONSENT

FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Patient Name: ____ **DOB:** ______________

I hereby consent to the use or disclosure of my protected health information by the practice of Constance M. Chen, M.D., P.C. hereinafter referred to as ("Practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warrantees, implied or otherwise, to the outcomes of any treatments or procedure.

I have been offered, read and/or understand the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. I understand that patient privacy rights and disclosure varies state by state.

I also understand that the *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. Thi *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the offices of Constance M. Chen, MD, PC.

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy be sent in the mail, or by requesting one at the time of my next appointment.

____ ____________________
Signature of Patient or Personal Representative if the Patient is a Minor Date

____
Printed Name of Patient or Personal Representative

____
Relationship of Personal Representative to the Patient

____
Signature of Practice Representative and Witness

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FINANCIAL POLICY

Patient Name: ____ DOB: ____________

INSURANCE POLICY: We will bill most insurance carriers for you if all necessary information is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time services are rendered.

DEDUCTIBLES: You are responsible for any unpaid deductibles. All fees determined by your insurance carrier are due prior to services being rendered. You will be notified by our office of any unpaid fees owed to us and to set up a payment arrangement.

REFERRALS: You are responsible for determining whether a referral is needed for your office visit. If you fail to obtain a required referral you will be responsible for payment of your office visit.

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PAYMENT AGREEMENT: Portions of your bill that are determined by your insurance to be patient responsibility are required to be completed in full at least two weeks prior to surgery. We accept all major credit cards, cash or certified cashier's checks. Contact the office to discuss this in further detail if you have any questions.

MISSED APPOINTMENTS: In fairness to other patients and the doctor we require at least 24 hours notice to cancel appointments. You will be charged $50 for any missed appointments.

I understand and agree to send Constance M. Chen, MD, PC any payments I may receive from my insurance company. I am aware that the payment is owed to Constance M. Chen, MD, PC and will send any payments promptly to the office of Constance M. Chen, MD, PC.

I have read, understood and agree to the above financial policy for payment of professional fees.

The patient is ultimately responsible for all professional fees and for any legal fees incurred by the practice as a result of having to enforce these policies.

______________________________________ ________________________
Signature (or Signature of Patient Representative) Date

______________________________________ ________________________
Signature of Witness Date

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AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH

Patient Name: ____ **DOB:** ____________

I consent to the taking of photographs by Dr. Constance M. Chen or her designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Constance M. Chen. I further authorize Dr. Constance M. Chen or one of her associates to release to the American Society of Plastic Surgeons® ("ASPS®") such photographs.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of Dr. Constance M. Chen and may be retained by Dr Constance M. Chen or released by Dr. Constance M. Chen for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, or Web sites for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Constance M. Chen.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because Dr. Constance M. Chen is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. Constance M. Chen, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

____ ____
Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of ___________________, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

____ ____
Signature Date

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Appointment of Representative for an Appeal

Patient Name: ______________________________ DOB: ______________

Insurance: ______________________________ ID #: ______________

Reference: ______________________________

I ________________________ authorize Dr. Constance Chen and her staff to represent me in the appeal process for the above referenced denial of insurance coverage for medically necessary evaluation and treatment.

______________________________ ______________

Patient Signature Date

______________________________ ______________

Witness Signature Date