YOASH R. ENZER, MD, FACS
Cosmetic, Laser, and Oculofacial Plastic Surgery
ASHLEY L. WRIGHT, FNP
Aesthetic Nurse Practitioner
120 Dudley Street, Suite 104 | Providence, RI 02905
Tel (401) 274-4464 | Fax (401) 831-0710 | www.doctorenzer.com

Existing Patient Update Form

PATIENT DEMOGRAPHICS

Name: _____
Nickname: _____
Gender ID: □Male □Female □Other: _____
Address: _____
City, State Zip: _____
E-Mail Address: _____
Home Phone: _____
Mobile Phone: _____
Work Phone: _____
Date of Birth: _____
Occupation: _____
Marital Status: _____
Whom do you currently live with?
_____

HEALTH INSURANCE INFORMATION

Primary Insurance:
Member ID: _____
Subscriber's Name: _____

Secondary Insurance:
Member ID: _____
Subscriber's Name: _____

PHARMACY INFORMATION

Name, Address: _____
City, State: _____
Phone #: _____

EMERGENCY CONTACT

Name: _____
Relationship to Patient: _____
Phone #: _____
☐ Check if we may disclose information protected by HIPPA to this contact person.

PERSONAL PHYSICIANS

Eye Doctor: _____
City, State: _____
Phone: _____

Medical Doctor: _____
City, State: _____
Phone: _____

Cardiology Doctor: _____
City, State: _____
Phone: _____

Skin Doctor: _____
City, State: _____
Phone: _____

MEDICAL CONDITIONS & SURGICAL HISTORY

_____
_____
_____
_____
_____

MEDICATIONS

List all of your current medications and any over-the-counter medications/supplements, including dosages: _____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS

_____
_____

Date: _____

YOASH R. ENZER, MD, FACS
Cosmetic, Laser, & Oculofacial Plastic Surgery
ASHLEY L. WRIGHT, FNP
Aesthetic Nurse Practitioner
120 Dudley Street, Suite 104 | Providence, RI 02905
Phone (401) 274-4464 | Fax (401) 831-0710 | www.doctorenzer.com

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

All Patients: I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits or cosmetic services directly to Enzer & Associates, P.C. In the event you are required to proceed with any collection proceedings, **I agree to be responsible for all reasonable billing fees associated with the collection of my debt, including but not limited to 1.5% per month interest on the outstanding balance, plus attorney and/or collections fees (up to 33.3%)**. I agree that I will be responsible to pay Dr. Enzer for all services rendered, including those not covered, co-insurance balances, or denied for payment by my insurance company.
Medicare Patients: I request that payment of authorized Medicare benefits be made to Enzer & Associates, P.C. for any and all services furnished to me by said medical company. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature:	Date:

MISSED APPOINTMENT POLICY

Any appointment missed, cancelled, or rescheduled less than one (1) business day will be subject to the following fees. Appointment fees may be charged to a credit card. Should you wish to be billed, there will be an additional $25.00 fee from our billing company. All appointment fees must be paid in full prior to booking another appointment. **Leaving a message with our answering service the night before a scheduled appointment does not constitute one (1) business day notice.** I have read and agree to the terms of the appointment policy as stated above.

Dr. Enzer Missed Appointment Fees

Follow-up = $50.00 New Patient = $100.00
20 minute visit = $100.00 30+ minute visit = $150.00

Nurse Provider/Licensed Esthetician Fees

One half of treatment cost

Signature:	Date:

PATIENT PHOTOGRAPHY CONSENT

Enzer & Associates, P.C. may need to photograph you to document a medical condition, help with the diagnosis and/or treatment of a condition, submit for insurance billing requirements, and/or to help plan details of surgery. Photographs taken for these clinical reasons do not require your written permission. Your provider **does** need your written permission to use your photographs and details regarding medical services for the non-clinical reasons below. I hereby authorize Enzer & Associates, P.C. to photograph me for the following purposes:

	YES	NO
• For non-profit educational purposes outside Enzer & Associates, P.C., including teaching, lectures, medical publications, and presentations at professional conferences.	☐	☐
• To show current or future patients for the purpose of education and consultation. This may include, but is not limited to, printed patient education materials, social media, and/or website photos. **Our policy is to not post any patient photo to social media or our website Photo Gallery without your written approval.**	☐	☐

Enzer & Associates, P.C. will take all safeguards to protect my privacy and confidentiality in the use of these photographs. I consent to release any photo other than a full face frontal or side ("identifying") photo for the uses above without inspection or approval on my part of the finished product or specific use to which these photographs may be applied. I understand that although my name will not be used, it may be possible to identify me from a photo. Copies of the photos may be released to me if I ask for them. I may revoke my authorization at any time by written request.

Signature:	Date:

YOASH R. ENZER, MD, FACS
Cosmetic, Laser, & Oculofacial Plastic Surgery
ASHLEY L. WRIGHT, FNP
Aesthetic Nurse Practitioner
120 Dudley Street, Suite 104 | Providence, RI 02905
Phone (401) 274-4464 | Fax (401) 831-0710 | www.doctorenzer.com

HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

I, _____, understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have had the opportunity to read and understand your Notice of Privacy Practices regarding the uses and disclosures of my health information (a hard copy is not been enclosed; please ask receptionist if you wish to read the full text or receive a hard copy). I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I may also request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

☐ **I give my permission to be contacted by the following option(s):**

Home phone	Y	N
May we leave a message?	Y	N
Cell phone	Y	N
May we leave a message?	Y	N
Work phone	Y	N
May we leave a message?	Y	N
Mail	Y	N
Email	Y	N

☐ **I do NOT give my permission to be contacted by Enzer & Associates, PC.** I assume full financial responsibility for any and all missed appointments.

Permitted **Uses & Disclosures covered by HIPAA**: I hereby authorize Enzer & Associates, PC to disclose the following information to the named person(s) below:

___ Appointment date/times ___ Financial/Insurance ___ Medical (diagnosis/lab results) ___ Care Plan

Name: _____ Relationship: _____ Phone #: _____

Signature: Date: