Monica Tadros, MD, FACS
300 Grand Avenue, Suite 104, Englewood, NJ 07631

PATIENT INFORMATION

Patient Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____ Age: _____

Soc. Sec. #: _____

(Please circle) Sex: Male Female Marital Status: Single Married Divorced Widowed

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email Address: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Phone: _____

EMPLOYER

Name: _____

Address: _____

Work Phone: ( ) _____

PRIMARY CARE PHYSICIAN or REFERRING PHYSICIAN (to whom reports may be sent)

Name: _____ Phone: ( ) _____

Address: _____

WHO REFERRED YOU TO THIS OFFICE?

Referring Physician Name: _____ Friend: _____

☐ HMO or Health Insurance Company ☐ Website ☐ Other: _____

INSURANCE INFORMATION	Primary #1	Secondary #2
Insurance Company		
Address		
City, State, Zip		
Phone #		
Policyholder Name		
Insured's Birthdate, SS#		
Relationship to Patient		
Policy #, Group #		
Co-Pay Amount		

I have received a copy of the Notice of Privacy Practices from the office of Dr. Monica Tadros. I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. In accordance with medical treatment, there may be procedures or tests performed at additional costs. I authorize direct payment of covered benefits to the provider of professional services. I am responsible for all fees, regardless of insurance coverage. Payment for office visits is expected at the time of service. Cash or check is accepted.

Patient Signature: _____ Date: _____

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PATIENT HEALTH QUESTIONNAIRE

Patient Name:_____ Height:_____ Weight: _____

REVIEW OF SYSTEMS - CHECK All THAT APPLY

Head & Neck
___ Eye Problems
___ Double vision
___ Blurred vision
___ Prior Ear Surgery
___ Earache
___ Ear Pressure/Popping
___ Hearing loss
___ Dizziness
___ Ringing in ears
___ Nasal Obstruction
___ Nosebleeds
___ Nasal Drainage
___ Stuffy Nose
___ Altered sense of smell
___ Sinusitis
___ Nasal Deformity
___ Excessive sleepiness
___ Facial pain
___ Pain with chewing
___ Recent dental work
___ Mouth sores
___ Bad Breath
___ Lumps in the neck
___ Allergies

Respiratory System
___ Hoarseness
___ Chronic cough
___ Throat clearing
___ Heart Burn
___ Regurgitation
___ Spitting up blood
___ Shortness of breath
___ Wheezing
___ Asthma
___ Chronic bronchitis
___ Chest Pain
___ Emphysema
___ Tuberculosis
___ Lung cancer

Neurologic
___ Headaches
___ Head injury
___ Numbness or tingling
___ Transient blackouts
___ Seizures
___ Strokes
___ Facial Paralysis

General
___ Sleep Problems
___ Snoring
___ Sleep Apnea
___ Night Sweats
___ Fevers
___ Skin diseases
___ Arthritis
___ Bleeding Disorder
___ Easily Bruise
___ HIV Infection or AIDS
___ Psychiatric Diseases
___ Herpes Breakouts

Gastrointestinal
___ Difficulty swallowing
___ Pain on swallowing
___ Diarrhea
___ Constipation
___ Jaundice
___ Liver Disease
___ Hepatitis
___ Kidney Disease
___ Heartburn or ulcers

Cardiovascular
___ Hypertension
___ Heart disease
___ Angina
___ Swelling of the ankles
___ Heart Surgery
___ Angioplasty
___ Pacemaker
___ Anemia

Endocrine
___ Diabetes
___ Heat/cold intolerance
___ Thyroid imbalance
___ Menstrual disorders

Urologic:
___ Difficulty on urination
___ Frequent urination
___ Blood in the urine
___ Prostate problems

Other: _____

Past and present medical Problems:
_____
_____
_____
_____
_____

Previous surgeries and dates (month/year)
_____
_____
_____
_____
_____

List all current medications And dosages (including OTC)
_____
_____
_____
_____
_____

Do you smoke? (Yes / No)

If yes, how often? _____

Do you drink? (Yes / No)

If yes, how often? _____

Do you have a history of any substance abuse? (Yes / No)
If yes, specify? _____

Do you have any allergies?
_____

Do you have a history of intranasal drug use? (Yes / No)
If yes, specify? _____

Are you Covid-19 vaccinated? **Yes** **No**
Are you boostered? **Yes** **No**

Date of Last Covid-19 Vaccine: _____
Last Covid-19 Positive Test/Infection: _____
Reason for today's visit: _____

Patient Signature: _____ Date: _____
Physician Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and 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 received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that you have the right to change your *Notice of Privacy Practices* from time to time, and that I may contact this office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may 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 that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: SELF PARENT SPOUSE
(please circle one)

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Monica Tadros, MD, FACS
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PERMISSION FOR TAKING AND PUBLICATION OF PHOTOGRAPHS, TAPE RECORDINGS, VIDEOTAPE AND MOVIES

PATIENT: _____

PHYSICIAN: Monica Tadros, MD

1 I hereby consent that photographs, tape recordings, videotapes, and/or movies may be taken of me/the above named patient by affiliated staff of Dr. Monica Tadros in connection with the medical and other services which I/the patient am receiving by the physician. I further consent that a history of my/the patient's social and medical problems and/or audio recordings of discussions about such problems may be taken by the physician.

2 Such photographs, videotapes, movies, histories, and/or otherwise used by the physician for any purpose of medical education, knowledge, or research which the physician may deem proper.

3 I understand that neither myself/the patient nor members of my/the patient's family will be identified by name in connection with any public use of this material.

4 I grant this consent as a voluntary contribution and I waive any and all rights I may have to royalties or other compensation in connection with any such use.

Print Name: _____

Patient/Relative or
Guardian* Signature: _____

Date: _____

Witness: _____

*The signature of the patient must be obtained unless the patient is under the age of 18 or incompetent.

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS / SLIDES / AND/OR VIDEO FOOTAGE
AUTHORIZATION FOR RELEASE OF PATIENT IMAGE

Name _____

Address _____
(street address, city, state and zip code)

I consent to the taking of photos, slides or video footage by Dr. Monica Tadros or her designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Monica Tadros.

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. Monica Tadros and may be retained or released for the purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic/surgery procedures and methods.

I hereby grant permission to photograph, videotape, or record images of me during the treatment process or surgery and images before and after the treatment. I further grant permission to copyright, use, publish, and show images in whole or in part without restrictions in all forms of media, including but not limited to DVD, website, print, and online publication, and presentation slide sets.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images 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. Monica Tadros.

I understand that I have the right to inspect and the right to revoke this authorization in writing at any time, but if I do so, it won't have any affect on any actions taken prior to my revocation.

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 release and discharge Dr. Monica Tadros from all rights that I may have in 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 have this authorization as a voluntary contribution in the interest of public education.

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FINANCIAL RESPONSIBILITY

I, _____, hereby undersign that I am responsible for any payment I receive from my Health Insurance Company towards Dr. Monica Tadros bills. I am aware that I have to remit payment immediately to Dr. Monica Tadros at her address.

Moreover, I am completely aware that I am responsible to pay my bills for surgery and services rendered by Dr. Monica Tadros whether or not I am covered by my Health Insurance coverage. If this account is assigned to an attorney for collection and/or suit, the undersigned agrees to pay 33 1/3% of the claim as payment for the attorney's fees and costs of collection.

Patient/Insured Signature: _____
Insurance ID & Policy #: _____
Social Security #: _____
Witness: _____
Date: _____

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PATIENT AUTHORIZATION FROM DESIGNATING PROVIDER AS AUTHORIZED REPRESENTATIVE FOR BENEFIT APPEAL

(Print clearly in ink)

Patient Name: _____ Provider Name: Monica Tadros, MD, FACS

Patient Date of Birth: _____ Provider Address: 300 Grand Ave, Ste. 104, Englewood, NJ 07631

Relationship to Insured (please circle one)

Self Spouse Child

Name of Insured: _____ Date of Service: _____

Primary Insured DOB: _____ Claim Number: _____

Primary Insured SSN#: _____

Member ID#: _____

This Section to be completed by patient. Parent can sign on behalf of child under 18 years of age.

I, _____, do hereby authorize Monica Tadros, MD, FACS and her office
Patient Name

to be my Authorized Representative for the purpose of appealing the denial of benefits for the above referenced claim. Please be advised that this information is valid for this claim only, and does not appoint the Provider to be the Authorized Representative for additional unrelated and future unrelated claims.

_____

Signature of Patient/Member

_____

Signature of Subscriber (if patient is not primary insured)

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PATIENT AUTHORIZATION FROM DESIGNATING PROVIDER AS AUTHORIZED REPRESENTATIVE FOR BENEFIT APPEAL

SECOND ROUND

(Print clearly in ink)

Patient Name: _____ Provider Name: Monica Tadros, MD, FACS

Patient Date of Birth: _____ Provider Address: 300 Grand Ave, Ste. 104, Englewood, NJ 07631

Relationship to Insured (please circle one)

Self Spouse Child

Name of Insured: _____ Date of Service: _____

Primary Insured DOB: _____ Claim Number: _____

Primary Insured SSN#: _____

Member ID#: _____

This Section to be completed by patient. Parent can sign on behalf of child under 18 years of age.

I, _____, do hereby authorize Monica Tadros, MD, FACS and her office
Patient Name

To be my Authorized Representative for the purpose of appealing the denial of benefits for the above referenced claim. Please be advised that this information is valid for this claim only, and does not appoint the Provider to be the Authorized Representative for additional unrelated and future unrelated claims.

_____

Signature of Patient/Member

_____

Signature of Subscriber (if patient is not primary insured)

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to _____ and _____ (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to _____ and _____ for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including Cohen Howard, LLP) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: _____ Date:_____

Patient Signature: _____