Anthony Sparano, M.D.
Facial Plastic Surgeon

Sparano Face & Nasal Institute
NJ Institute for Robotic Hair Surgery
Skin Sense Spa

Legal Name: _____ DOB: _____ Date: _____

Name I prefer to be called (if different): _____ Preferred pronoun? She [ ] He [ ] They [ ]

Home Phone: (_____) _____-_____ Mobile Phone: (_____) _____-_____

E-mail Address: _____ Primary Care Physician: _____

Please check box if you'd like to be notified of specials, events or to receive educational information. Yes [ ] No [ ]

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security Number: _____-_____-_____ Sex: Male [ ] Female [ ]

Gender Identity: Male [ ] Female [ ] Transgender Female to Male [ ] Transgender Male to Female [ ] Other _____

Relationship Status: Married / Single / Divorced / Widowed / Legally Separated / Domestic Partnership-Civil Union / Partnered

Race/Ethnicity: Caucasian / African American / Asian / Native America / Latino / Hispanic / Other

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Work Phone: (_____)_____-_____

Emergency Contact: _____ Relation: _____ Contact Phone: (_____)_____-_____

If patient is a minor: Guardian/Guarantor _____ Relation: _____ DOB _____

Guardian Contact Phone: (_____)_____-_____

Please be specific with regard to how you heard about our practice. Select one of the following:

- General internet search
- Google Ad
- Social Media (Please specify: Facebook or Instagram)
- Email marketing
- Referral from a friend, family, or acquaintance (Name: _____)
- Referral from another physician (Name: _____)
- Other: _____

Insurance Information

Primary Insurance: _____ Subscriber Name & DOB: _____

Secondary Insurance: _____ Subscriber Name & DOB: _____

Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone: (_____) _____-_____

Assignment and Release

I, the undersigned, hereby certify that I (or my dependent) has insurance coverage with the above noted insurance company and assign directly to Anthony Sparano, M.D., all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____

Patient Name:_____ DOB:_____ Date:_____

Medications:

Name	Dose (e.g., 10mg daily)

Drug Allergies:

Name	Reaction (e.g., hives)

Non-Drug Allergies:

Name	Reaction (e.g., hives)

Previous Medical Illnesses (please circle Y or N)

Anemia	Y	N	Depression	Y	N	Heart Murmur	Y	N
Anxiety	Y	N	Diabetes	Y	N	Hepatitis	Y	N
Asthma/COPD	Y	N	Glaucoma	Y	N	HIV	Y	N
Cataract	Y	N	Heart Disease	Y	N	Hypertension	Y	N
Defibrillator/Pacemaker	Y	N	*If heart disease explain below:*					

_____

Additional Illnesses:_____

Previous Surgeries:

Surgery	Year

Visit us on our website at www.DrSparano.com and Facebook (@DrSparano)

Patient Name:_____ DOB:_____ Date:_____

Family History (Please check if any blood relative has experienced any of the following):

	Maternal	Paternal		Maternal	Paternal
Anemia	☐	☐	Diabetes	☐	☐
Anesthesia Complications	☐	☐	Easy Bleeding	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐
Cancer	☐	☐			

Other notable family history: _____

Social History (please circle appropriate response):

Alcohol Use: Never Occasional Daily

Tobacco/Nicotine/Vaping Use: Never Previously but quit _____ years ago Actively

Please specify: Vape Cigarettes Chewing tobacco Other: _____

Recreational Drug Use: Never Occasional Actively

Height:_____in. Weight: _____lbs.

Review of Systems (please circle Y or N)

Constitutional			**Cardiovascular**			**Psychiatric**		
Fatigue	Y	N	Chest pain	Y	N	Anxiety	Y	N
Fevers	Y	N	Heart Palpitation	Y	N	Depression	Y	N
ENT			**Gastroenterology**			**Respiratory**		
Decreased Smell	Y	N	Constipation	Y	N	Chronic Cough	Y	N
Difficulty Swallowing	Y	N	Diarrhea	Y	N	Shortness of breath	Y	N
Nasal Obstruction	Y	N	Heartburn	Y	N			
Nose Bleeds	Y	N	Nausea	Y	N	**Hematology**		
Sinus Pain	Y	N				Easy bleeding	Y	N
Sinus Pressure	Y	N	**Eyes**			Easy bruising	Y	N
			Blurry Vision	Y	N			
Skin			Dry Eyes	Y	N	**Neurology**		
Rash	Y	N				Dizziness	Y	N
						Headaches	Y	N
Musculoskeletal			**Genitourinary**					
Weakness	Y	N	Burning urinations	Y	N			

Financial Policy

The Sparano Face and Nasal Institute is committed to providing the highest standard of care. In so doing, we aim to build secure and successful professional relationships with our patients. To do so, we feel it is important for you to understand our financial policy.

Insurance:

-You must provide proof of current insurance at every visit and update us with any demographic changes.
-You must provide a referral, if required by your insurance company, prior to your visit or otherwise pay for evaluation and any balance due.
-You are responsible for any co-pays, deductibles, and co-insurance as required by your insurance company at the time of service. A $10 processing fee will be added if the co-pay is not provided.
-Your insurance policy is a contract between you and your insurance company; therefore, it is your responsibility to know your benefits.
-All fees generated are the responsibility of the patient.
-Insurance plan participation is subject to change.
-If we are not contracted with your insurance company, we do not accept their fee schedule as payment in full. Any balance is the patient's responsibility.

Diagnostic Endoscopy:

-Use of endoscopes is often important and necessary to appropriately diagnose nasal and other related conditions.
-Your insurance company may consider endoscopy a "surgical procedure" for billing purposes.
-The associated charge may be subject to deductible or co-insurance fees according to your surgical plan benefits.
-As with all healthcare services, you can decline endoscopy, but Dr. Sparano may feel it affords optimal diagnosis and/or treatment.

Fees:

To reschedule or cancel an appointment, 24-hour notice from scheduled time is required. If proper notice is not given or the appointment is missed, the fees will automatically be charged to your credit card on file. Fees are as follows:

- **Medical appointment - $50**
- **Office procedure/consultation - $125**
- **Returned check fee - $25**

Collection Agency:

All patient accounts that become 60 days delinquent may be sent to an outside collection agency, or attorney. This can result in possible discharge from the practice.

I have read and understand the terms and conditions set forth in the above policy. I understand that a duplicate copy of the financial policy is available for my reference upon request.

Print Name: _____

Signature: _____

Date: _____ / _____ / _____

Cancellation and Missed-Appointment Policy

Please understand this practice recognizes there are times a patient has no other option but to cancel an appointment. However, such cancellations or missed appointments have a cumulative effect on our practice. Because ours is a busy surgical practice with surgical block-time occupying time available for patient visits, each slot reserved for a patient is valuable. Dr. Sparano generally sees each of his patients, pre- and post-operatively, as a fundamental core value of the practice. Thus, appointments are for dedicated time Dr. Sparano has reserved for each patient, and missed appointments leave hollow voids in the practice schedule. In addition to loss of available appointment time, the practice maintains the cost of staffing employees and supplies, both of which are consumed during missed appointments.

At the time of scheduling any appointment, our staff is clear to express there is a 24-hour cancellation or missed-appointment policy. Additionally, we reserve staff members to call each patient 48 hours in advance of their scheduled visit, reminding them of the date and time, and of the cancellation policy.

For clarity, our cancellation and missed-appointment policy is as follows:

- Our office requires a valid credit card on file to schedule an appointment. The card would be charged a fee for violation of the cancellation policy.

- Any patient cancellation beyond 24 hours from the date and time of an appointment yields no charge.

- A patient cancelling a medical visit (typically billed to an insurance company), less than 24 hours prior to the appointment, will be charged a fee of $50.

- A patient cancelling any elective cosmetic appointment (including elective injections, consultations, laser procedures, other minor elective procedures) less than 24 hours prior to the appointment, will be charged a fee of $125.

- A patient cancelling any elective service scheduled at our Skin Sense Spa, whether with Dr. Sparano or one of our skin care specialists, less than 24 hours prior to the appointment, will be charged a fee of $50.

- A separate cancellation policy is applied to more significant elective surgeries, and is reviewed independently.

- *The federal government has acknowledged this is an issue of concern for many physician practices, and has authorized the charge of such fees.*

Please sign below to acknowledge you understand and consent to this policy. Thank you.

Patient Name: _____

Signature: _____

Date: _____

Patient Privacy Form

I. Acknowledgement of Sparano Face and Nasal Institute Notice of HIPAA Privacy.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information/ I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice if Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ DOB: _____

Signature of Patient/Guardian: _____ Date: _____

II. Designation of relatives, friends, or other caregivers:

I agree that Sparano Face and Nasal Institute may disclose certain health information to a family member, close personal friend, or other caregiver, since such person is involved with my health care. In that case, Sparano Face and Nasal Institute will disclose only information that is directly relevant to the person's involvement with my health care.

I wish to be contacted in the following manner (check all that apply):

Home/Mobile telephone number: (_____) _____ - _____
_____ Acceptable to leave message with detailed information
_____ Leave message with call back number only
_____Acceptable to mail my home address as listed on the patient information form
_____ Acceptable to e-mail this address: _____

Work telephone number: (_____) _____ - _____
_____Acceptable to leave message with detailed information
_____Leave message with call back number only

I designate the persons listed below as persons involved with my healthcare, for the purpose of the practice making the limited disclosures as described above. I understand that I am not required to list anyone below. I also understand I may change this list anytime.

PLEASE NOTE: We will not release information to anyone who is not listed on this form.

Print Name: _____ DOB_____ _____
Your initials here

Print Name: _____ DOB_____ _____
Your initials here

Print Name: _____ DOB_____ _____
Your initials here

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for, patient health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/guardian. Healthcare entities must keep record of protected health information disclosures. Uses and disclosures for treatment, payment, and healthcare operations may be permitted without prior consent.

Signature: _____ Date: _____