Melinda A Costa, MD, FACS
ADULT & PEDIATRIC, CRANIOFACIAL, & PLASTIC SURGEON

2516 Samaritan Drive, Suite N
San Jose, CA 95124
(408) 659-6757
info@costamd.com
costamd.com

PATIENT INFORMATION FORM

Patient Name _____ **Date of Birth** _____
Last First MI

Name You Go By _____ Sex Assigned at Birth: M/ F Gender Identity: M / F / X Pronouns:_____

Address _____

City: _____State: _____ Zip Code: _____

Home Telephone _____ Mobile Phone Number _____

OK to leave Voice Message? YES/NO
Preferred Contact Number _____
OK to text? YES/NO

If you are unavailable, Dr. Costa's office has permission to speak with: _____

E-mail Address _____ Driver's License #_____

Employer _____ Occupation _____

Address _____

Work Telephone _____Extension _____ Hours _____

Parent/Guardian _____ Contact Number _____ Relationship_____

Parent/Guardian _____ Contact Number _____ Relationship _____

Emergency Contact _____

Relationship _____ Telephone _____

Preferred Pharmacy Name: _____ Phone Number: _____

Address: _____

City: _____State: _____ Zip Code: _____

Patient Referred By_____

If a Physician did not refer you, please tell us how you heard about our office

Office Website Online Review Website Social Media Insurance Carrier Referral/Word of Mouth

_____ _____

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Signature Date

SKIN HISTORY

Last Name: _____ First: _____ Date: _____

Please Check All Items of Concern:

- ☐ Skin Care Regimen and Sunscreen
- ☐ Facial, Chemical Peel
- ☐ For Fine Lines
- ☐ Lack Of Volume, Wrinkles, and Facial Contouring
- ☐ Freckles, Sun Damage, Age Spots, Birthmarks
- ☐ Acne Scars, Facial Wrinkles, Fine Lines, Loose Skin, Enlarged Pores, Smoother Texture
- ☐ Body Skin Tightening, Cellulite, Stretch Marks
- ☐ Body Fat Reduction
- ☐ Other, Please Specify: _____

I'm Interested In: (Please Check All That Apply)

- ☐ Botox
- ☐ Sun Damage
- ☐ Skin Care Advice/Products
- ☐ Fillers
- ☐ Cellulite Reduction
- ☐ Rosacea
- ☐ Skin Tightening
- ☐ Acne Treatments
- ☐ Fat Reduction
- ☐ Fine Lines/ Wrinkles
- ☐ Other, Please Specify: _____

Do You Use Sunscreen? O Yes, If Yes, SPF # _____ O No

When You Sunbathe, How Does Your Skin Respond?

- ☐ Always Burn, Never Tan
- ☐ Usually Burn, Tan with Difficulty
- ☐ Sometimes Burn, Tan About Average
- ☐ Almost Burn, Tan Very Easily
- ☐ Rarely Burn, Tan Easily
- ☐ Never Burn, Always Tan

Do You Have Any Particular Skin Sensitivities? _____

What Products Are You Currently Using on Your Skin? _____

Have You Ever Used or Currently Using Retin-A or Glycolic Acid? If Yes, Please Specify. _____

Have You Ever Used or Are You Currently Using Accutane? If Yes, Please Specify. _____

Have You Ever Had a Chemical Peel? If Yes, Please Specify. _____

Have You Ever Had Any Laser Treatments? If Yes, Please Specify. _____

Do You Have Any Tattoos or Permanent Makeup in The Area to Be Treated? If Yes, Please Specify. _____

Do You Sunbathe or Use Self-Tanning Lotions or Use Tanning Beds? If So, Then How Often? _____

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Have You Ever Had Filler or Botox/ Dysport Injections in The Area to Be Treated? If Yes, Please Specify.

_____

MEDICAL HISTORY

Medical History: (Check the Appropriate Box Next to Any Condition for Which You Have Been Treated)

- ☐ Acne
- ☐ Herpes or Cold Sores
- ☐ Skin Pigmentation (Melasma)
- ☐ Hirsutism
- ☐ Vitiligo
- ☐ Port Wine Stain
- ☐ Keloid Scars /Other Scars
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Shingles
- ☐ Autoimmune Disorder
- ☐ Pacemaker
- ☐ Kidney Disease
- ☐ Blood Disorders
- ☐ Hormonal Imbalances
- ☐ Cancer Or Radiation Therapy
- ☐ Anemia
- ☐ Diabetes/ Diabetic Neuropathy
- ☐ Steroid Or Hormonal Therapy
- ☐ Arthritis
- ☐ Hospitalization
- ☐ Psychiatric/Mental Health Hospitalization
- ☐ Anorexia/Bulimia
- ☐ Body Dysmorphia
- ☐ Anxiety
- ☐ Depression
- ☐ Cutting or Other Self Harm Behavior
- ☐ Drug Use
- ☐ _____

Have You Past or Present Used / Use:

yes/no Tobacco
yes/no Marijuana
yes/no Vaping
yes/no Cocaine
yes/no Methamphetamines

Additional Questions:

Height: _____ Weight (Estimate Ok): _____

Do You Have Any Allergies? If Yes, Please Specify. _____

Are You Currently Taking Any Medications, Including Herbal Preparations, Medical patches, or Aspirin? If Yes,

Please Specify. _____

_____

_____

_____

_____

Do You Have a Pacemaker? _____

Are You Currently Pregnant? _____Any history of spontaneous abortion or pregnancy loss? _____

Do You Have Any Mental Health Issues That You Are Being Treated For? _____

Have You Ever Been Treated by an Endocrinologist (Hormone Imbalance)? If Yes, Please Specify. _____

_____

Do You Have Any Dental or Acrylic Implants, Crowns, or Bridgework? If Yes, Please Specify. _____

_____

Please Sign Below to Indicate all the Information on This Form is Accurate and Complete.

It is very important to disclose all requested health information to our office to ensure safe & appropriate treatments. Not sharing or providing this information could negatively impact your care.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and any amended notice at each appointment and I further acknowledge that a copy of the current notice is posted in the reception area.

I would like to receive a copy of any amended Notice of Privacy Practices (circle one): Yes / No

_____ _____
Signature Date

INSURANCE RELEASE

If you are not using insurance for this appointment, you can leave blank

Primary Insurance Company: _____

Subscriber Name: _____ Self Spouse Father Mother Partner Other

Subscriber Address: _____

Subscribers ID Number: _____ Subscriber's Date of Birth: _____ /_____ /_____

Secondary Insurance Company: _____

Subscriber Name: _____ Self Spouse Father Mother Partner Other

Subscriber Address: _____

Subscribers ID Number: _____ Subscriber's Date of Birth: _____ /_____ /_____

To submit a claim to your insurance carrier on your behalf, we are required to have the following signatures on file:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to Melinda A. Costa, M.D., FACS, or to the party who accepts the assignment below.

_____ _____
Patient's or Authorized Person's Signature Date

I authorize payment of medical benefits to Melinda A. Costa, M.D., FACS for the services described on the Health Insurance Claim Form.

_____ _____
Patient's or Authorized Person's Signature Date

I understand that if I am informed that Melinda A. Costa, M.D., FACS is not contracted with my insurance carrier I will be responsible for all fees not covered by the third-party insurance carrier.

_____ _____
Patient's or Authorized Person's Signature Date

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PATIENT FINANCIAL POLICIES

Identification: Please present your ID card and if you are using medical insurance, current health insurance card(s). A photocopy of both is made at the time of your visit. This will assist in making sure your claim is filed correctly. Please notify Melinda A. Costa, M.D. at the time of check-in of any changes in insurance, address, telephone, or family status.

Medical Insurance:
You are responsible for verifying that our physician is in-network with your insurance plan. We are contracted with several insurance plans. As the Insurance Subscriber, it is also your responsibility to know your eligibility status and insurance benefits. At the time of service, you will be fully responsible for any amount not covered by the insurance carrier including any co-pays, co-insurance, deductible, and non-covered service or items received. You agree to pay any portion not covered (i.e., patient responsibility amount) by the insurance provider. If an insurance carrier has not paid within 60 days of billing, office and surgery fees are due and payable in full from you, the patient. You will receive an account statement from our office for any balance due to us. Payment is due upon notice.

Referrals if required, authorizations must be obtained and brought to our office for the initial consultations and follow up visits.

Non- Covered Services and Denials: We will bill your insurance carrier for you if we are a participating provider and if the proper paperwork is provided to us. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier did not pay within 60 days of billing. If an insurance carrier has not paid within 60 days, office and surgery fees are due and payable in full from you. Payment is due upon notice. Any care not paid by your insurance at the time of the service will require payment in full the day services are provided or upon notice of insurance claim denial.

Signature on File: I request payment of authorized insurance benefits be made on my behalf to Dr Melinda Costa, MD, Inc for any services furnished to me by the listed provider. I authorize any medical information about me to be released to the health care financing administration and its agents to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of my medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown.

For medically necessary services only, if you do not have medical insurance or choose to be served as a Self-paying patient and your service is medically necessary based on Dr. Costa's initial consultation, Melinda A. Costa, M.D. will provide a 20% reduction on surgeon fee, for cash, check, and credit card payments made in full.

Disability forms, Insurance Forms, Family and Medical Leave Act (FMLA) Forms, Physician Statement fee:
$50 for the completion of each form. You may be required to schedule an appointment.

Returned Check Fee: $25.

Aesthetic Surgery / Procedures

- Are elective and not covered by insurance
- A 10% non-refundable deposit is required to schedule your operation. This deposit holds your date & time of surgery and allows us to engage operating room (OR) staff and reserve the OR and Anesthesiologist.
- The remaining balance is due in full 2 weeks before the date of surgery at your pre-operative appointment.
- A 3% Reduction will be applied for any patients paying Cash or Check for Aesthetic Services
- Our office offers payment plans through CareCredit and Alpheon, if these payment plans are not used there is a 6% fee reduction

No Show/Cancellation Policy: We understand that a situation may arise that could force you to postpone/cancel your appointment or surgery. Please understand that such changes affect not only your surgeon's time but other patients as well. The surgeon's time, as well as that of the staff, is a precious commodity and we request your courtesy and concern. Should you need to cancel or reschedule your appointment the following fees will be charged:

- **Office Visit:** If an office visit is not cancelled or rescheduled in at least 2 days in advance you will incur a **$75 fee.** This will be charged to the card that was given at the time of scheduling your appointment. This will not be covered by your insurance.

_____
Patient Initial

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- **Surgery Change or Cancel Fees:** If a scheduled **surgical date** is changed or canceled, you will incur a **$200 fee.** This will not be covered by your insurance.
- **Collections Agency Fee:** $50.

***Collections*:** Accounts that are not paid within 30 days will begin collection process**.** *If Melinda A. Costa, M.D. needs to send your account balance to a collection agency for non-payment or bankruptcy, Melinda A. Costa, M.D. will no longer be able to provide medical care to the patient. In this case, the person responsible for the account will be notified by certified mail and given adequate time to find a new medical provider. All accounts sent to the collection agency will be reported to the Credit Bureau, a $50 Collection Agency fee will be assessed.*

The signing of this form indicates that you fully understand and agree to the above policy for payment of professional and surgery fees. The patient is ultimately responsible for all fees.

Patient Name: _____Date: _____ / _____ / _____

Signature of Patient/Guardian: _____Relationship to Patient: _____

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Credit Card Agreement and Policy

Melinda A. Costa, M.D., FACS Credit Card Agreement and Policy: before your consultation or service, your credit card information is obtained and kept securely with **Melinda A. Costa, M.D., FACS** until your payment has been received, and may be used later to pay any balance due on your bill. This will be used when we have not received any payment for your patient dues.

Aesthetic Services: All Aesthetic Services are due prior to surgery or on the day and time of your office visit if your service is done in Dr. Costa's office. If the payment declines you will have 24 hours to provide a new payment method, or we will charge your credit card on file for the full amount of service. Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

Medical Insurance: If you are using Medical Insurance for services, please refer to the following. You will be sent a statement, which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card. Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

By signing below, I authorize **Melinda A. Costa, M.D., FACS** to keep my credit card information and signature securely on-file in my account (a federally insured and accredited merchant services company). I authorize **Melinda A. Costa, M.D., FACS** to charge my credit card for any outstanding balances when due.

If the credit card that I give today changes, expires or is denied for any reason, I agree to immediately give **Melinda A. Costa, M.D., FACS** a new, valid credit card, which I will allow them to charge over the telephone. Even though **Melinda A. Costa, M.D., FACS** is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

Visa □ MasterCard □ Discover □ American Express □

Patient Full Name (Print): _____ DOB: _____/_____/_____

Name on Card (Print): _____

Credit Card Number: _____

Exp. Date: _____/_____ CVC _____ Zip Code_____

Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice? Yes, this is standard practice and our policy.

How do you safeguard the credit information you keep on file? We use the same methods to guard your credit card information securely on-file in my account as we do for your medical information. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. This system stores the card information for future transactions using the same technology that any online retailer would (a federally insured and accredited merchant services company). There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice management system.

Why do I have to do this? In attempt to reduce unnecessary costs in our private medical practice we find this process essential.

What if there is a payment discrepancy or I have other payment questions? If this is regarding medical insurance related questions, please contact Crestmar Billing Services at (916) 941-1159. If this is regarding any Aesthetics services please contact Melinda A. Costa, M.D., FACS offices directly with payment questions.