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

Preferred Name: _____ Sex: M / F / X Preferred Pronoun: _____

Address _____

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 _____ Drivers License #_____

Parent/Guardian _____ Contact Number _____ Relationship _____

Parent/Guardian _____ Contact Number _____ Relationship_____

Employer _____ Occupation _____

Address _____

Work Telephone _____Extension _____ Hours _____

Emergency Contact _____

Relationship _____ Telephone _____

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

_____ _____
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: _____ /____ /_____

In order 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., or to the party who accepts assignment below.

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

I authorize payment of medical benefits to Melinda A. Costa, M.D. 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. are not contracted with my insurance carrier that I will be responsible for all fees not covered by third party insurance carrier.

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

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PATIENT FINANCIAL POLICIES

Identification: Present your current health insurance card and photo ID upon arrival. A photocopy of both at the time of your visit. Please notify Melinda A. Costa, M.D. at time of check-in of any changes in insurance, address, telephone, or family status.

Medical Insurance: It is the responsibility of the Insurance Subscriber to know his/her eligibility status and coverage provided by the insurance carrier. The practice of Melinda A. Costa, M.D. requires that you verify coverage limitations and physician in-network status, prior to your appointment; otherwise, you will be fully responsible for any amount not covered by the insurance carrier. The practice of Melinda A. Costa, M.D. will send you a statement after your appointment for any patient responsibility amount indicated on an explanation of benefits (EOB) issued by the insurance provider. You agree to pay any portion not covered (i.e., patient responsibility amount) by the insurance provider.

For medically necessary services only, if you do not have medical insurance or choose to be served as a SELF PAYING patient, Melinda A. Costa, M.D. will provide a 20% discount for cash, check, and credit-card payments made in full.

Aesthetic Surgery / Procedures

- Aesthetic procedures are elective and not covered by insurance
- A 10% non-refundable deposit is required to book 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 prior to the date of surgery
- A 3% Discount will be applied for any patients paying Cash for Aesthetic Services

Please note these important fees:

- **Office Visit Fees:** A 24-hour notice is required to cancel or reschedule an office visit; otherwise, you will incur a $25 cancellation fee. If you have not contacted our office to cancel or reschedule, we will consider this a "no show" and the fee $100.
- **Surgery Change or Cancel Fees:** If a **surgical date** (operating room is reserved) is changed or cancelled, you will incur a $200 Fee.
- **Returned Check Fee:** $25.
- **Collections Agency Fee:** $25.

NOTE: 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, with the Collection Agency fee assessed.

All statements issued by Melinda A. Costa, M.D. are due and payable upon receipt, and the above fees apply to both medically necessary and aesthetic procedures.

The signing of this form indicates that you fully understand and agree to the above policies and conditions.

Patient Name: _____Date: _____ / _____ / _____

Signature of Patient/Guardian:_____Relationship to Patient: _____

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Credit Card Agreement and Policy

Melinda A. Costa, M.D. 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.** 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: You will be sent a statement, which is due upon receipt. After 24 hours, if the bill remains unpaid, we will charge your credit card. 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.** 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.** 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.** a new, valid credit card, which I will allow them to charge over the telephone. Even though **Melinda A. Costa, M.D.** 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_____

If you have any questions about our policy, please do not hesitate to ask.

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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. offices directly with payment questions.