Farrell Plastic Surgery & Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center

Leo D. Farrell, M.D.
Deborah M. Farrell, M.D.

Suite 204, 2025 Technology Parkway
Mechanicsburg, PA 17050-9497

(717) 732-9000
fax (717) 732-9011

Welcome to Farrell Plastic Surgery & Laser Center!

Dear Patient,

Welcome and thank you for scheduling an appointment with Farrell Plastic Surgery & Laser Center. We appreciate your interest and will do our best to make your visit pleasant and informative. We look forward to seeing you at your upcoming appointment. In order to help us provide you with the best care and service, please read through these instructions before your appointment.

- Please arrive at least 15 minutes prior to your appointment time. This will allow our office staff to check you in and prepare your chart.
- Please complete the available paperwork and bring it along with you to your appointment. This will decrease your wait time on the day of your appointment.
- Please bring your insurance card and valid identification card.
- Please do not wear make-up on the day of your appointment. Some skin conditions can be subtle and not able to be adequately evaluated through make-up.
- Please refrain from wearing scented products such as perfume, cologne, and fragrant personal care products while in our office, as they can trigger serious health issues for those with fragrance allergies.
- For medical appointments, bring any required copayments, which will be collected at the time of check out. For self-pay patients, payment in full at the time of service is required, unless discussed otherwise. We accept cash, checks, and all major credit cards.

We value your time and will make every effort to stay on schedule and avoid unnecessary waiting. If you are late, we may need to reschedule your appointment.

If you will not be able to make the appointment and need to reschedule, please notify us as soon as possible.

Please contact us at any time with questions or concerns at 717-732-900.
We look forward to seeing you soon at your upcoming appointment!

Sincerely,

Dr. Farrell & Staff at Farrell Plastic Surgery & Laser Center

Farrell Plastic Surgery & Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center

PATIENT INFORMATION – Please Print

Patient's Last Name	First	M.I.	Nickname

Age	Date of Birth	□ M □ F	Street Address	Apt. #

City	State	Zip Code	Social Security #	Marital Status (Please circle) Single Married Divorced Widowed

Primary Phone	Secondary Phone	Third Phone	E-Mail: Do we have permission to email you? Yes / No
cell / home / work	cell / home / work	cell / home / work	

Patient's Occupation	Employer's Name	Address

Person to Notify in case of an emergency	Relationship	Emergency Contact Phone #

How did you hear about our office? (please circle all that apply)

Friends/Family Doctor Web Social Media The Patriot The Sentinel Other_____

Referred By	Address

Family Physician	Address

Preferred Pharmacy	Address	Pharmacy phone #

FINANCIAL RESPONSIBILITY

Relationship to Patient	Last Name	First	M.I.	SS #	Date of Birth

Street Address	City	State	Zip Code

Home Phone	Work Phone	Employer's Name and Address,* **Employer Paid Deductible Yes/No**

INSURANCE – Please present your insurance card to the receptionist

Insurance Company Name & Address		

Identification #	Group	Effective Date

Policy Holders Name and Address	Date of Birth

SECONDARY INSURANCE – Please present your insurance card to the receptionist

Insurance Company Name & Address		

Identification #	Group	Effective Date

Policy Holders Name and Address	Date of Birth

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and/or family physician and insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by Farrell Plastic Surgery & Laser Center, P.C. whether or not paid by said insurance.
I agree to pay all reasonable attorney fees and collection cost in the event of default of payment of my charges.
I authorize and request that insurance payments be made directly to Farrell Plastic Surgery & Laser Center, P.C. as applicable.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I have read and fully understand the above and sign with the intent to be legally bound.

_____ _____ _____

Signature of Patient or Responsible Party

_____ _____ _____

Date

Farrell Plastic Surgery & Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center

Name _____ Date _____

Height _____ Weight _____

PATIENT HEALTH HISTORY: (Check any illnesses you have had)

☐ Artificial joints/implants/ stents/shunts	☐ Collagen Disorder/Lupus	☐ Gold Therapy (ever)	☐ Psoriasis/Eczema
	☐ Collagen Vascular Disorders	☐ HIV/AIDS	☐ Rheumatoid Arthritis
☐ Accutane Date_____	☐ Depression/Anxiety	☐ Heart Disease	☐ Rosacea
☐ Acne	☐ Diabetes	☐ High Blood Pressure	☐ Skin Cancer/Melanoma
☐ Asthma/Emphysema	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Skin Disease/Condition
☐ Bleeding Tendencies	☐ Fibromyalgia	☐ Liver Disease/Hepatitis	☐ Sleep Apnea
☐ Cancer/Type_____Date_____	☐ Gastrointestinal Disease	☐ Mental/Emotional Disorder	☐ Stroke
☐ Cold sores/Fever Blisters	☐ Glaucoma/Eye Disorder	☐ Phlebitis/Venous Disease	☐ Thyroid Disease
☐ High Cholesterol	☐ Other _____		

SOCIAL HISTORY:

Occupation _____ Hobbies _____

FAMILY HISTORY: (Check any listed conditions which have occurred on either side of your family)

☐ Bleeding Tendencies	☐ Gastrointestinal Disease	☐ Kidney Disease	☐ Mental Disease
☐ Breast Cancer	☐ Heart Disease	☐ Malignant Hyperthermia	☐ Skin Cancer
☐ Diabetes	☐ High Blood Pressure	☐ Melanoma	☐ Other _____

Have you ever used Prednisone, Cortisone or other steroids? ☐ No ☐ Yes
If yes, when _____

Do you exercise? ☐ No ☐ Yes If so, how frequently? _____

Have you used insulin? ☐ No ☐ Yes Do you use tobacco? ☐ No ☐ Yes
Do you use alcohol? ☐ No ☐ Yes Do you use narcotics? ☐ No ☐ Yes

ALLERGIES: (Check if you are allergic to any of the following) ☐ None

☐ Aspirin ☐ Codeine ☐ Demerol ☐ Latex ☐ Lidocaine ☐ Morphine ☐ Penicillin ☐ Sulfa ☐ Iodine/Betadine

Other allergies: _____ Reaction: _____

OPERATIONS: Type	**Month/Year**	**Hospital**
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS: (List all medications you are presently taking including aspirin, vitamins & herbs)

Medication	**Strength**	**Dosage**	**Medication**	**Strength**	**Dosage**
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Current Skin Care _____

_____

I understand the above information will be used for my medical care. I agree that the information I have provided is true and correct to the best of my knowledge.

Patient Signature _____

Farrell Plastic Surgery & Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center
Leo D. Farrell, M.D. • Deborah M. Farrell, M.D.

FINANCIAL POLICY

Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

PAYMENT OF COPAYS IS DUE AT THE TIME OF SERVICE, unless you are instructed otherwise, or other arrangements have been made.

**** WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS CARDS ****
A fee of $30.00 will be charged for any returned check.

CREDIT CARD DISCLOSURE: Services that are paid with a credit card are not eligible for post – care payment challenges.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We will bill your insurance carrier according to our agreement with them based on the insurance information you have provided to us. **We file insurance claims as a courtesy to you.** We will not become involved in disputes between you and your insurance company regarding deductibles, copays, referrals, covered and non-covered services, secondary insurance, etc., other than to supply factual information as necessary. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

Any service provided to you that is determined to be cosmetic or non-covered for any reason by your insurance company is your responsibility. Preauthorization or precertification by your insurance company, or a referral, is no guarantee that they will cover your treatment. It is important to understand that your insurance company may at any time, after charges have been paid on your behalf, ask for a refund of payment. If this should occur, you are responsible for payment.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY.
PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING OUR FEES, FINANCIAL POLICY, OR YOUR FINANCIAL RESPONSIBILITY.

I understand that I am financially responsible for all charges, whether or not covered by my insurance. I understand that if I have not made any attempt to make payment or set up a payment schedule after my account is 90 days delinquent, I may be sent to a collection service and incur additional costs related to that.

I agree to release protected health information to my insurance, financial, and credit card companies, when requested, to facilitate payment. I further agree that I will not challenge credit, debit, or financing card payments once the services are provided, and that this non-challenge agreement is irrevocable.

Responsible Party Signature: _____ Date: _____

2025 Technology Parkway~Suite 204~Mechanicsburg, PA 17050~(717)732-9000~fax (717)732-9011

Farrell Plastic Surgery & Laser Center, P.C.

Farrell Laser & Cosmetic Medicine Center

Appointment Cancellation, Rescheduling, and No-Show Policy

Effective May 1, 2022

Our priority is providing outstanding medical care, and this requires policies to ensure appropriate scheduling. When an appointment is missed, that time cannot be used to treat another patient in need of care. We thank you for your cooperation and compliance to allow a smoother office flow and more efficient use of time.

As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, this Policy will remain in effect.

Cancellation, Late Rescheduling, and No Shows:

We require patients to give our office **at least 24-hour notice** if you are unable to keep your appointment. If you do not provide us with a 24-hour notice, or do not show for the scheduled appointment, you will be charged a $50 office fee.

A patient who is a "no-show" 3 times for an appointment will not be rescheduled for future appointments.

A patient who reschedules an appointment multiple times may be charged to hold an appointment or future appointments may be refused. The charged fee would be forfeited if the appointment is rescheduled or cancelled within a 24-hour notice.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your appointment. If you should experience extenuating circumstances, please let our office know as soon as possible, and we will determine if the fee can be waived. Illness and inclement weather will always be taken into consideration.

Cancellation, Rescheduling, and No Show fees are not billable to any form of insurance and must be paid prior to scheduling your next visit. If you refuse to pay the fee, we reserve the right to refuse scheduling any future appointments.

I have read and understand the Appointment Cancellation, Multiple Rescheduling, and No Show Policy and I agree to its terms. I understand and agree that such terms may be amended from time to time by the practice.

_____ _____ _____

Patient Signature (Parent/Legal Guardian) Printed Name Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Mail: Farrell Plastic Surgery& Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center
Attn: Privacy Officer
2025 Technology Parkway, Suite 204, Mechanicsburg, PA 17050
Telephone: (717) 732-9000
Fax: (717) 732-9011

Acknowledgement and Consent

I have received the Notice of Privacy Practices for Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center. Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center are authorized to use and disclose health information about **_____(pt name)**
for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of patient(or patient's personal representative) Date

_____
Witness (Staff Representative)

Personal representative information (if applicable):

_____
Name of personal representative

_____
Relationship to patient (or other authority)

Farrell Plastic Surgery & Laser Center, P.C.
Farrell Laser & Cosmetic Medicine Center

RELEASE OF PATIENT HEALTH CARE INFORMATION TO FAMILY/FRIENDS

Patient Name:_____ Date:_____

Date of Birth:_____

Address:_____

Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center **may release my patient health care information to** the following individual(s):

_____		_____
name	(relationship)	phone number
_____		_____
name	(relationship)	phone number
_____		_____
name	(relationship)	phone number
_____		_____
name	(relationship)	phone number
_____		_____
name	(relationship)	phone number

I hereby request that Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center **restrict the release and disclosure of health care information** contained in my medical record to the following individual(s):

_____
name

_____
name

_____
name