Plastic Surgery Specialists, P.C.

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PATIENT NAME: _____ SEX: M / F

DATE OF BIRTH: _____AGE: _____S.S# _____

ADDRESS: Street: _____

City:_____ State:_____ Zip Code:_____

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

☐ **Home Phone: (_____)_____**
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with callback number only**

☐ **Work Phone: (_____)_____**
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with callback number only**

☐ **Cell Phone: (_____)_____**
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with callback number only**

☐ **I give permission to use and disclose my protected health information to the following people:**

☐ **_____**
relationship_____
initials: _____

☐ **_____**
Relationship_____
initials: _____

☐ **EMAIL: _____**

EMPLOYER: _____

PRIMARY PHYSICIAN & PHONE #: _____

REFERRING PHYSICIAN & PHONE #: _____

EMERGENCY CONTACT: _____

How is this person related to you? _____

Emergency contact phone number: _____ Work Home Cell

How did you hear about our office? _____

INSURANCE INFORMATION

Please provide a copy of your insurance card and a driver's license or other government issued picture ID.

If your insurance card is in a different name or if the patient is under the age of 18 years, the following information is required:

Responsible Party

NAME: _____ **SEX: M / F**

ADDRESS: _____

_____

Employer: _____

BIRTH DATE: _____ **S.S.#** _____

Phone Number: _____ **Relationship:** _____

WORKER'S COMP: ← Circle which is applicable → AUTO ACCIDENT

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

PHONE #: _____ **ADJUSTOR:** _____

DATE OF ACCIDENT: _____ **CLAIM #:** _____

AUTHORIZATIONS

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PROVIDER FOR SERVICES FURNISHED TO ME, AND I AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION/MEDICAL RECORDS / DOCUMENTATION TO THE INSURANCE COMPANY, THIRD PARTY PAYORS, AND ANYONE ASSISTING THEM IN OBTAINING PAYMENT, INCLUDING BILLING, CODING AND COLLECTION AGENTS, THEIR ATTORNEYS AND CONSULTANTS FOR SERVICES RENDERED TO ME AS NEEDED TO OBTAIN BENEFITS. I UNDERSTAND THAT I MAY BE SEEN BY A NURSE PRACTITIONER AND THAT I ALWAYS HAVE THE CHOICE OF SEEING A DOCTOR INSTEAD OF THE PRACTITIONER. I AUTHORIZE THE PHYSICIAN TO USE ANY PHOTOGRAPHS TAKEN DURING THE COURSE OF MY TREATMENT FOR SCIENTIFIC, EDUCATIONAL AND/OR PROMOTIONAL PURPOSES. I WILL NOT BE IDENTIFIED BY NAME, NOR WILL PHOTOGRAPHS OF MY FACE BE USED WITHOUT A SEPARATE, SPECIFIC AUTHORIZATION. I FURTHER AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION, MEDICAL RECORDS AND/OR DOCUMENTATION TO OTHER PHYSICIANS, MEDICAL FACILITIES, INSURANCE COMPANIES, FOR QUALITY ASSURANCE, PEER REVIEW, CONSULTATIONS, AND DIAGNOSTIC STUDIES. IF I DO NOT PAY MY CHARGES WITHIN 90 DAYS OF INCURRING THE CHARGE, I WILL PAY AN ADDITION $25 FEE FOR COLLECTION SERVICES.

_____ _____

SIGNATURE **DATE**

HIPAA NOTICE

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. A copy of this form is available for review in our office. If you desire a copy to take with you, one will be provided. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

I understand that…
(Initial all four boxes):

_____ A referral from my Primary Care Physician may be required for any and all non-Emergency outpatient hospital/specialist services, based on my insurance plan in effect at the time of the service. I acknowledge that if I do not have a referral with me at the time of the appointment, and I choose to receive the services without the required referral, I will be held responsible for any payments incurred for these services.

_____ I understand that if I have a noncovered service for which my insurance carrier will not make payment and I agree to be financially liable for any payments incurred for these services.

_____ I understand that I will be responsible for all fees incurred if this visit or any other service precedes the effective date that has been assigned to my enrollment or my dependent's enrollment or occurs after termination of coverage.

_____ I understand that I will be responsible when an insurance company will not pay a benefit or contracted claim, or if the insurance company requests money back on a previously paid claim. There can be several reasons why the claim is denied or reversed:

1) The service was not covered under the patient's health insurance contract.
2) The claim was allegedly received in an untimely manner.
3) The service was considered as not being medically necessary.
4) There is another insurance company that is primary.
5) The procedure or service submitted is included with another procedure or service being billed at the same time.
6) The patient's policy was terminated with NO COBRA continuance.
7) The medical condition was deemed by the insurance company as being pre-existing.
8) The patient's policy is new and not effective on the date services were provided.
9) Authorization or Precertification was not obtained prior to rendering the service.
10) Benefits ran out. In other words, the patient may have been limited to a certain number of visits. This can usually happen with chiropractic visits.
11) The patient's insurance policy is not in effect at the time of service.

_____ _____

SIGNATURE **DATE**

MEDICAL HISTORY

WHAT IS YOUR REASON FOR SEEKING CARE WITH OUR PRACTICE? _____

_____

WHAT ARE YOUR SYMPTOMS?_____

WHAT MAKES THIS PROBLEM WORSE?_____

IF YOU HAVE BEEN TREATED FOR THIS PROBLEM BEFORE, WHAT TYPE OF TREATMENT DID YOU RECEIVE?_____

_____

PAST MEDICAL/FAMILY/SOCIAL HISTORY:

HEIGHT _____ WEIGHT _____

LIST ANY ALLERGIES:_____

_____.

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? • YES • NO

MEDICATION	DOSAGE	REASON FOR TAKING
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST PREVIOUS SURGERIES:

TYPE OF SURGERY	YEAR PERFORMED	REASON FOR HAVING SURGERY
_____	_____	_____
_____	_____	_____
_____	_____	_____

IS THERE ANY CHANCE THAT YOU MAY BE PREGNANT? • YES • NO

ALCOHOL/CAFFEINE/TOBACCO USE:

	AMOUNT OF USE	PAST USE	STOPPED USE
ALCOHOL • YES • NO	_____	_____	_____
TOBACCO • YES • NO	_____	_____	_____
CAFFEINE • YES • NO	_____	_____	_____

PREFERRED PHARMACY: _____

REVIEW OF SYSTEMS:

GENERAL	YES	NO	CURRENT	PAST
Diabetes Mellitus				
Rheumatoid Arthritis				
Stroke				
Recent Chemotherapy				
Recent Radiation				
HEAD,EYES, EARS				
Frequent Headaches				
Dizziness				
Ringing in Ears				
Change in Hearing				
Sore Throat				
Trouble Swallowing				
Blurred/Double Vision				
Poor Vision/Glasses				
RESPIRATORY				
Frequent Colds				
Difficulty Breathing				
Cough-Productive				

DIGESTIVE	YES	NO	CURRENT	PAST
Heartburn				
Vomiting				
Constipation				
Diarrhea				
Black Stools				
Blood with Stools				
CARDIOVASCULAR				
Chest Pain				
High Blood Pressure				
Use Oxygen at Home				
Pacemaker				
Swelling Ankles/Legs				
Other				
MUSCLE, BONE, JOINTS				
Leg Pain at Rest				
Leg Pain Walking				
Back Pain				

	YES	NO	CURRENT	PAST
Asthma/Hay Fever				
Emphysema				
Other				
NEUROLOGICAL				
Change in Memory				
Trouble with Balance				
Change in Sensation				
Where				
Other				
BLADDER/KIDNEY				
Frequent Urination				
Burning on Urination				
Blood in Urine				
Difficulty Urinating				
Other				

	YES	NO	CURRENT	PAST
Joint Aching/Pain				
Swelling of Joints				
Difficulty Joint Motion				
Other				
SKIN				
Rash				
New Growths/Lumps				
Color Change in Lesion				
Skin Cancer				
Other				
GYNECOLOGICAL				
Last Menstrual Period				
Hormone Therapy				
Prostate or Testicular				
Currently Pregnant				

COMMENTS:

FAMILY HISTORY	FATHER	MOTHER	SIBLING	CHILD	GRANDPARENT
Autoimmune Disordes	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐
Malignant Melanoma	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Premature Coronary Heart Disease	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐

Completed by:_____Date_____Reviewed by:_____Date_____

Patient or Guardian Signature Physician's Signature