The Plastic Surgery Center

NAME: ____ **DATE:** ________________

AGE________________**HEIGHT:** __________________**WEIGHT:** ____________________

ALLERGIES: ____

REASON FOR CONSULT: ____

PRIMARY CARE PHYSICIAN:____

Current Prescription Medications

Drug	Dosage	Times/Day

Current Herbs, Vitamins, Supplements

MEDICAL CONDITIONS:

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PREVIOUS SURGICAL PROCEDURES: ***INCLUDE DATES**

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PATIENT INFORMATION

Name ____ Home Phone ________________
Last First Middle

Sex ________ Date of Birth ________________ Age ________ Social Security # ________________

Email ____ Guarantor SS # ________________

____ ________________
Patient Address Cell Number

____ ________________
City State Zip

Your occupation ______________________________ Employer ______________________

Employer Address ____ Phone ______________

Are you: Married ________ Single ________ Divorced ________ Widowed ________

Name of Spouse or Guarantor if minor child __________________ Spouse or Guarantor Employer ________________

Employer Address ____ Phone ______________

PATIENT REFERRAL:

How did you hear about our office: Doctor ______ Another Patient ______ Relative ______ Friend ______ Employer ______

Yellow Pages ________ Internet ________ Other ______________

ALL FINANCIAL ARRANGEMENTS FOR PAYMENT SHOULD BE MADE PRIOR TO YOUR TREATMENT.

INSURANCE: PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance Co. __________________________ Claims Address __________________________

Insured's Name __________________________ Group # or Name ______________ Policy # ______________

Primary Insurance Co. __________________________ Claims Address __________________________

Insured's Name __________________________ Group # or Name ______________ Policy # ______________

Primary Insurance Co. __________________________ Claims Address __________________________

Insured's Name __________________________ Group # or Name ______________ Policy # ______________

____ ________________
Friend or Relative – Not living with you Phone

____
Address City State Zip Relationship

I hereby authorize my insurance benefits to be paid directly to the physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Patient/Guarantor Signature ________________________________ Date ______________

RELEASE FORM

Date:

I, ____

want to communicate via e-mail with The Plastic Surgery Center on matters related to my health and /or my medical treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via email.

My email address is: ____

I also understand that it is not the policy of the practice to encrypt any Confidential Health information I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

I would also like to receive cosmetic updates and reminders (Botox and Juvederm) via email.

Name: ____

Signature: ____

You may also contact me at (check all that may apply)

_____ Cell Phone ________________________________
Cell Phone Number

_____ Home Phone ________________________________
Home Phone Number

_____ Work Phone ________________________________
Work Phone Number

Name: ____

Signature: ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledge of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ❒ The patient refused to sign
- ❒ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ❒ We weren't able to communicate with the patient.
- ❒ Other *(Please provide specific details)*

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_______________________________ _______________________

Employee signature *Date*

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:

Patient's Date of Birth: Patient's SSN:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, ______________________________, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

______________________________ ____________
Patient's Signature or Signature of Patient's Representative Date

______________________________ ____________
Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Leslie Favreau

Practice Address: 5807 21st Ave. W., Bradenton, FL 34209

Phone: (941) 792-4157 FAX: (941) 794-3277 E-Mail: