Plastic Surgery Associates

Patient Information:

Name: _____

Address: _____

City: _____State:_____ Zip_____

Daytime Phone: _____

Email: _____

Date of Birth: _____ Sex: ___M ___F

Occupation: _____

Employer:_____

Patient's Spouse/Guardian:

Spouse/Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____

Reason for consultation:

_____

_____

Who were you referred by?

_____ Another Physician

Name:_____

_____ Internet Search

_____ Insurance Plan

_____ Dr. Perry's Patient

Name: _____

Primary Care Physician:

Name: _____

Address: _____

City: _____ State:_____ Zip: _____

Phone: _____

Insurance Information:

Insured Name: _____

Relationship to patient: _____

Address: _____

City: _____State:_____ Zip: _____

Daytime Phone #: _____

DOB: _____ Sex: _____

Employer: _____

Insurance Carrier: _____

Insurance Phone Number: _____

Policy #: _____

Group #: _____

Is this plan a PPO _____ POS _____ HMO_____

Are Referrals Required: _____

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also have received a Notice of Privacy Practices and Disclosure of Investment from Plastic Surgery Associates.

Signature: _____

Date: _____

Patients Name: _____
Date: _____

PATIENT MEDICAL HISTORY

MAJOR ILLNESS/MEDICAL HISTORY:
If you answer yes to any of the following, please include date of diagnosis or onset.

	Date:		Date:
Heart Disease: ____ Yes ____ No	_____	Seizure Disorder: ____ Yes ____ No	_____
High Blood Pressure: ____ Yes ____ No	_____	Anxiety Disorder: ____ Yes ____ No	_____
Diabetes: ____ Yes ____ No	_____	Depression: ____ Yes ____ No	_____
Cancer: ____ Yes ____ No	_____	Blood Clots: ____ Yes ____ No	_____
Type: _____		Bleeding Disorders: ____ Yes ____ No	
Kidney Disease: ____ Yes ____ No	_____	**Other:**	
Asthma: ____ Yes ____ No	_____	_____	
Thyroid Disorder: ____ Yes ____ No	_____	_____	
____ Hypoactive ____ Hyperactive		_____	
Hepatitis: ____ Yes ____ No	_____	_____	
Anemia: ____ Yes ____ No	_____	_____	

SURGICAL/PROCEDURE HISTORY:

Date	**Type/name of procedure**	**Anesthesia or wound complications:**

MEDICATION HISTORY:
Please include all **prescription and NON-prescription medications** you take as well as dosage and instructions. Include separate sheet if necessary.

Medication/Strength	**Dosage/Instructions**	**Why do you take this medication?**

Do you routinely take aspirin or aspirin products (including Advil, Aleve or the generic equivalent)? ____ Yes ____ No
Do you take Phentermine? ____ Yes ____ No

Allergies
Please list any medical allergies as well as reactions:

_____
_____

Pharmacy Authorization:
In Order to maintain accurate medication records and history, we are requesting authorization to access your medication history. Please notate your pharmacy information below:

_____ _____
Pharmacy Name and Location Phone

I, _____ (patient's name) hereby give Plastic Surgery Associates authorization to access my medication history for the purpose of maintaining accurate medication records and history. This authorization will remain in effect as long as I am an active patient under the care of Dr. Landon Perry. I may terminate the authorization at any time with a written request.

_____ Date: _____ _____ Date: _____
Patient signature **Printed Name**

Patient Medical History continued

Health Maintenance History:

Have you ever had a mammogram? ____ Yes ____ No If yes when/where was the most recent exam?

When was your last physical? _____ Have you had an EKG in the past 6 months ____ Yes ____ No

Social History:

Do you currently smoke? ____ Yes ____ No If yes how many packs per day? ____
If you are a past smoker how long ago did you quit? _____ Do you drink alcohol? ____ Yes ____ No
How often? _____
If you were have a surgical procedure, who would assist you at home during your recovery?

Family History:

Condition **If yes, who had this? Please indicate maternal/paternal relative.**

Diabetes: __Y __N _____
Breast Cancer: __Y __N _____
Other Cancer: __Y __N _____
Type: _____
Bleeding Disorder: __ Y __N _____
Type: _____
Heart Disease: __ Y __N _____
Hypertension: __ Y __N _____

____ **Adopted**

Additional:

Ethnicity: ____ Caucasian/White ____ African American/Black ____ Asian ____ Hispanic/ Latino ____ Native American ____ Middle Eastern ____ Other
Height: _____
Weight: _____

Please list any additional medical conditions you may have:

The information I have provided about my medical history is accurate and complete to the best of my knowledge.

Patient signature **Date**

Photo Consent:

" I hereby grant permission for photographs to be taken, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures."

Signature: _____ Date: _____

Financial Policy

We are committed to providing you with the best possible health care, and we are pleased to discuss our professional fees with you at any time. If you have any medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies. Please ask if you have any questions about our fees, your responsibility, or the financial policy.

All patients must complete our Patient Information Form and inform our office of any changes in address or insurance. In order for us to treat and care for our patients, we must have complete and correct information.

Payment for services rendered is ***due at the time of service.*** We accept cash, check, Mastercard, Visa, Discover, and American Express. There will be a $ 25.00 service charge for any returned checks.

We expect **TOTAL PAYMENT** two weeks prior to all aesthetic procedures.

Insurance policy:
We will gladly answer questions regarding your insurance. If the proposed services are medically necessary, we will attempt authorization from your insurance company. You must realize, however that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- We do not handle third party billing, therefore, you are responsible for payment to the practice and being reimbursed by the third party.
- Not all services are a covered benefit in your contract. Some insurance companies arbitrarily select certain services they will not cover and these are a patient responsibility.
- If your insurance coverage is through a plan that we are ***not*** contracted with, regardless of your carrier's rate of reimbursement, you will be responsible for the ***FULL*** balance of your account. This includes any amount over the "reasonable and customary".

We must emphasize that as a medical care provider, the relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, you are encouraged to contact us promptly for assistance in the management of your account.

"I hereby assign, transfer, and set over to Plastic Surgery Associates all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with my current insurance company."

_____ ***Initials***

*** Dr. Perry provides his personal cell phone number as a courtesy to his patients, we ask that you respect his time after hours and only use this number in case of a* ***TRUE MEDICAL EMERGENCY.*** *Any calls or texts to his cell phone that is not a medical emergency or as instructed per Dr. Perry will be subject to a $ 25.00 after hours call. ***

Signature: _____ Date: _____

HIPPA Privacy Rule

In effort to comply with the Privacy Rule to implement the requirement of the Health Insurance Portability & Accountability Act of 1996 (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please check your response to the following:

May we leave a message concerning your appointments with a co-worker, receptionist or secretary that regulary answers your calls? _____ Yes _____ No _____N/A

May we leave messages on a voice mail at work/home regarding an appointment, referral or test results?
_____ Yes _____ No _____ N/A

May we discuss your appointments/treatments with your spouse: _____ Yes _____ No _____ N/A

May we discuss your appointments/treatments with your children or other family members? Please list names:
_____
_____
_____ Yes _____ No _____ N/A

May we share your pertinent medical information with specialist you may be seeing? _____ Yes _____ No _____ N/A

Request for Electronic Communication:

I request that the following communications from the practice be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

Communications: _____ Appointment reminders _____ Prescription Refill Reminders

_____ Other (list specifically) _____

Method: _____ Email: _____
_____ Text- Phone number: _____

Acknowledgment and Agreements:
I understand and agree that the requested communication method is not secure, making PHI (Private Health Information) at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

You must inform us, in writing of any changes in your directives. This record takes effect immediately and will be kept in your file along with acknowledgement of Receipt of Your Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Print Name: _____ Phone No: _____

Address: _____