ATLANTIC PLASTIC SURGERY CENTER

Patient Information

Last Name:______________________________ First:___________________________ M.I.________

Mailing Address____
Street City State Zip Code

Physical Address (if different)____

DOB______/______/_______ Age: _____ Gender: M F SS#_______-______-_________

Marital Status: D S W M(Spouses name if applicable)____

Home Phone (______)_________________ Work (_____)____________________Cell (______)____________________

Indicate Best Contact: Home ___ Work ____ Cell ___ E-Mail _____
OK to leave a message: Home: Yes / No Work: Yes / No Cell: Yes / No (circle preference)

Indicate any privacy instructions: ____

E-Mail ___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
Your e-mail address will be stored in a protected database and will remain confidential.

Occupation _____________________________________ Employer ____
Employer
Address____
Street City State Zip Code

Responsible Party ____

Emergency Contact_________________________Relationship________________Phone (______)_____________

Reason for Today's Visit:____

How were you referred to us?
Website:___________________________ **Physician:________________________**
Patient: ____________________________ **Other: ____________________________**

Insurance Information

Primary Care Physician: ___________________________________ Workman's Compensation? Yes__ No__
Insurance Company________________________I.D.#___________________________Group #___________________
Insured Party(Subscriber): __________________________________ Relationship: __________________________
Subscribers DOB:_______________ Subscribers SS #______________________Employer:_______________________

AUTHORIZATION

I understand that a fee is charged for all visits, examinations, cosmetic evaluations, and medical reports. PAYMENT IS EXPECTED AT THE TIME OF VISIT. If it is necessary for you to cancel or re-schedule your appointment, Atlantic Plastic Surgery must receive **at least 24 hour** notice of that change. There will be a $150 fee for Consultation appointments and $50 for Skin Wellness appointments cancelled with less than 24 hours' notice. **For your convenience you may leave a message on our answering machine to cancel an appointment after hours**.

AUTHORIZATION OF ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of insurance benefits to the physicians of the surgical, medical and/or facility at Atlantic Plastic Surgery Center. I understand that although Atlantic Plastic Surgery Center will bill my insurance company as a courtesy, I am ultimately responsible for any charges, bills, and balances relating to the services rendered to me by Atlantic Plastic Surgery Center. I agree to pay for all costs of collection, including reasonable attorney fees.

AUTHORIZATION FOR CONSULTATION AND TREATMENT: I hereby authorize consultation and any necessary medical treatment performed by the physicians of the surgical, medical and/or facility of Atlantic Plastic Surgery Center.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I hereby authorize the release of medical information to my insurance company(s), including but not limited to, records regarding HIV, alcohol and drug information that is necessary to secure payment of medical bills incurred as a result of services received at Atlantic Plastic Surgery Center.

AUTHORIZATION TO OBTAIN AND USE PHOTOGRAPHS: I hereby authorize the physician to obtain photographs before, during and after my treatment. I understand and agree that these photographs shall be the property of Atlantic Plastic Surgery Center as a part of my permanent record. As well I understand and agree that these photographs may be used for internal patient education and/ or teaching purposes.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, PATIENT'S BILL OF RIGHTS AND COMPLAINT PROCEDURES: I have been presented with a copy of the Patient's Bill of Rights and Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I have also received Complaint procedures.

This facility has a quality improvement program that monitors and evaluates the quality of patient care. In doing so, peer physicians need to have authority to review your chart to obtain information about the medical care you received. In signing this authorization you have authorized a peer review.

Signature of Patient (or responsible party, if patient is a minor) **Date**