RICHMOND PLASTIC SURGEONS INC.

Today's Date:

Prefix Mr. Mrs. Miss Ms. Dr. Preferred Name:

Patient's Name

First Middle Last

Address:

Street & Apt # City State Zip

SS# : Birthdate: Age: Sex: ❑ Female ❑Male

Marital Status ❑ Single ❑ Married- Spouse: ❑ Other:

Home Phone: Cell Phone: May we text you for appointment confirmation? ❑Yes ❑No

Preferred Contact: ❑Home ❑ Work ❑Cell ❑Email E-mail

Patient's Employer Occupation Work Phone: Ext:

Emergency Contact: Relationship to Patient: Phone#:

Ethnicity: ❑Hispanic ❑Non-Hispanic Language:

Race: ❑African-American ❑Asian ❑ American Indian/Native Alaskan ❑Native Hawaiian or Other Pacific Islander ❑White

How did you hear about us? ❑ Friend ❑ Insurance ❑ Internet ❑ Other Details:

Referring Dr.: **Primary Care Dr**.:

INSURANCE INFORMATION

Primary Ins:. ID #: Group #:

Policy holder's name: DOB: SS#:

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other

Secondary Ins.: ID #: Group #:

Policy holder's name: DOB SS#

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other

PRACTICE INFORMATION & CONSENTS

PRIVACY PRACTICES NOTICE & WRITTEN ACKNOWLEDGEMENT FORM

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices of Richmond Plastic Surgeons. I understand Richmond Plastic Surgeons reserves the right to change this Notice and will post a copy of the revised Notice in the waiting areas of the office and will provide me with a copy upon request.

Initial Here: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Are there any family members or other persons whom we may contact about your general medical condition and diagnosis (including treatment, payment and health care operations)?

Name: Phone #:

Name: Phone #:

Name: Phone #:

Initial Here:_____

Can confidential messages be left on your telephone answering machine or voicemail? □ Yes □ No

Initial Here:_____

FINANCIAL POLICY

I have reviewed and agree to the posted FINANCIAL POLICY (copies available upon request) **Initial Here: _____**

AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION

I request payment of authorized insurance benefits be paid to RICHMOND PLASTIC SURGEON's, INC. & authorize release of PHI to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this request, Richmond Plastic Surgeons may decline to provide treatment to me.I understand that I am financially responsible for all charges whether or not covered by insurance.I hereby authorize the above named physicians to release the information requested to the insurance company(ies) named hereon. I hereby assign payment directly to the above named physicians of benefits otherwise payable to me. I understand that regardless of the insurance coverage that I might have, I am financially responsible for all charges. I understand if my account is referred to a collection agency and /or attorney for legal action I will be responsible for 33-1/3 % , interest at 18% per annum from the last date of payment,and any and all applicable court costs.(initial)_____

Signature of Patient/Guardian: **Date:**