RICHMOND PLASTIC SURGEON'S 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 Other Phone

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 Alaskin ❑Native Hawaiian or Other Pacific Islander ❑White

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

Referring Dr.: Primary Care Dr.:

INSURANCE INFORMATION

Primary Ins. ID # Group #

Insured: Name DOB SS#

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

Secondary Ins. ID # Group #

Insured: 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 received 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.

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