Politis Plastic Surgery

New Patient Registration Form

SSN: _____ Email: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Marital Status: ☐Single ☐Married ☐ Divorced ☐ Other

Gender: ☐ Female ☐ Male Race: (Optional) ☐ Black ☐ White ☐ Asian ☐ Hispanic ☐ Other

Occupation: _____

How did you hear about us? : ☐ Personal Reference ☐ Physician ☐ Internet ☐ Other _____

Emergency Contact

Name: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

Insurance Information (Please provide staff with a copy of your card)

Primary Insurance Company: _____

Insured Name: _____ Relationship: _____

SSN of Insured: _____ Date of Birth of Insured: _____

Secondary Insurance Company: _____

Insured Name: _____ Relationship: _____

SSN of Insured: _____ Date of Birth of Insured: _____

Primary Care Physician

Name: _____ Phone: _____

Pharmacy

Name: _____ Phone: _____

Politis Plastic Surgery

New Patient Registration Form

PHI Disclosure

We cannot discuss your protected health information(PHI) with anyone other than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below unless you notify us otherwise in writing>

_____ _____

_____ _____

Please specify anything that you do not want to be released:

_____

I understand this authorization extends to all or any part of my medical record, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS, and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained., except to the extent that action has already been taken on the authorization. I understand that my PHI used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my PHI may no longer be protected by the law. Parents/Guardians: Minor patients may consent to certain services and limit access to certain protected health information such as care related to pregnancy, birth control, STI/STD's, and HIV under state law.

Consent to Use Electronic Communication

It may be useful during the course of treatment, to communicate by email, text message, video conference, social media, or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Politis Plastic Surgery, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. These parties include but are not limited to:

People in your home who can access your phone, computer, or other devices

Your employer, if you use your work email or computer

Third parties on the internet such as server administrators and others who monitor and/or intercept internet traffic

Consent to the use of electronic messages includes your agreement with the following statements. All electronic messages to or from you concerning your treatment may be printed out or stored electronically as part of your medical record. Politis Plastic Surgery may forward messages internally to staff, as necessary for diagnosis, treatment, payment, health care operations, and other purposes. Although our office will endeavor to read and respond promptly to a message from you, we cannot guarantee that any message will be read and responded to within any particular period of time. Thus, you agree that you will not use email or other electronic messages for medical emergencies or time sensitive matters.

Politis Plastic Surgery

New Patient Registration Form

Insurance Authorization Release and Assignment of Benefits

I hereby authorize Politis Plastic Surgery to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Politis Plastic Surgery on behalf of myself and/or my dependents, and I understand by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including, Medicare, Medigap, private insurance and any other health/medical plan to issue payment directly to Politis Plastic Surgery, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage.

Consent to Treat

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services are provided through examination, testing and use of procedures to the aid of diagnosis or treatment of a medical condition or conditions. I request and authorize Politis Plastic Surgery to provided me with medical services as described above. I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of medical care/services that is established.

I acknowledge I have received a copy of Politis Plastic Surgery's "Our Office Policy". I have read and understand all of the above and agree to comply.

Date: _____ Signature: _____

Responsible Party Signature (patient under 18): _____