

CHART #: \_\_\_\_\_

PROVIDER: \_\_\_\_\_

NEW PATIENT INFORMATION

PATIENT NAME: \_\_\_\_\_ GENDER:  MALE  FEMALE

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE #: ( ) \_\_\_\_\_ WORK PHONE #: ( ) \_\_\_\_\_

ALT PHONE #: ( ) \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

MARITAL STATUS:  Single  Married  Separated  Divorced  Widowed LANGUAGE:  English  Spanish  Other: \_\_\_\_\_

ETHNICITY:  Not Hispanic/Latino  Hispanic/Latino RACE:  American Indian  Asian  African American  White  Other: \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_

WHAT PROMPTED YOU TO CALL FOR AN APPOINTMENT? (Please check all that apply):

- PHYSICIAN REFERRAL  HOSPITAL  WEBSITE  INTERNET SEARCH  BILLBOARD  NEWSPAPER  TV
- YELLOW PAGES  MAGAZINE  RADIO  FAMILY MEMBER  FRIEND  OTHER:

\*IF FAMILY/FRIEND REFERRED, MAY WE CONTACT THEM TO SAY "THANK YOU"? YES NO

WHO MAY WE CONTACT (FAMILY/FRIEND NAME): \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ REASON FOR REFERRAL: \_\_\_\_\_

IS TODAY'S VISIT RELATED TO AN INJURY? Y N WORK RELATED? Y N AUTO RELATED? Y N

If Yes: DATE OF ACCIDENT/INJURY: \_\_\_\_\_ EMPLOYER CONTACT: \_\_\_\_\_

CASE WORKER NAME: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

RESP. PARTY INFORMATION

Please complete if patient is under 18 OR Insurance is under Parent/Guardian

RESP. PARTY NAME: \_\_\_\_\_ GENDER: MALE FEMALE

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: Self Spouse Child Other: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE #: ( ) \_\_\_\_\_ WORK PHONE #: ( ) \_\_\_\_\_

ALT PHONE #: ( ) \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

RESP. PARTY EMPLOYER: \_\_\_\_\_

PLASTIC & HAND SURGERY ASSOCIATES, PLLC

INSURANCE INFORMATION

Please complete this section below accurately & bring your insurance cards/drivers license up with you for scanning.

PRIMARY INSURANCE COMPANY: \_\_\_\_\_ Copay \$ \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ CONTRACT (ID#) NUMBER: \_\_\_\_\_

SUBSCRIBER DOB: \_\_\_\_\_ SUBSCRIBER SSN: \_\_\_\_\_

GROUP NAME: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER: Self Spouse Child Other: \_\_\_\_\_

SECONDARY INSURANCE COMPANY: \_\_\_\_\_ Copay \$ \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ CONTRACT (ID#) NUMBER: \_\_\_\_\_

SUBSCRIBER DOB: \_\_\_\_\_ SUBSCRIBER SSN: \_\_\_\_\_

GROUP NAME: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER: Self Spouse Child Other: \_\_\_\_\_

\*\*\*If you have Medicare\*\*\*:

\*Are you covered under \_\_\_\_\_ Regular Medicare or \_\_\_\_\_ Medicare Replacement Plan (Managed Care Plan)

\*If you are covered by a Medicare Replacement Plan, what is the name of the company? \_\_\_\_\_

Authorization and Release of Information

According to office policy, test results or release of medical information will be provided to the patient only. If you would like your information to be made available to someone else, please specify below whom information may be released to other than yourself.

Name & Relationship: \_\_\_\_\_

I understand that Plastic & Hand Surgery Associates, PLLC (PHSA) may release to my insurance company, managed care organization, State or Federal agencies, and third party administrators and/or Workers Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also understand that PHSA may utilize a fax machine to transmit any or all records pertaining to my medical care or insurance reimbursement. I understand that faxing my medical records may increase the risk of accidental disclosure. I also understand that it may be necessary for PHSA to release all or part of my medical records to any consulting entity that may be involved in my care. I understand and acknowledge that PHSA may use and disclose my records under state and federal law for the purposes described in the Notice of Privacy Practices, in some cases without the requirement of authorization. Nonetheless, I authorize PHSA to use and disclose my medical records for all necessary purposes under state and federal law and regulations.

Signature: \_\_\_\_\_

I consent to the photographing or televising of the appropriate portions of my body for medical, scientific, educational or marketing purposes, provided my identity is not revealed by the pictures. This includes, but is not limited to, testing facilities, consulting physicians, outpatient facilities and website.

Signature: \_\_\_\_\_

Third Party Laboratory

I understand that all lab testing and pathology services utilized while in the care of Plastic & Hand Surgery Associates (PHSA) will be performed by a third party laboratory. I understand that I will receive a separate bill for those services rendered and I am responsible for payment of those services. PHSA has agreed to transfer my insurance information at the time of service so that rendered pathology services may be filed with my insurance company on my behalf.

Signature: \_\_\_\_\_

Notice of Privacy Practices

I have received the Plastic & Hand Surgery Associates, PLLC Notice of Privacy Practices explaining the uses and disclosures of my health information.

\*PATIENT/GUARANTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PLASTIC & HAND SURGERY ASSOCIATES, PLLC

**Assignment of Benefits Form**

*Included Facilities: Plastic Hand and Surgery Associates, The Plastic Surgical Center of MS, Rankin Laboratories*

I, *(responsible party)* \_\_\_\_\_ with insurance benefits through *(responsible party employer name)* \_\_\_\_\_ (Medicare, Medicaid or Individual Plan) **hereby authorize all entitled benefits under my governing Plan/Policy to be directly paid to the provider listed above for all services rendered.** I understand that I am entitled to all benefits that my Health and Welfare Plan is legally obligated to provide. I understand that my Plan Sponsor and Insurance Company are both required to accept this HIPAA compliant agreement and provide all entitled benefits following all terms, conditions and requirements of the governing Plan for all services rendered, as well as comply with all applicable state and federal governing laws based on all protected rights. This authorization includes any and all rights permissible under my governing Health and Welfare Plan; applicable Social Security Act; Federal, City or State Government program; state and federal law in assuring all rights and entitled benefits are received for services rendered by the said provider. I understand this authorization also covers any other provider of service directly associated with services rendered and requested by the above provider, including but not limited to surgical related services, anesthesia, diagnostic testing, labs, pathology, radiology, implants, tissues, durable medical equipment or any other services as ordered by the provider above involving treatment.

I hereby certify that all insurance information provided is true and accurate and that I am responsible for keeping it updated. I hereby authorize the Provider listed above to submit claims, on my behalf, to the insurance company responsible for administering entitled benefits for all services rendered in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and in full compliance of applicable state and federal laws. ***I also understand I may be responsible for any and all amounts not payable by my insurance company including deductibles, co-pay, coinsurance amounts as well as any portion paid and not applied to in network benefits for any out of network services, non-covered services, services determined by the insurer as not medically necessary, or any failure by my insurer to comply with all applicable laws.***

I hereby irrevocably, designate, authorize and appoint Provider listed above as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments, rights and remedies due under my Health and Welfare plan/Policy to include all medical services rendered or to be rendered as ordered by the provider listed above. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider has received payment in full as entitled under my governing Plan, along with all rights and remedies under applicable governing law for all medical care and services provided. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my insurer to assign and transfer any and all entitled plan benefits and rights to Provider listed above and any appointed business associates working with them for the sole purpose of making sure all protected rights and entitled benefits under my specific health and welfare plan or governing policy are administered accurately and not withheld for services rendered, including all protected rights under applicable law to receive a copy of all relevant documents or data, governing plan documents, remedies, disclosures, appeal, administrative reviews and litigation on my behalf. This is a direct assignment of my rights and benefits under the governing plan/policy. I understand this payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment where entitled benefits are not paid pursuant to applicable federal and /or state laws.

I hereby instruct and direct my Insurance Company to pay all entitled plan benefits as required by the governing Plan/Policy directly to any applicable Provider(s) listed above and rendering services following all terms, conditions and requirements of the governing Health and Welfare Plan. I understand under applicable governing law that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my protected rights pursuant to applicable state, federal or ERSIA law hereby instruct and direct my Insurance Company to provide specific SPD documentation stating such non-assign ability clause to myself and the applicable Provider, along with the regulatory guideline that allows for such non-assignability. Upon proof of specified non-assignability documentation, **I then instruct** that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by any and all healthcare providers listed in this assignment of benefits will be immediately signed over and sent directly to such provider. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment due on my account. I authorize the release of any information pertinent to my case including medical records to any business associate, insurance company, adjuster, Plan Sponsor, governmental agency or attorney involved in this case or responsible for making sure all protected rights and entitled benefits are provided pursuant to the governing Plan, state and federal laws. I authorize all applicable Providers listed providing medical services or appointed business associates to be my personal representative, which allows them as my legally binding authorized representative to: (1) submit any and all claims and appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information, appeals, remedies and protected disclosures from my Plan or insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or plan benefits. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that all delinquent accounts bear interest or administrative fees at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to Provider acting as my personal representative. I understand this assignment will remain in effect until revoked by me in writing.

I authorize all providers included in this agreement to provide medical care reasonable and at the standard of care as required by state law. A photocopy of this Assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
*Signature of Patient/Responsible Party (if under age 18)*

\_\_\_\_\_  
*Date*

**STANDARD MEDICAL HISTORY**

Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Is your problem work related? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, list Date of Injury? \_\_\_\_\_

What doctor referred you to this office? \_\_\_\_\_ Phone: \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Have you consulted any other physician about this problem? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, who? \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_ Describe your general health (circle one): Excellent Good Fair Poor

\*Usual Blood Pressure: \_\_\_\_\_ \*Current Height: \_\_\_\_\_ \*Current Weight: \_\_\_\_\_

List previous operations or admissions to the hospital: (additional space on reverse side)

Operation:	Year	Doctor	Hospital	Complications (yes/no)

**HAVE YOU EVER HAD: (CIRCLE YES OR NO)**

Arthritis	Yes No	Glasses	Yes No	Nausea (recent)	Yes No
Rheumatoid Arthritis	Yes No	Blurring Vision	Yes No	Vomiting (recent)	Yes No
Asthma	Yes No	Snoring	Yes No	Reflux	Yes No
Blood or		Breathing Problems	Yes No	Prostate Problems	Yes No
Bleeding Disorders	Yes No	Difficulty Hearing	Yes No	Frequent Urination	Yes No
Cancer	Yes No	Thyroid Disease	Yes No	Difficulty Urinating	Yes No
(if yes, please list type below)		Diabetes	Yes No	Broken Bones	Yes No
Sleep Apnea	Yes No	Chest Pain	Yes No	Back Pain	Yes No
Stomach Ulcers	Yes No	Rapid Heart Beat	Yes No	Depression	Yes No
Hypertension	Yes No	Shortness of Breath	Yes No	Migraine Headaches	Yes No
Heart Disease	Yes No	Cough (recent)	Yes No	Seizures	Yes No
Lung Disease	Yes No	Kidney Disease	Yes No	Gout	Yes No
Pulmonary Embolism	Yes No	Deep Vein Thrombosis	Yes No		

\*Do you have any family history of Deep Vein Thrombosis or Pulmonary Embolism? Yes No

Please provide details to "yes" answers above and/or list any other known medical conditions not listed above:

**Medications You Are Now Taking:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Are You Allergic To: (Circle Yes or No)**

penicillin..... Yes No  
 sulfa..... Yes No  
 aspirin..... Yes No  
 codeine..... Yes No  
 latex allergy..... Yes No

**List Any Other Allergies:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DO YOU USE:**

Alcohol Yes No If yes, how much per day? \_\_\_\_\_  
 Tobacco Yes No If yes, how much per day? \_\_\_\_\_

**HAND PATIENTS** – What kind of hand problem do you have?

When did this problem start? (please provide a date if possible) \_\_\_\_\_

Have you ever had a nerve conduction study (or other nerve test) performed? Yes No If yes, when? \_\_\_\_\_

Are you right or left handed? (Circle One) Right Left Which hand are you experiencing problems with? (Circle One) Right Left

## Notice of Privacy Practices

### **THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about your privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created, and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

### **TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION**

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement. For example: We may disclose medical information about you to doctors, nurses or other healthcare professionals involved in your care. For example, your doctor will need to know if you are allergic to any medicines. The doctor may share this information with pharmacists and others caring for you.

We may also disclose information to other professionals providing your health care. For example, we may need to tell a specialist about your medical conditions if we refer you to a specialist so you may receive proper care.

**Disclosure:** We may disclose and/share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances. If you have health insurance, we request payment from your health plan for the services we provide. For example, we may need to give your health plan information about your visit, your diagnosis, procedures, and supplies used so that we can be compensated for the treatment provider. However, we will not be able to disclose your health information to a third party payer without your authorization except required by law. We may also tell your health plan about your recommended treatment to get their prior approval, if that is required under your insurance plan. For example, if you need surgery, we will call your health plan to make sure the surgery is covered and will be paid for by the health plan.

**Emergencies:** We may use and disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. For example, we may use your health information to review the quality of services you receive or to provide training to our staff.

**Required by Law:** We may use or disclose your health information when we are required by law to do so. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and/or Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or other possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voice mail messages, postcards or letters.

### **YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, a record of these disclosures is not kept; therefore it would not be available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

**Confidential Communication:** You have the right to request to receive confidential communications by alternative means or at alternate locations. We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. We will not request an explanation from you as the basis for the request. Requests must be made in writing to our Privacy Officer.

### **QUESTIONS AND COMPLAINTS:**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

### **HOW TO CONTACT US**

Practice Name: Plastic & Hand Surgery Associates, PLLC  
Phone: (601) 939-9999 | Fax: (601) 939-0590  
Address: 2550 Flowood Drive, Suite 200, PO Box 321433, Flowood, MS 39232