

PATIENT REGISTRATION FORM

RECONSTRUCTIVE & AESTHETIC
SURGEONS, INC.

Patient Name: (First) _____ (M.I.) _____ (Last) _____

Street Address: _____ Male: _____ Female: _____

City: _____ State: _____ Zip Code: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security Number: _____

Email Address: _____ Include in Newsletter Mailing: Yes No

Employer: _____ Preferred Pharmacy: _____
(name & location)

Emergency Contact Information: Home
 Cell
 Work

Name: _____ Relationship: _____ Phone: _____

How did you hear about us?

Friend/Family: _____ Phonebook: _____ Website/Internet: _____ Bella Via: _____ Word of Mouth: _____ Other: _____

Referring Physician: _____ Address: _____

Family Physician (PCP): _____ Address: _____

Responsible Party Information (If other than patient):

Name: _____ Relationship: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Is your visit today being filed as a Workers Compensation Claim? Yes No

Primary Insurance Information

Insurance Company: _____ ID/Policy #: _____

Cardholder Name: _____ Relationship to Patient: _____

Cardholder Date of Birth: _____ Cardholder Social Security #: _____

Name of Employer: _____ Group #: _____ Co-Pay Amount: _____

Secondary Insurance Information

Insurance Company: _____ ID/Policy #: _____

Cardholder Name: _____ Relationship to Patient: _____

Cardholder Date of Birth: _____ Cardholder Social Security #: _____

Name of Employer: _____ Group #: _____ Co-Pay Amount: _____

I hereby authorize my insurance benefits to be paid directly to Reconstructive & Aesthetic Surgeons, Inc. and authorize the release of my medical information to process my insurance claims. I understand I am financially responsible for all services rendered. I agree to pay reasonable attorney fees and all costs of collection, in the event of default.

Signed: _____ Date: _____

PLEASE COMPLETE REVERSE SIDE



In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Oral Communication:

Home Phone:

- DO NOT CALL
- Detailed Message *
- Call Back Number Only **

Cell Phone:

- DO NOT CALL
- Detailed Message *
- Call Back Number Only **

Work Phone:

- DO NOT CALL
- Detailed Message *
- Call Back Number Only **

* A ***Detailed Message*** would include where we are calling from (physician's name), office phone number and a **brief** message as to the reason for the call.

** A ***Call Back Number Only*** would include **just the office phone number and no other identifying information** (such as the physician's name or brief message).

Written Communication:

- DO NOT MAIL TO HOME OR WORK
- OK to mail to my Home Address
- OK to mail to my Work Address
- Other: _____

I permit the Practice to discuss my PHI with, and to disclose my PHI to, the following individuals:

<i>Name</i>	<i>Relationship</i>	<i>Home Phone</i>	<i>Cell Phone</i>

Patient Signature

Date

I have an Advance Directive for Health Care: **Yes** **No**

The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for protected health information (PHI) to the minimum necessary to accomplish the intended purposes. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.