RECONSTRUCTIVE & AESTHETIC
SURGEONS, INC.

Patient Registration Form

How did you hear about us?
☐ Family/Friend
☐ Phone Book
☐ Internet
☐ Bella Via
☐ Physician
☐ Other _____

First, Middle, Last Name | Preferred Name | Maiden Name

Address | City, State, Zip Code | Gender: ☐ Male ☐ Female

Date of Birth | Social Security Number | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: | Cell Phone: | Work Phone:

Email Address ☐ OK to email ☐ DO NOT email | Employer

Race: _____ Ethnicity: _____ Language: _____

Preferred Pharmacy (name) | Pharmacy Location/Address

Family Physician (PCP) City/State/Phone Number | **Referring Physician** City/State/Phone Number

Emergency Contact Information:

Name | Phone Number | Relationship to Patient

If patient is a minor, please list person responsible for payment:

Name/Relationship | Address | Phone Number

Primary Insurance Information

Insurance Company | ID/Policy# | Group# | Co-Pay Amount

Subscriber Name | Relationship to Patient | Subscriber D.O.B. | Subscriber SS# | Employer

Secondary Insurance Information

Insurance Company | ID/Policy# | Group# | Co-Pay Amount

Subscriber Name | Relationship to Patient | Subscriber D.O.B. | Subscriber SS# | Employer

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 HIPPA 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 communication of protected health information be made by alternative means, such as sending correspondence to the individuals office instead of the individuals home.

In order to facilitate prompt notification of appointments, surgery dates and biopsy or lab results we need your permission to leave a detailed message on your home, cell or other phone number provided.

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

☐ Home ☐ Cell ☐ Work ☐ On the answering machine ☐ With anyone who answers the phone

☐ Please DO NOT CALL _____

☐ OK to MAIL to Home ☐ DO NOT MAIL TO HOME ☐ OK to Mail to Other: _____

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

Name	***Relationship***	***Home Phone***	***Cell Phone***

All Patients have the right to participate in their own health care decisions and to make "Advance Directives" or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the Patients expressed wishes when the Patient is unable to make decisions or unable to communicate decisions.

Please initial below as applicable:

_____ Yes, I have an "Advance Directive", Living Will or Health Care Power of Attorney
_____ No, I do not have an "Advance Directive", Living Will or Health Care Power of Attorney
_____ I would like to have information on "Advance Directives".

Signed: _____ **Date:** _____

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.

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