PLASTICSURGERY

OF TUCALOOSA

PATIENT PAPERWORK

Date: _____

First Name: _____ MI:_____ Last Name: _____

Marital Status: _____ Sex: _____ DOB: _____ SSN #:_____

Mailing Address: _____City: _____State:_____ Zip:_____

Physical Address: _____ City: _____ State:_____ Zip:_____

Email Address: _____

Cellphone Number: _____ Home Telephone Number: _____

Which telephone number would you like us to contact you? _____

Occupation: _____ Work Number: _____

Employer: _____

Pharmacy Used: _____ Pharmacy Telephone Number: _____

Referred By: (Please list the name of physician, friend, or family member) if no one referred you, then how did you hear about us? _____

Due to federal government requirements, please circle the following for patient being seen:

Race: Native American or Alaskan Asian African American Caucasian Native Hawaiian

Pacific Islander Prefer not to answer Other:_____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Preferred Language: English Spanish Other: _____

In Case of Emergency:

Name: _____ Relationship:_____ Telephone #:_____

Insurance Information

Primary Insurance Name: _____ Contract #:_____

Effective Date: _____ Copay Amount: _____ Group #:_____

Subscriber's Name: _____ Subscriber's Birthdate:_____

Secondary Insurance Name:_____ Contract #:_____

Effective Date: _____ Copay Amount: _____ Group #:_____

Subscriber's Name: _____ Subscriber's Birthdate:_____

Does your insurance require a referral? _____

Patients responsibility for the referral if not received patient is liable for all fee occurring during office visit

PATIENT HISTORY AND PHYSICAL

Reason for your visit:_____

Height: _____ Weight: _____

Are you allergic to any medications? Yes or No (if yes please list)_____

Are you allergic to Latex? Yes or No

Please circle: Current Smoker (_____ packs per day) Former Smoker Never Smoked

Recreational/Illegal Drug: Yes or No (if yes explain_____)

Do you regularly drink alcohol or beer? Yes or No

Do you take any diet pills, appetite suppressants, dietary supplements? Yes or No (if yes list_____)

Who is your primary care physician? _____ Telephone # _____

When was your last Flu Vaccine?_____ When was your last Pneumonia Vaccine?_____

Do you have or have you had: (check and give date of occurrence)

	Arthritis		Colitis		Leukemia
	Asthma		Diabetes		Migraine
	AIDS or HIV		Epilepsy/Seizure Disorders		Psychological Disorders
	Back Injury/Surgery		Goiter/Thyroid Disease		Pneumonia
	Bladder Infection		Heart Attack/Disease		Sleep Apnea/COPD
	Bleeding Tendency		Heart Murmur		Stomach Ulcers
	Bronchitis		Hepatitis		Stroke
	Cancer		High Blood Pressure		Tonsillitis
	Clotting Disorders &/or Blood Clots		Kidney Disease		Tuberculosis

Other serious illness which you may have:

_____

Do any of your family members suffer from any of the following: (check all that apply, and list the family member)

	Arthritis			Diabetes			Kidney Disease	
	Asthma			Epilepsy/Seizure Disorders			Leukemia	
	AIDS or HIV			Goiter/Thyroid Disease			Migraine	
	Bleeding Tendency			Heart Attack/ Heart Disease			Psychological Disorders/Suicide	
	Blood Clots			Hepatitis			Stomach Ulcers	
	Breast Cancer			High Blood Pressure			Stroke	
	Other Cancer			High Fever after Surgery			Tuberculosis	
	Colitis			Sleep Apnea				

Please List the names and year of any operation you have ever had:

_____

_____

_____

_____

Please list any medications you have taken in the last month (include herbal supplements and non-prescription medications):

_____

_____

_____

Do you have a history of Staph Infection? No Yes (if yes, please explain) _____

_____

Have you ever had any complications from anesthesia? No Yes (if yes please explain)

_____

_____

Serious Injuries or Accidents:

_____

Date of Accident or Injury:_____

Have you had a blood transfusions? Yes or No Any Adverse Reactions? _____

Do you take Aspiring regularly or Ibuprofen or Vitamin E? Yes or No How often?_____

WOMEN ONLY

Is there any chance you may be pregnant? _____

How many pregnancies have you had? _____

How many children born alive? _____

How many cesarean operations?_____

Any complications? _____

Date and results of last breast exam? _____

Date and results of last mammogram? _____

Where was it preformed? _____

PlasticSurgery
OF TUSCALOOSA

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices describes how we may use and disclose your protected health information (from this point referred to as your PHI) to carry out treatment, payment or health care operations and for other purposes. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you & that relates to your past, present or future physical or mental health or condition & related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used & disclosed by your physician, our office staff & others outside of our office that are involved in your care & treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, & any other use required by law.

Treatment: We will use & disclose your PHI to provide, coordinate, or manage your health care & any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. Also, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or to treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the healthcare plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, & conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name & indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization: As required by law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food & Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, & Organ Donation, Research, Criminal Activity, Military Activity & National Security, Worker's Compensation, Inmates, Required Uses & Disclosures. Under the law, we must make disclosures to you & when required by the Secretary of the Department of Health & Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted & Required Uses & Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect & copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, & PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask use not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested & to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use & disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us & we may prepare a rebuttal to your statement & will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice & will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health & Human Services if you believe your privacy rights have been violated by us. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, & provide individuals with, this notice of our legal duties & privacy practices with respect to PHI. Signature below is an acknowledgement that you have received this notice of our Privacy Practices.

Signature: _____ Date: _____

Ross Bunch, M.D. 1847 Commons North Drive, Tuscaloosa, AL 35406 P: 205-349-0049 F: 205-345-1684

Consent for Use and Disclosure of Health Information

This is to inform you that, Plastic Surgery of Tuscaloosa, may use and disclose your health information that identifies you, and that consists of your past, present or future physical or mental health or condition, the provision of your health care; and the past, present or future payment for the provision of your healthcare (this health information is referred to herein as "Protected Health Information").

1. The use and disclosure of your Protected Health Information will be to carry out treatment, payment and healthcare operations.
2. For a more complete description of how Plastic Surgery of Tuscaloosa, may use and disclose your Protected Health Information, please refer to the attached Notice of Privacy Practices. The terms of the Notice of Privacy Practices may change from time to time; therefore, to obtain a revised Notice of Privacy Practices, please contact our office.
3. You have the right to request that be restricted from using or disclosing your Protected Health Information in carrying out Treatment, Payment or Health Care Operations; however, Plastic Surgery of Tuscaloosa is not required to agree to your requested restrictions. If does agree to your requested restrictions, then it will comply with your request.
4. You have the right to revoke this Consent. This revocation must be made in writing. This revocation will be valid except to the extent that has taken action in reliance on this Consent.

By signing this document, you acknowledge that you have read and understand this Consent. Further, you hereby consent and authorize Plastic Surgery of Tuscaloosa, to use or disclose your Protected Health Information in conjunction with Treatment, Payment or Healthcare Operations in accordance with the terms of this Consent.

_____ _____

Signature (Patient) Signature (Authorized Representative)

_____ _____ _____

Date Date of Birth Account Number

I have received a copy of the Notice of Privacy Practices:_____(initials)

Further, I hereby authorize and give my consent to leave messages on my answering machine/voicemail system for the following:

_____ Appointment Reminders _____Prescription Refills

_____Medical Information (including returned telephone calls) _____Test Results

Further, I hereby authorize and give my consent to to communicate any of my Protected Health Information to the following persons:

Name	Relationship

Patient Photo Release

Privacy of patients and visitors, as well as the confidentiality of medical and related information, are among our highest priorities. Plastic Surgery of Tuscaloosa utilizes many outlets to share our services to the community, such as radio, television, social media and websites Any photos used in any of these forms are presented in such a way that the patient's identity is protected.

To make certain that we are using your personal information with your authorization, keeps on file a copy of your written permission. Would you, therefore, please take a moment to fill out and sign this form?

YES, I hereby give permission to copyright and/or publish, or use photographic portraits or pictures of me or reproductions thereof in color or otherwise, made through any media, for print, advertising, education or any other lawful purpose.

Patient Initials: _____

NO, Photos are to be used solely for educational/medical purposes by Plastic Surgery of Tuscaloosa. They are not to be used for advertising and/or media purposes.

Patient Initials: _____

I hereby release, discharge and agree to from any and all liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form that may occur or be produced in the taking of said pictures, or in any processing tending towards the completion of the finished product. If any of the permissions above are given, I hereby release and waive all claims to compensation and rights regarding such use and/or publication.

_____ _____

Patient Signature Print

_____

Parent/Guardian (if under 18 years of age)

_____ _____

Date Witness

I _____ represent to the physician and staff that I am at least 18 (eighteen) years of age, or if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of process insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original.

I understand that my deductible, if any, will be collected after my insurance claim has been processed. I agree to pay my deductible, if any, at my post-operative follow up appointment, unless other arrangements have been previously made.

I agree I am responsible for all charges for goods and services rendered by Plastic Surgery of Tuscaloosa, including reasonable attorney's fees and cost of collection in the event of default.

I understand that there is a consultation fee of $75.00 for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

I understand that in the event my check payment is returned for insufficient funds, a $30.00 return check charge will be added to my account, of which I am fully responsible.

Signature of Patient: _____ Date: _____

_____

Signature of Guardian (if pt under 18)

If you have a second home you reside in for part of the year, please list that address and telephone number below.

Home/PO Box address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Contact Information and Medical Records Release

May we contact you in the following manner?

_____Call or leave a message on your home/mobile telephone

_____Call or leave a message on your work telephone

_____ Written communication may be mailed to your home address

_____Fax to this telephone number: _____

_____E-mail _____

_____Text message

_____Social Media (if so which one) _____

I hereby give my permission for to disclose the information about my care to my physician upon my request.

Physician/Practice Name: _____

In signing this release, I authorize any available medical records to be faxed, mailed or emailed to

_____

Patient (or Responsible Part) Signature Date