CHART#_____

HEIGHT_____ WEIGHT_____

BP_____/_____ PULSE_____

Carolina Coastal Plastic Surgery

Name_____ DOB: _____

Address:_____

Billing Address:_____

Phone Number: (H)_____(C)_____(W)_____

EMAIL ADDRESS_____

Sex: Male / Female **Marital Status: M S D W** **Are you Right or Left Handed?**

Race: African American White Hispanic Other_____

Occupation_____ Employer:_____

Medical History: Do you have or have you ever had any of the following? **(Circle all that apply)**

Asthma Bleeding Disorder Blood Clots in Legs Diabetes High Blood Pressure Hypothyroidism

Seizure Disorder CAD COPD Atrial Fibrilation Breast Cancer Colon Cancer Heart Attack

High Cholesterol Lung Cancer Melanoma Skin Cancer

Reason for today's visit_____

Do you smoke? YES/NO (if yes) _____Packs per day Year Quit_____

MEDICATIONS:_____

_____

_____

SURGERIES:_____

_____

_____

DRUG ALLERGIES: _____

Are you allergic to latex? _____

PRIMARY CARE DOCTOR_____**REFERRING DOCTOR**_____

PHARMACY _____**LOCATION**_____

PATIENT'S SIGNATURE_____**DATE:**_____

PATIENT'S SS# _____-_____-_____

CHART#_____

FINANCIAL POLICY

BALANCE: All balances need to be paid or payment arrangements need to be established before seeing the doctor. If you do not have your co-payment you may be asked to reschedule your appointment and a $25.00 cancellation fee will be charged to your account.

FEE SCHEDULE: Examination charges are based on professional times utilized for the particular procedure. Our office policy states "Payment for all office visits are to be made at the time of the visit."

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION (HIPAA): I authorize release of medical information necessary to process this claim. I also request that payment benefits be made to CAROLINA **COASTAL PLASTIC SURGERY** with the understanding that any unpaid balance from co-pays or deductibles or any non-covered charges will be my responsibility.

INSURANCE: We will bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at time of service. Patients with an outstanding balance 90 days or more overdue, must make arrangements for payment prior to scheduling appointments.

I understand that should my check for payment of service be returned for NSF, I will be responsible for validating the check and for a $25.00 returned check fee.

MANAGED CARE: Should you be enrolled in a managed care insurance plan (i.e.,HMO, Tricare Prime, Medicaid), you **must have a referral** to be seen by our physician. Retroactive referrals are not guaranteed.

WORKER'S COMPENSATION PATIENTS: YOU MUST HAVE ALL BILLING INFORMATION INCLUDING CLAIM NUMBER AND AUTHORIZATION TO BE SEEN IN THIS OFFICE. If we do not have authorization to see you, YOU will be responsible for the charges at time service is rendered (Paid before seeing the Physician).

COLLECTIONS: I understand that I am responsible for full payment of any balance, interest accrued, and any collection costs and legal fees incurred to collect this account. I also authorize the release the release of any information pertinent to my case to any insurance company, adjuster, attorney, or collection agency for the purpose of securing payment under this agreement.

When the first bill is sent to me from this office, if I am not able to pay it in full it is my responsibility to contact the office and set up a payment plan to keep my account in good standings. I understand that if no payment is made on my account within 90 days it becomes eligible for collections and statements will no longer be sent to me from this office.

SIGNATURE OF RESPONSIBLE PARTY:_____**DATE**_____

Responsible Party SS#_____-_____-_____**DOB**_____/_____/_____

CHART # _____

MEDICAL INSURANCE

PRIMARY INSURANCE NAME: _____

SUBSCRIBERS NAME: _____

RELATIONSHIP TO PT: _____

DOB: _____ SS# _____

SECONDARY INSURANCE NAME: _____

SUBSCRIBERS NAME: _____

RELATIONSHIP TO PT: _____

DOB: _____ SS# _____

TERTIARY INSURANCE NAME: _____

SUBSCRIBERS NAME: _____

RELATIONSHIP TO PATIENT: _____

DOB: _____ SS# _____

RELEASE OF MEDICAL RECORDS / HIPAA

I am aware of this office's Notice of Privacy Practices, which explains how medical information about me may be used and disclosed. I understand that I am entitled to receive a copy of this notice. _____ **(Initial)**

I give permission to Carolina Coastal Plastic Surgery to discuss my protected health information with the person(s) listed below. Protected health information includes but is not limited to diagnosis, current treatment, future treatment, appointments, medications, surgery and billing/insurance issues.

NAME	RELATIONSHIP