The PLASTIC SURGERY GROUP
Confidence is Beautiful®

455 Patroon Creek Blvd, Suite 101, Albany, NY 12206
Telephone: (518) 438-0505 | Fax: (518) 438-4517

PATIENT INFORMATION

Last Name: _____ Suffix: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Marital Status: _____ Sex: Female / Male

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Social Security #: _____ Employer: _____ Student: Yes / No

Preferred Language (optional): _____ Ethnicity (circle one): Hispanic / Other

Race (circle one): Caucasian African American Asian American Indian Other: _____

Appointment Reminder: [ ] Email [ ] Text [ ] Voicemail (circle one): Home / Mobile

Email Address: _____ Would you like to receive our e-newsletter?: Yes / No

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Contact in case of emergency: _____

Relationship: _____ Phone #: _____

Pharmacy Preference: _____ Address: _____ Phone #: _____

Primary Insurance: _____ Subscriber #: _____

Group #: _____ Copay: _____

POLICYHOLDER INFORMATION (please complete this section if different from the patient information above)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Social Security #: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____ Phone #: _____

Secondary Insurance: _____ Subscriber #: _____

Group #: _____ Copay: _____

POLICYHOLDER INFORMATION (please complete this section if different from the patient information above)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Social Security #: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____ Phone #: _____

Is injury work related?: Yes / No (If yes, please fill out additional information worksheet)

Is injury related to car accident?: Yes / No (If yes, please fill out additional information worksheet)

PLEASE COMPLETE REVERSE SIDE

I HEREBY CONSENT TO THE FOLLOWING:

Authorization

I authorize The Plastic Surgery Group/Plastic Surgery Associates, LLP to release all medical records pertaining to medical history, services rendered or treatment for me or my dependents for insurance claims.

I authorize payment of benefits to the Plastic Surgery Group/Plastic Surgery Associates, LLP.

I promise as guarantor for the above patient, to pay for medical services at the time of my service, unless prior arrangements have been made.

I understand that I am financially responsible for all charges incurred, whether or not they are covered/paid by my insurances.

Permission for Taking Photographs

I hereby consent that photographs may be taken of me or the names patient by The Plastic Surgery Group/Plastic Surgery Associates, LLP in connection with the medical care and treatment received.

I **give / do not give** (circle one) permission for my photographs to be used for educational purposes.

Consent to Release and HIPAA Acknowledgment

I hereby authorize The Plastic Surgery Group/Plastic Surgery Associates, LLP to discuss my medical and payment information with:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

I acknowledge that I have received a copy of The Plastic Surgery Group/Plastic Surgery Associates, LLP's Notice of Privacy Practices. This notice describes how The Plastic Surgery Group/Plastic Surgery Associates, LLP may use or disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Patient/Guardian Signature Date