CHARLOTTE
PLASTIC SURGERY.

# PATIENT INFORMATION FORM

## Patient Information

Patient Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

DOB: _____ Gender: _____

Email Address: _____

How did you hear about us?

☐ Web: _____ ☐ Patient Referral: _____ ☐ Friend: _____
☐ TV: _____ ☐ Magazine: _____ ☐ Dr. Referral: _____
☐ Other: _____

Reason for Consult? _____

## Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

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

Do you have Medicare? (if yes, please sign "Notice of Medicare Provider Non-Coverage" Yes _____ No _____

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## Request to Receive Confidential Information

Please mark the ways that you prefer we communicate with you:

| Method | Ok to Leave Voicemail | Ok to Leave Message with Another Person | Preferred Contact Method(s) |
|---|---|---|---|
| ☐ Call Work Phone | ☐Yes ☐No | ☐Yes ☐No | ☐ |
| ☐ Call Cell Phone | ☐Yes ☐No | ☐Yes ☐No | ☐ |
| ☐ Call Home Phone | ☐Yes ☐No | ☐Yes ☐No | ☐ |
| ☐ Send Email<br>☐ Email Appointment Reminders<br>☐ Email Medical Information<br>☐ Email Office Specials | | | ☐ |
| ☐ Send Regular Mail<br>Mail to which Address: ☐ Home ☐ Other (please list): | | | ☐ |
| ☐ Send Text Message - if ok, please list cell carrier (e.g., AT&T):<br>☐ Text Appointment Reminders<br>☐ Text Office Specials | | | ☐ |

If it's ok to leave a message with another person, please list them:

| Name | DOB | Relationship | OK to Release Results | Any Comments |
|---|---|---|---|---|
| _____ | _____ | _____ | ☐Yes ☐No | _____ |
| _____ | _____ | _____ | ☐Yes ☐No | _____ |

Signature: _____ Date: _____

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# PATIENT INFORMATION FORM

**HIPAA Information and Consent Form**

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is an overview of our policy. A complete version is available if you wish.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with medical care. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. (www.hhs.gov/ocr)

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents that may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services unless authorized by you.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, <PersonalInfo.FirstName> <PersonalInfo.LastName>, do hereby consent and acknowledge my agreement to the terms set forth in this document and any subsequent changes of office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____