Green Hills Plastic Surgery

Stephen M. Davis, MD, FACS

General Information

Date: ___________________________

Patient Name: ___________________________ M.I. Date of Birth: _______________________ Age: _______

How would you like to be addressed by our office staff? ____

Sex: ____ Marital Status: _____________ Spouse or Significant Other's Name: ____________________________

Occupation: ___________________________________ Employer: ____

Social Security Number: _______-____-_________ Insurance Company: __________________________________

Address: ____

Home Street City State Zip Code

Emergency Contact: ____________________________ Emergency Phone: _________________________

Phone Numbers

Please circle the phone number you prefer us to use FIRST in contacting you.

Home: _(_____)______________ Work: _(_____)________________ Cell: _(_____)____________________________

Fax: _(_____)________________ E-Mail: ____

Today's Visit

Referred By: ____________________________________ May we correspond with them? Yes / No

What would you like to discuss with Dr. Davis today? ____

____

____

Have you consulted other physicians concerning this? Yes / No

Medical History

Primary Care Physician: ________________________________ Current Weight: __________ Height: ___________

When did you have the following last?

Physical Exam: _____________ EKG: _____________ Chest X-Ray: _____________

Blood Work: _____________ Mammogram: _____________ T-Cell Count: ____________

Please circle all of the following medical conditions you have or had in the past

Heart	Resp	Bleeding/Liver	Eyes	GI	Mental
High Blood Pressure	TB	Bleeding Tendency	Glaucoma	Intestinal Ulcers	Depression
Heart Attack	Asthma	Hepatitis	Cataracts	Intestinal Bleeding	Mental Illness
Irregular Heart Beat	Wheezing	Diabetes	Dry Eyes	Heartburn	Alcohol or
Chest Pain	Emphysema	HIV	Eye Surgery	Reflux	Drug Addiction
Heart Disease	Bronchitis				

Surgical History

Please list all types of surgical procedures including *injuries, hospitalizations,* and *cosmetic procedures*.

Name of Surgery: **Date:**

1. ____
2. ____
3. ____
4. ____
5. ____

Anesthesia History

Please circle all which apply:

Nausea: Yes / No Vomiting: Yes / No Headaches: Yes / No

Breathing Problems: Yes / No High Fever: Yes / No Muscle Weakness: Yes / No

Other anesthesia problems or complications: ____

Gynecological History

Number of Pregnancies: __________ Normal Deliveries: __________ C-Sections: __________

Miscarriages: __________ Last Menstrual Period: ______________

Date of Last Gynecological Exam: ______________ Do you take oral contraceptives or Estrogen? Yes / No

Social History

Do you exercise regularly? Yes / No If so, how? ____

Have you ever smoked? Yes / No If yes, do you still smoke? Yes No

What age did you start smoking? ____________ What age did you stop smoking? ____________

How many packs per day do/did you smoke? __________

Do you drink alcohol? Yes / No

How much do you drink per day/week? __________________

Family History

Do any diseases run in your family including blood related diseases/conditions? Yes / No

Name of Disease/Condition

1. ____
2. ____
3. ____

Medicines:

Name of Medicine: **Dose:** **Frequency Taken:**

1. ____
2. ____
3. ____
4. ____
5. ____

Do you have allergies to any medicines? Yes / No

Name of Medicine:

1. ____
2. ____
3. ____

Patient's Signature: ________________________________ Date: __________________

Patient Authorization for Use/Disclosure of Healthcare Information by Green Hills Plastic Surgery

Patient's Name: ___________________________________ Date of Birth: _________________________

Effective April 14, 2003 the Federal Government set a law in place to protect you and the release of your medical information whether it is in written or oral form. Our office is not permitted by law to release protected health information without your written consent, including to family members.

Please list the people or companies to whom you authorize us to release your information:

1. ____
   Relationship: _______________________________ Phone: __________________________________

2. ____
   Relationship: _______________________________ Phone: __________________________________

3. ____
   Relationship: _______________________________ Phone: __________________________________

4. ____
   Relationship: _______________________________ Phone: __________________________________

_____ This Authorization applies to Healthcare information relating to the following treatment(s), condition(s) or date(s) of treatment:

____

_____ This Authorization applies to all Healthcare information.

_____ I authorize Green Hills Plastic Surgery to contact me and leave a message via phone and/or non-encrypted email. The phone number to leave a voicemail is: ___________________________________

I hereby authorize Stephen M. Davis, MD and Green Hills Plastic Surgery to release my protected Healthcare information to the people listed above. I understand I have the right to revoke this consent at any time in writing. I am also aware that this Consent is binding and will expire 2 years from the date of signature.

Patient Signature: ____ Date: ______________________

INSURANCE INFORMATION and AUTHORIZATION

Name of Insured: ____

Relationship to Patient: Self ______ My Spouse ______ My Parent(s) ______

If your insurance is under another person's plan, please complete the following information:

Insured's Date of Birth: ____________ Insured's Social Security Number: _____/_____/_____

Insurance Authorization:

I hereby authorized my insurance benefits to be paid directly to *Green Hills Plastic Surgery*. I realize that I am responsible for any fees not covered by my insurance policies. I also authorize the release of pertinent medical information to my insurance carriers.

Patient's Signature: ________________________________ **Date:** ____________________

PATIENT'S RIGHTS

Effective April 14, 2003, the Federal Government set a law in place to protect you and the release of your medical information. We at *Green Hills Plastic Surgery* promise to do our part in upholding this law. Our office is permitted by Federal law to make uses and disclosures of your health information for purposes of treatment, payment and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examinations, test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

A copy of the Federal Privacy Law will be given to you at your initial visit.

I have read the above information regarding the Federal Privacy Law and have received a copy of my rights as a patient of *Green Hills Plastic Surgery*.

Patient's Signature: _______________________________ **Date:** ____________________

Patient Agreement

Limitation of Practice: Patient understands that Dr. Davis's practice is limited to Plastic and Reconstructive Surgery.

Patient Consent: Patient hereby gives my consent, if needed, for drawing blood samples for diagnosis or in case of accidental puncture of exposure to medical personnel during my course of treatment either in the offices or in the hospital. These tests may include HIV testing.

Collection Policy

Insurance Claims Filing

In all cases, the patient is responsible for payment of their account. As a courtesy, we will file claim(s) to the patient's insurance(s).

Assignment and Release: Patient hereby authorizes and assigns applicable insurance benefits to be paid directly to the physician. The patient is financially responsible for non-covered services. The patient authorizes release of information necessary to process insurance claims. Patient authorizes photographs to be restricted for medical, education, or insurance purposes and information released to other practitioners in good faith effort for my medical care.

Medicare: Patient requests that payment of authorized Medicare benefits be made either to the patient or on the patient's behalf to Stephen M. Davis, M.D. and their associates for any services furnished the patient by that physician. Patient authorizes any holder of medical information about the patient to release to the Health Care Financing Administration (Medicare) or its agents any information needed to determine these benefits payable for related services. This form is not to be used by the patient for Medicare reimbursement.

Managed Care Plans and Referrals

Managed care plans (e.g. HMO's) require specialist and sub-specialists to obtain a referral number before a patient can be seen by the physician. The patient is responsible for obtaining a referral number, not this office. Failure to have a referral number prior to service will result in reduced benefits by the managed care plan. Therefore, the patient is responsible for any balance not paid by the coverage plan.

Co-Payments

In all cases, the patient is responsible for making co-payments at the time of the patient visit in the form of cash or check. If a co-payment is not made at the time of the patients visit, Stephen M. Davis, MD reserves the right to require co-payment to be made prior to all future patient visits.

Maximum 30 Day Period for Unpaid Balances

Patient Balances are due 30 days after insurance coverage payment has been made. In the alternative, the patient must make acceptable payment arrangements by contacting the Administration. Balances may be paid via cash, check, Visa, MasterCard, Discover or American Express. *There is a $30 returned check fee that will be assessed in the case of any check returned.*

Unpaid Balances

If for any reason the patient cannot make scheduled payments, the patient must immediately contact the Administrator to make acceptable arrangements. Stephen M. Davis, MD reserves the right to refer all unpaid accounts to collection agencies. Any fees associated with collection, including attorney fees, collection agency contingency fees and court costs, will be added to the patient's account balance. After accounts are placed with collection agencies, all patient visits and procedures will be one cash only basis.

Service Charge

Stephen M. Davis, MD reserves the right to assess a service charge, not to exceed $20 per month, to a patient account for any unpaid balance over 30 days after the insurance coverage has been paid. No service charges will be assessed to patient account where the patient has made payment arrangements with the Administrator and payments are being made as agreed.

Patient Signature____ Date____________

Responsible Party Signature_________________________________ Date____________

*If Responsible Party is different than the patient, please complete:

Name: ____

Address: ____

Date of Birth: ____________________ SSN: __________________________________

Employer: _________________________ Employer Phone Number: ________________

Employer Address: ____

ALL QUESTIONS CONCERNING THESE POLICIES
SHOULD BE DIRECTED TO THE OFFICE MANAGER
AT (615) 327-7407.