PATIENT REGISTRATION

(Please Print)

Name_____Social Security Number_____-___-_____

Address_____City_____State___Zip Code_____

Date of Birth___-___-_____Sex___ Home Phone(___)_____ Cell Phone(___)_____

Employer_____Full/Part time(Circle) Address_____Phone_____

RESPONSIBLE PARTY INFORMATION(If different from above)

Name_____Relationship to patient_____DOB___-___-___

Address_____City_____State___Zip Code_____

SSN#___-___-_____Employer_____Home Phone(____)_____

Address_____Work Phone(_____)_____

Reason for visit today_____

Date of injury or onset of symptoms_____ Is this your first visit to the office?_____

Spouse name_____D.O.B._____Spouse SSN#_____

Are you covered by any type of insurance?_____ Please present your insurance cards to receptionist for copying.

If you are over 18 and covered under parents' plan, are you a full-time student?_____

Is your injury A. work-related?_____ B. resulting from an auto accident?_____

If it is the result of an accident, is there liability insurance?_____ Name of adjuster_____

Company Name_____ Address_____

Did another doctor refer you?_____If so, which one?_____

Emergency contact:_____Telephone(_____)_____

Relationship_____Address_____

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS AND CARRIER, I AM RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE CONSENT FOR LUFKIN PLASTIC SURGERY TO RELEASE ANY INFORMATION, MEDICAL OR OTHERWISE NECESSARY FOR TREATMENT, PAYMENT BY THIRD PARTY, OR OPERATIONS TO CONDUCT BUSINESS. I AUTHORIZE PAYMENT OF ANY MEDICAL/SURGICAL BENEFITS DUE ME FROM INSURANCE OR MEDICARE TO BE MADE DIRECTLY TO THE PHYSICIAN THAT RENDERED SERVICES. I ACKNOWLEDGE THAT I HAVE READ THE PRIVACY RIGHTS STATEMENT PRINTED ON THE BACK OF THIS FORM AND THAT I HAVE RECEIVED A COPY OF THE STATEMENT. I ACKNOWLEDGE THAT I HAVE RECEIVED A BROCHURE WITH THE DOCTORS CREDENTIALS AND EDUCATION BACKGROUND.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

x_____W itness_____Date _____

Notice of Privacy of Medical Record Effective 5-10-02

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

The physical record belongs to the physician but the information contained in the record belongs to you. By signing the consent on the reverse side of this document you give your permission to use the information to treat your condition, to seek payment from a third party for treatment provided or to carry out normal healthcare operations.

For example, your insurance or third party payer may require that we sent an operative report or copies of special studies you have had when we submit claims for payment.

Another example of information release may be a letter or reports sent to another doctor informing them about your condition.

Another example of information release may be for research or national data registry information that may track certain conditions for public health.

Another example of information release may be to allow professionals to review random records when seeking accreditation or board certification.

We will never release information to your employer or another person unless it is required by law or unless we have your written authorization.

Biological parents have the right to information about their children under age 18 regardless of marital status.

We do not conduct medical business by email and we ask that you do not correspond with the doctor via email regarding health related matters.

You have the right to access your protected health information upon written request. We may require at least 14 days to locate and copy your records depending on their accessibility. We may require a copying charge for excessive copies.

You have the right to request an amendment or correction to your protected health information but only if the request is made in writing.

You have the right to authorize release of your protected health information to other requesters or to object to the release to other requesters and previous authorizations may be revoked or amended upon your written request.

You have the right to **not** consent to the release of the information for treatment, payment or healthcare operations but in that event the doctor may not be able to see you or treat you and the professional relationship may be terminated.

_____Patient Initials