Raleigh Plastic Surgery Center, Inc.
PATIENT INFORMATION

Chart # ________

Are you a new patient? ________ How did you learn about our office? ________________________

Patient's Name: ________________________ (Last, First, Middle) Birthdate: __/__/__ (M D YR) Age: ______ Sex: ______

Patient's Address: ________________________ (Street, Apt#, City, State, Zip Code)

Patient's SS# ____________ Phone (H):____________ (WK): ____________ ext.____ Cell ____________

At which number may we reach you? ❑Home ❑Work ❑Cell

Preferred Pharmacy: ____________ Location: ________________________

<u>Race:</u>
- ❑ (1) Asian or Pacific Islander
- ❑ (3) Caucasian
- ❑ (5) American Indian or Alaskan Native
- ❑ (6) Black or African American
- ❑ (9) Other

<u>Ethnicity:</u>
- ❑ (1) Non-Hispanic
- ❑ (2) Hispanic
- ❑ (9) Declined/Unavailable

<u>Preferred Language:</u> ________________________

Employer and Address: ____

Emergency Contact: ____________________ Phone: ____________ Cell: ____________

Relation: ____________________

Receive information regarding special offers? ❑ Yes ❑ No ❑ Home ❑ Email ____________________

Is this a work related injury? ❑ Yes ❑ No Is this an attorney referred appointment? ❑ Yes ❑ No

Are you the Primary Insurance Holder?: ❑ Yes ❑ No

<u>If you checked NO, information below MUST be completed.</u>

Primary Policy Holders Name: ____________ **SS#** ____________ **DOB:** ____________

Employer: ____

PRIVACY POLICIES NOTICE ACKNOWLEDGEMENT, IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

I ____________________ acknowledge that a copy of RPSC, Inc.'s Privacy Policies Notice has been made available to me in accordance with the Health Insurance Portability And Accountability Act of 1996 (HIPAA).

Signed ________________________________ Date ____________

(Patient Signature or Responsible Party)

Authorization and Assignment

I hereby authorize Raleigh Plastic Surgery Center, Inc. to furnish all necessary information to appropriate parties such as insurance carriers, physicians, and attorneys concerning treatments rendered. I understand that I am responsible for ALL medical expenses whether or not there is insurance coverage (and/or ANY expenses incurred as a result of collecting a past due account). I understand that payment for office visits is due the day of service and if insurance submitted for surgical services is not paid by 60 days, I must pay in full unless arrangements are made. I consent to be photographed and understand that the photographs are necessary for my treatment and/or determination for insurance benefits. The photographs will not be used for advertising purposes.

Patient (or legal representative) Signature: ________________________ Date: ____________

Relationship to Patient (if legal rep.) ________________________