Garrison Plastic Surgery

Health Questionnaire

Date:_____

Name:_____ **Birthdate:**_____ **Age:**_____

Referred by:_____ **Marital Status:**_____

(Physician, Family ,etc)

Reason For This Visit:_____

Current Medications: (include all over the counter medications)

Name of Medicine	Strength of Dose (mg)	How Often Taken	Reason Taken

Drug Allergies/Reactions:

_____

_____

Latex Allergic?_____

Family Medical History:

Father:_____

Mother:_____

Brother(s): _____

Sister(s): _____

Maternal grandparents:_____

_____

Paternal grandparents:_____

_____

Medical History

Height_____ **Weight**_____

Surgeries: Date/Operation

_____

_____

_____

_____

Medical Illnesses: (Check past & Present)

__Arthritis __Kidney Disease __Thyroid Disease

__Diabetes __Liver Disease __AIDS __Depression

__Heart Disease __Lung Disease __Cancer (type)_____

__High Blood Pressure __Stomach Ulcers __Other:_____

__High Cholesterol __Stroke _____

Do you use tobacco? __No __Yes How many years?_____ __Quit?/Date _____

(Circle One) Cigarettes Cigars Pipe Chew Daily Amount_____

Do you use alcohol? __No __Yes How many years?_____ Have Quit/Date:_____

Daily amount_____ Type:_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

__ **Home Telephone**_____

__ O.K. to leave message with detailed information

__ Leave message with call-back number only

__ **Work Telephone** _____

__O.K. to leave message with detailed information

__Leave message with call-back number only

__**Written Communication**

__O.K. to mail to my home address

__O.K. to mail to my work/office address

__O.K. to fax to this number_____

__ **Cell Phone**_____

__O.K. to receive text messages

__Leave message with call back number only

__**E-mail address**_____

__O.K. to send e-mail for appointment confirmations or patient communication.

_____ _____

Patient Signature **Date**

_____ _____

Print Name **Birthdate**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. ***NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency***.

AUTHORIZATION FOR DISCLOSURE: I give express permission to discuss with the individual(s) I have listed:

Please check the appropriate box(es)

☐ Any aspect of my Health Care ☐ Health information only ☐ Financial information only

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Garrison Plastic Surgery
Notice of Privacy Practices: Use and Disclosure of Health Information Protected under HIPAA

This document provides a summary of how medical information about you may be used and disclosed and how you can obtain access to this information.

We understand that medical information about you and your health is personal. We are committed to protecting your medical information. It is our policy that the privacy of your protected health information (PHI) be uncompromised while still allowing necessary access to assure that the medical care you receive is appropriate and of the highest possible quality.

We pledge to you that we will protect the confidentiality of information provided to us. Your information will be used in the following manner, known as Treatment, Payment, and Healthcare Operations (TPO):

1. To provide medical treatment and/or services.

2. To bill third party payers, when appropriate, for treatment you receive from us.

3. To facilitate the mechanisms which allow the operation of our facility.

In every use of your information, we will be responsible custodians of your PHI and adhere to the standards set forth in the legislation which created these privacy practices. We recognize that all patients have the right to privacy in matters relating to their health and we will not use your PHI for uses outside of our facility without your express permission.

You have the following rights regarding the medical information we maintain about you:

1. To inspect and copy information that may be used to make decisions about your care.

2. To request restriction or limitations on the medical information we use or disclose about your treatment, payment, or health care operations. While we are not required to agree to your request, we will do our utmost to comply unless the information is needed to provide emergency treatment.

3. To amend the PHI we maintain if you believe that the medical information we have about you is incorrect or incomplete.

4. To request an accounting of disclosures we have made for uses other than our own

5. To request confidential communications; i.e. that we communicate with you in a certain manner or at a location.

6. To receive a paper copy of this notice.

All members of our staff are committed to adhering to the conditions set forth in this notice of privacy practices. Any violation will be grounds for disciplinary action. We reserve the right the change this policy in the future; such change will be available to all patients.

Should you believe that your privacy rights have been violated, you may file a complaint with this facility or with the State oversight department; all complaints must be submitted in writing. You will not be penalized for filing a complaint.

Patient Acknowledgment:

I acknowledge receipt of this information regarding my right to PHI privacy.

Signature:_____

Date:_____

GARRISON PLASTIC SURGERY

PATIENT CONSENT, BILLING and INSURANCE INFORMATION

Patient's Name: _____

DOB: _____ **SS#:** _____ **Marital Status:** □ S □ M □ D □ W **Sex:** □ M □ F

Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino **Preferred Language:** _____

Race: □ White □ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian/Other Pacific Islander

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer: _____ **Employer Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Physician: _____ **Phone:** _____

PERSON RESPONSIBLE FOR PAYMENT

Responsible Party: _____ **Relationship to Patient:** _____

DOB: _____ **SS#:** _____

Home Phone: _____ **Cell Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer: _____ **Employer Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

EMERGENCY CONTACT PERSON

Name: _____ **Relationship to Patient:** _____

Home Phone: _____ **Cell Phone:** _____

Employer Name: _____ **Work Phone:** _____

PRIMARY INSURANCE ***(Include Medicare/Medicaid)*** **SECONDARY INSURANCE** ***(Include Medicare/Medicaid)***

□ **(Check here if no insurance coverage)**

Insurance Name: _____ **Insurance Name:** _____

Insurance Address: _____ **Insurance Address:** _____

_____ _____

Effective Date: _____ **Effective Date:** _____

Policy/Medicare/Medicaid #: _____ **Policy/Medicare/Medicaid#:** _____

Group#: _____ **Group #:** _____

Relationship to Policyholder: _____ **Relationship to Policyholder:** _____

Name of Policyholder: _____ **Name of Policyholder:** _____

Policyholder's DOB: _____ **Policyholder's DOB:** _____

****CONTINUED ON THE BACK****

CONSENT

I consent to medical examination, laboratory procedures and other studies ordered by physicians, advanced practice nurses, physician assistants or other health care providers of Carla Garrison, M.D.

I authorize Carla Garrison, M.D. to disclose to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, and/or my insurance company listed above, any information relating to the identity, diagnosis, prognosis or treatment of the patient named above. I understand the purpose of this disclosure is to facilitate the payment of insurance benefits.

I request payment of authorized Medigap benefits be made to Carla Garrison, M.D. and authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine benefits payable for services.

In consideration for services rendered, I hereby assign to Carla Garrison, M.D. benefits to which I am entitled under the terms of my insurance policy(ies) listed above, and agree to be responsible for services not paid in whole or in part by my insurance company, which I hereby certify is in full force and effect. This authorization will remain in force and effect until revoked by me in writing.

Note: If you are found to have a condition, such as cancer, which must be reported to a county, state or national health agency, your diagnosis will be reported as required by law to the appropriate agency.

Date: _____ **Signature: _____**

CHILDREN ONLY

OTHER PARENT OR GUARDIAN

Name: _____ **Relationship to Patient: _____**

Home Phone: _____ **Work Phone: _____**

Street: _____

City: _____ **State: _____** **Zip: _____**

SS#: _____ **DOB: _____**

Employer Name: _____

PERMISSION TO TREAT MINOR CHILDREN IN ABSENCE OF PARENT OF GUARDIAN

Person Responsible in Parents' Absence: _____

Street: _____

City: _____ **State: _____** **Zip: _____**

Home Phone: _____ **Work Phone: _____**

The undersigned hereby consents to and authorizes Carla Garrison, M.D., its physicians and surgeons, to furnish medical services and treatment to the above-named minor, whenever the minor is presented for treatment. I will pay the charges incurred.

Date: _____ **Signature: _____**

☐ Parent ☐ Guardian

Payment Due at Time of Service