Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____

_____is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of Information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other
☐ Give information to employer ☐ Give information to school '	☐ Appointment absentee information
☐ Spouse	☐ Family billing information ☐ Financial ☐ Medical as follows:
☐ Parent (provide name)	☐ Family Billing Information ☐ Financial ☐ Medical as follows
☐ Other (provide name)_____	☐ Financial ☐ Medical as follows
☐ Support Group (provide name) _____	☐ Demographic Information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to

_____.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

Office Financial Policy

Welcome to Carolina Plastic Surgery and Laser Center! We are committed to providing you with the best possible care. Please carefully review our office financial policies...

It is our policy to request payment for services at the time services are rendered. We accept cash, check and the following major credit cards: Mastercard, Visa, Discover, and American Express. ***If we do not have a contract with your insurance company, you will be asked to pay for your visit in full and as a courtesy we will file your insurance for you.*** If we are contracted with your insurance, you will be requested to pay your co-pay or 20% of your bill.

Please keep in mind however, that you are ultimately responsible for all charges. You will also be responsible for obtaining and keeping current authorizations which may be required by your insurance company. ***Remember, if you do not have a required authorization for a visit, the total charges will become your responsibility. All insurance plans are different so please be sure to review your booklet for more information on your plan.

Also, please note that some insurance companies only pay for what they consider medically necessary. This usually excludes the removal of benign lesions/skin growths. Each insurance company has its own policies and these change from time to time therefore, we cannot be responsible for assuring that the procedure you are having will be covered. If your insurance does not cover a procedure, we will be happy to quote you a cash fee to have it done. **Note** If you have a medically necessary major surgical procedure and are not able to pay your 20% up front, we can possibly set up payments on the portion owed by you. Your portion will be divided into no more than 4 monthly installments. If we set up payments with you, keep in mind that if you miss a payment, you could be charged a billing fee and/or turned over to our collection agency without further notice. ****** Also*** If your account is turned over to our collection agency at any time, collection costs will be added to your account. Therefore you will be responsible for any collection costs added to your account.***

If you cannot keep your appointment, please call our office within 48 hours. A $15 fee will be charged if you do not call and cancel your appointments. If the patient is a minor, a parent or guardian must be present at all visits in order to grant permission to Carolina Plastic Surgery and Laser Center to treat this patient.

In order to give each patient the equal amount of time that they deserve, the initial appointment is for evaluation only. Any procedures that need to be done will be scheduled by our nurse for the next available date and time.

If your injury is work related, we will need the case number, carrier name, and phone number prior to being seen by the Doctor in order to verify that this is work-comp related. Please give this information to the receptionist before you are seen.

If you are seen for cosmetic reasons, we now offer Patient Financing through a company which specializes in helping patients finance medical procedures not covered by insurance. Please ask staff for more details.

_____ _____

Signature of Patient (Parent or Guardian if minor) Today's Date

Carolina Plastic Surgery & Laser Center, P.A.
1721 Ebenezer Road, Ste 205
Rock Hill, SC 29732

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Name:_____ Reason for visit:_____ Age_____
Primary Care Doctor:_____

Height_____ Weight_____ Blood Pressure_____ Pulse_____

Patient Medical: Please circle if you have ever had the following

Asthma/CPAP	bleeding disorder	breast cancer	cancer
Chest pain/tightness	diabetes	eczema	heart disease
Heart murmur	hepatitis	high blood pressure	hives
Kidney stones	skin cancer	skin disease	stroke
Thyroid disorder	tuberculosis	ulcers	x-ray therapy

Urinary tract infection Other_____
Do you have Sleep Apnea_____
Past surgeries:
Surgery/hospitalization and Date/Any problems_____
_____
_____

Family History: afflicted family member/immediate family only

Abnormal bleeding_____	heart disease_____
Abnormal clotting_____	hemophilia_____
Adopted_____	high blood pressure_____
Anesthesia Pros_____	kidney disease_____
Autoimmune disorders_____	liver disease_____
Brain tumor_____	lung cancer_____
Breast cancer_____	other cancer_____
Cleft lip/palate_____	ovarian cancer_____
Diabetes_____	prostate cancer_____
Endocrine disease_____	skin cancer_____
Hearing loss_____	von willebrand_____

Patient allergies and reactions_____

What medications are you currently

_____
_____
_____

Do you drink alcohol_____ Do you smoke_____ Do you use illegal drugs_____

Do you have regular periods_____Are you going through menopause____ Are you lactating or pregnant_____ During Pregnancy did you have hyper pigmentation of the face_____

Patient signature:_____ Date_____

MEDICARE PATIENTS:SIGNATURE ON FILE

I request payment of authorized Medicare benefits be made on my behalf to "Chris R Crawford MD" for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and the non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patients Name (print) Date

_____

Patients Signature

Date _____ (PLEASE PRINT) Home Phone (____) _____

– Patient Information –

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ Cell Phone (____) _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

– Primary Insurance –

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

– Additional Insurance –

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

– Assignment and Release –

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

– Registration Form –

+CAROLINA PLASTIC SURGERY & LASER CENTER

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____

Address:_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_____ An emergency existed & a signature was not possible at this time

_____ The individual refused to sign

_____ A copy was mailed with a request for a signature by return mail

_____ Unable to communicate with the patient for the following reason:

_____

_____ Other:_____

Signature:_____ Date:_____