



NEW LEAF PLASTIC & RECONSTRUCTIVE SURGERY

(940) 626-1998

2000 Ben Merritt Dr. Suite B , Decatur, TX 76234

Health Information as of _____ (enter today's date)
 (Please Print Legibly & Fill In or Correct All Fields)

Patient: _____

Chief complaint (what is the reason for today's visit): _____

Please List Any and All Allergies (Please describe what the reaction was):

Please List Any Medications That You Are Currently Taking (Please include dosage if known):

Do You take Any Vitamins or Minerals: No ___ Yes ___ (If you answered yes please list them below)

PAST MEDICAL HISTORY

Patient denies any past medical history	Yes	No
Abdominal Bleeding	Yes	No
Asthma	Yes	No
Blood Clots	Yes	No
Breast Cancer	Yes	No
Cancer	Yes	No
Carpal Tunnel Syndrome	Yes	No
Chest Pain/Tightness	Yes	No
COPD/Emphysema	Yes	No
Diabetes	Yes	No
Eczema	Yes	No
Heart Disease	Yes	No
Heart Murmur	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No

High Cholesterol	Yes	No
Kidney Stones	Yes	No
Hives	Yes	No
Neurofibromatosis	Yes	No
Skin Cancer	Yes	No
Skin Disorder	Yes	No
Stroke	Yes	No
Thyroid Disease	Yes	No
Trigger Finger	Yes	No
Tuberculosis	Yes	No
Ulcers	Yes	No
X-ray Therapy	Yes	No
Chemotherapy	Yes	No
Peripheral Vascular Disease	Yes	No

Please List Any and All Past Surgery (Please include the name of the procedure, date of procedure and any complications that you may have encountered):

ANESTHESIA HISTORY

Patient denies any past anesthesia problems	Yes	No
Never received general anesthesia	Yes	No
Difficult Intubation	Yes	No
Difficult Extubation	Yes	No
Malignant Hyperthermia	Yes	No
Post op nausea and /or vomiting	Yes	No
Local anesthesia complications	Yes	No

ANESTHESIA COMPLICATIONS

Allergic reaction	Yes	No
Difficulty waking up	Yes	No
Nausea	Yes	No
Sensitivity to Anesthesia Agent	Yes	No
Vomiting	Yes	No

FAMILY HISTORY

Denies any family history	Yes	No	Abnormal clotting	Yes	No
Abnormal Bleeding	Yes	No	Anesthesia Problems	Yes	No

DO YOU NOW OR HAVE YOU EVER HAD..... (You must circle an answer for each individual item)

Good health lately	Yes	No
Recent weight gain	Yes	No
Recent weight loss	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Headache	Yes	No
Ear/nose/throat normal	Yes	No
Hearing loss	Yes	No
ringing in the ears	Yes	No
Earaches/drainage	Yes	No
Sinus problems	Yes	No
Nose bleeds	Yes	No
Mouth sores	Yes	No
Bleeding gums	Yes	No
Bad teeth	Yes	No
Sore throat/voice changes	Yes	No
Gastrointestinal normal	Yes	No
Loss of appetite	Yes	No
Change in bowel movements	Yes	No
Nausea/vomiting	Yes	No
Frequent diarrhea	Yes	No
Painful bowel movements/constipation	Yes	No
Blood in stool	Yes	No
Stomach pain	Yes	No
Hematologic/lymphatic normal	Yes	No
Slow to heal after cuts	Yes	No
Bruise/bleed easily	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Past transfusion	Yes	No
Enlarged glands	Yes	No
Skin normal	Yes	No
Rash or itching	Yes	No
Change in skin color	Yes	No
Change in hair or nails	Yes	No
Varicose veins	Yes	No
Psychiatric normal	Yes	No
Memory loss/confusion	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Sleep problems	Yes	No
Cardiovascular normal	Yes	No
Heart trouble	Yes	No
Chest pain	Yes	No
Sudden heart beat changes	Yes	No
Swelling in hands or feet	Yes	No

Eyes normal	Yes	No
Generally good vision	Yes	No
Eye disease/injury	Yes	No
Wears glasses/contacts	Yes	No
Blurred or double vision	Yes	No
Glaucoma	Yes	No
Respiratory normal	Yes	No
Frequent cough	Yes	No
Spitting up blood	Yes	No
Shortness of breath	Yes	No
Asthma/wheezing	Yes	No
Genitourinary normal	Yes	No
Frequent urination	Yes	No
Burning or painful urination	Yes	No
Blood in urine	Yes	No
Change of force of strain when urinating	Yes	No
Incontinence or dribbling	Yes	No
Kidney stones	Yes	No
Musculoskeletal normal	Yes	No
Joint pain	Yes	No
Joint stiffness/swelling	Yes	No
Weakness of muscles/joints	Yes	No
Muscle pain/cramps	Yes	No
Back pain	Yes	No
Cold extremities	Yes	No
Difficulty walking	Yes	No
Neurological normal	Yes	No
Frequent/recurring headaches	Yes	No
Light headed/dizzy	Yes	No
Convulsions/Seizures	Yes	No
Numbness/tingling sensations	Yes	No
Tremors	Yes	No
Paralysis	Yes	No
Stroke	Yes	No
Endocrine normal	Yes	No
Glandular/hormone problem	Yes	No
Thyroid disease	Yes	No
Excessive thirst/urination	Yes	No
Heat/cold intolerance	Yes	No
Dry skin	Yes	No
Change in hat/glove size	Yes	No
Allergic/immunologic normal	Yes	No
Environmental allergy	Yes	No
Sneezing fits	Yes	No

Family History Continued

Autoimmune Disorders	Yes	No	High blood pressure	Yes	No
Breast Cancer	Yes	No	Hemophilia	Yes	No
Cancer	Yes	No	Kidney disease	Yes	No
Cleft lip	Yes	No	Liver disease	Yes	No
Cleft Palate	Yes	No	Lung disease	Yes	No
Diabetes	Yes	No	Malignant hyperthermia	Yes	No
Drug allergies	Yes	No	Skin cancer	Yes	No
Endocrine disease	Yes	No	Skin disease	Yes	No
Hearing loss	Yes	No	Substance Abuse	Yes	No
Heart disease	Yes	No	Von Willebrand	Yes	No

Do you drink alcohol? Yes No

If so, how much? _____

Do you smoke? Yes No If so, how much? _____ For how long? _____

When did you quit? _____

Do you have a history of sexually transmitted diseases, and if so, what kind? _____

Type of treatment for this? _____

Tanning History (Please Check One)

<input type="checkbox"/>	Always burns, never tans
<input type="checkbox"/>	Always burns, tans with difficulty
<input type="checkbox"/>	Burns mildly, tans slowly
<input type="checkbox"/>	Rarely burns, tans with ease
<input type="checkbox"/>	Very rarely burns, tans very easily
<input type="checkbox"/>	Never burns, tans very easily

Do you use tanning beds? Yes No

Ability To Heal

Does your skin appear fragile, burns easily?	Yes	No
Do you form thick or raised scars from a cut or burn?	Yes	No
Do you wax or use hair removal creams?	Yes	No
Do you ever get cold sores?	Yes	No

Do you exercise? Yes No If yes, how much? _____

Female Questions

	Yes	No	N/A	Details
Do you have regular periods?				
Are you going through menopause?				
Are you pregnant or lactating?				
During pregnancy, did you ever get hyperpigmentation or masking?				
Do you have children? How many?				
Age of menarche?				

When was your last eye examination? _____ By whom? _____

When and where was your last chest x-ray? _____ EKG? _____

Who is your personal physician, if any? _____ Please list all physicians presently caring for you.

Have you ever been under psychiatric care? Yes No When? _____ Why? _____

Have you had any recent blood work done? Yes No Where? _____

Is there anything else you think the doctor should know? _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____



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Patient: _____

Procedure Date: _____

(940) 626-1998

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Patient Signature

Witness Signature

Date



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PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, _____, authorize Wise Clinical Care Associates, Dr. Lovelace, and/or their representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s): _____, and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please **initial** in the boxes marked Yes or No for each item)

Yes	No	Medium
<input type="checkbox"/>	<input type="checkbox"/>	in the office photo album for prospective patients.
<input type="checkbox"/>	<input type="checkbox"/>	in office seminars for prospective patients.
<input type="checkbox"/>	<input type="checkbox"/>	on our website for prospective patients.
<input type="checkbox"/>	<input type="checkbox"/>	in print advertisements .
<input type="checkbox"/>	<input type="checkbox"/>	on television .
<input type="checkbox"/>	<input type="checkbox"/>	In personal chart and for board certification purposes.
Additional Comments:		

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. _____ and/or Wise Clinical Care Associates in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about dermatology methods. I understand that such uses may also include marketing on behalf of Dr. _____, for which Dr. _____ may be receive direct or indirect remuneration.

2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to **Dr. Candis Lovelace, M.D.** at 2000 Ben Merritt Dr. Suite B, Decatur, TX 76234. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.



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Patient: _____ Procedure Date: _____ (940) 626-1998

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. and/or Wise Clinical Care Associates.
5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
6. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. and/or Wise Clinical Care Associates from all liability, including liability for negligence, that in any way arises out of:

- any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and
- any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact **Dr. Canis Lovelace, M.D.** at 940-626-1998

_____ is a minor, _____ years of age, and we, the undersigned, are the parents or legal guardians of _____ and do hereby have legal authority to consent and do consent for him/her.

Signature _____ Date _____

Witness _____



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NOTICE OF PRIVACY PRACTICES

Effective Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE?

This Notice describes the practices of Wise Clinical Care Associates and the practices that will be followed by all of Wise Clinical Care Associates workforce members who handle your medical information.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

Wise Clinical Care Associates understands that medical information about you and your health is personal. We are committed to protecting medical information about you. We maintain our records and conduct our treatment environment with a goal of providing the highest level of protection for your medical information, while still providing you with the highest level of medical care. This Notice applies to all of the records of your medical care which are received or created by Wise Clinical Care Associates.

Your other medical treatment providers (e.g., doctors, hospitals, home health agencies, etc.) may have different policies or notices regarding the use and disclosure of your medical information.

This Notice will tell you about the ways in which Wise Clinical Care Associates may use and disclose medical information about you. Your medical information, also referred to as "protected health information," is that information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health information and related health care services.

In this Notice, we also describe your rights and certain obligations Wise Clinical Care Associates has regarding the use and disclosure of your protected health information. We are required by law to:

- * make sure that medical and other information that identifies you (protected health information) is kept private;

- * give you this Notice of our legal duties and privacy practices with respect to protected health information about you; and
- * follow the terms of the Notice that is currently in effect.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

By becoming a patient of Wise Clinical Care Associates, you are giving consent for Wise Clinical Care Associates to use your protected health information for certain activities, including treatment, payment and other health care operations. Sometimes, you may hear these three activities referred to as "TPO."

First of all, we may use and disclose protected health information about you so that Wise Clinical Care Associates and its medical professionals can treat you. For example, we may use your past medical information in order to diagnose your present condition or we may provide information regarding your medical condition to another doctor to whom we refer you for additional care. We may also use and disclose protected health information about you so that we may be paid for the medical treatment we provide you. For example, we will submit protected health information about you to your insurance company in order to receive payment for services we have provided to you. We may also use and disclose protected health information about you for Wise Clinical Care Associates 's health care operations, in other words, those other tasks that we need to perform to make sure that you are provided the highest quality of medical care. For example, we may use your protected health information to evaluate how we can better meet your needs or we may provide protected health information about you to an auditor who reviews our books so that we can keep our license to provide medical services in TX

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following uses of your protected health information may be made without any additional authorization from you. (Not every use or disclosure is listed, but be assured that all uses and disclosures made by Wise Clinical Care Associates are only those which are permitted under the law):

For use in referral purposes, to share with other providers and to obtain payment for which Wise Clinical Care Associates does not want to have to seek additional authorization.

USES AND DISCLOSURES FOR APPOINTMENT REMINDERS

We may use and disclose your medical information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing at 2000 Ben Merritt Dr. Suite B Decatur, Texas 76234. We will accommodate all reasonable requests.

USES AND DISCLOSURES TO OTHERS INVOLVED IN YOUR HEALTH CARE

We may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your medical care. If you are unable to agree or object to this disclosure, we may disclose such information as necessary if we determine that it is in your best interests based on our professional judgment. We may also use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

USES AND DISCLOSURES IN EMERGENCY SITUATIONS

We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician will attempt to obtain your acknowledgment of this Notice as soon as reasonably practicable after the delivery of treatment.

USES AND DISCLOSURES FOR HEALTH-RELATED BENEFITS OR SERVICES

From time to time, Wise Clinical Care Associates may use and disclose protected health information to tell you about certain health-related benefits or services that may be of interest to you.

USES AND DISCLOSURES REQUIRED BY LAW

We will use or disclose protected health information about you when required to do so by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if the law requires us to do so, of any such uses or disclosures. We must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the law.

USES AND DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES

We may disclose your protected health information for public health activities and disclosure for such purposes will be to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for purposes such as controlling disease, injury or disability. Disclosures to public health authorities may include disclosure to a foreign authority that is working with the public health authority.

USES AND DISCLOSURES RELATED TO COMMUNICABLE DISEASES

We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

DISCLOSURES FOR HEALTH OVERSIGHT ACTIVITIES

We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, and inspections. These activities are necessary for the government to monitor the health care

system, the delivery of health care, government benefit programs, other government regulatory programs and civil rights laws.

DISCLOSURES OF ABUSE OR NEGLECT

We may disclose your protected health information to a public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to a governmental entity or agency authorized to receive such information. In such cases, the disclosure will only be made in accordance with TX law.

DISCLOSURES TO THE FOOD AND DRUG ADMINISTRATION

We may disclose your protected health information to a person or company required by the Food and Drug Administration (FDA) to report adverse events, product defects or other problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements; or to conduct post-market surveillance, as required.

DISCLOSURES FOR LAWSUITS AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court order or administrative order. We may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

DISCLOSURES TO LAW ENFORCEMENT

We may release protected health information if asked to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons, or similar process. Other related disclosures may include disclosures relating to individuals who are Armed Forces personnel, to national security and intelligence agencies, as well as disclosures to authorized federal officials for the protection of the President of the United States or other authorized persons or foreign heads of state.

DISCLOSURES TO CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION

We may disclose protected health information about you to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties required by law. We may also disclose protected health information about you to a funeral director in order to permit the funeral director to carry out legal duties, and may do so if death is reasonably anticipated. Your protected health information may also be disclosed for certain organ donations to which you may have agreed.

DISCLOSURES FOR RESEARCH

We may disclose your protected health information to researchers when their research has been approved and protocols have been established to ensure the privacy of your

information. We may also disclose a limited set of your information, as allowed under the law, for research purposes.

DISCLOSURES RELATED TO CRIMINAL ACTIVITY

We may disclose your protected health information, consistent with federal and TX laws, if we believe that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, or if it is necessary for law enforcement authorities to identify or apprehend an individual.

DISCLOSURES FOR WORKERS' COMPENSATION

We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

Right to Inspect and Copy. You have the right to inspect and copy protected health information that may be used to make decisions about your medical care. Usually this right includes both medical and billing records. You must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. Your request to inspect and copy your information may only be denied in very limited circumstances and you have a right to request that any such denial be reviewed.

Right to Request Restrictions. You have the right to request that we restrict the use and disclosure of your protected health information for treatment, payment and health care operations. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to 2000 Ben Merritt Dr. Suite B. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

Right to Confidential Communications. You also have the right to request to receive private health information communications by alternative means or at alternative locations. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to 2000 Ben Merritt Dr. Suite B. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you have the right to request that your protected health information be amended. Only the health care entity (e.g., doctor, hospital, clinic, etc.) that created your protected health information is responsible for amending it. For more information regarding the procedures for submitting such a request, contact 2000 Ben Merritt Dr. Suite B.

Right to an Accounting of Disclosures. You have a right to an accounting of disclosures of your protected health information, for purposes other than treatment, payment or health care operations by Wise Clinical Care Associates or any of the people or companies who perform treatment, payment or health care operations on our behalf. To request this list of disclosures we made of protected health information about you, you must submit a request in writing to 2000 Ben Merritt Dr. Suite B Decatur, Texas 76234. Your request must state a time period which may not be longer than six (6) years prior to the date of your request and may not include dates before April 16, 2003. Your request should indicate the form in which you want the list (for example, on paper or electronically).

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time.

- * You may obtain a copy of this Notice at our website:
NewLeafPlasticSurgery.com
- * To obtain a paper copy of this Notice, contact 940-626-1998.

To learn more about these procedures, or to make any of these requests, you should contact 940-626-1998.

CHANGES TO THIS NOTICE

Dr. Candis Lovelace M.D., P.A. reserves the right to change this notice. We reserve the right to make the revised or changed Notice effective for protected health information we already have about you, as well as any information we create or receive in the future. We will post a copy of the current Notice on Dr. Candis Lovelace M.D., P.A.'s website: NewLeafPlasticSurgery.com. The Notice will contain, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated and/or that Dr. Candis Lovelace M.D., P.A. has not followed this policy, you may file a complaint with Dr. Candis Lovelace's Clinic Manager or with the Secretary of the Department of Health and Human Services. To file a complaint with Dr. Candis Lovelace M.D., P.A., contact Lisa Malone at 940-626-1998, All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information not covered by this notice or the laws that apply to **Dr. Candis Lovelace M.D., P.A.** will be made only with your written permission ("authorization"). If you provide us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your authorization. You understand that we are unable to take back any disclosures we have already made

with your permission, and that we are required to retain our records of the medical treatment or other services that we have provided to you.

QUESTIONS?

If you have any questions regarding this notice, please contact **Dr. Candis Lovelace M.D., P.A.** at 940-626-1998.

**NEW LEAF PLASTIC AND RECONSTRUCTIVE SURGERY
CANDIS LOVELAVE, M.D., P.A.
PATIENT ACKNOWLEDGMENT FORM**

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Date

Name

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Contact Drivers License # _____
Restrictions: _____ (include State)

Age _____ Birthdate ____ / ____ / ____ SS# ____ - ____ - ____ Sex Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Lovelace to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Lovelace and myself.

Signature _____ **Date** _____

New Leaf Plastic and Reconstructive Surgery

FINANCIAL POLICY

Patient: _____ SSN: _____ Date: _____

Thank you for choosing Clinical Care Associates as your healthcare provider. This office is committed to your health and successful treatment. Please understand that payment of your services is considered part of your treatment. We ask that you please read the following FINANCIAL POLICY and sign this form prior to any treatment.

ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME THE SERVICE IS RENDERED. IF OTHER ARRANGEMENTS NEED TO BE MADE, PLEASE SPEAK WITH THE RECEPTIONIST PRIOR TO YOUR VISIT. ALL COSMETIC FEES ARE DUE AT THE TIME OF SERVICE. THERE IS ALSO A \$500 SCHEDULING FEE DUE FOR SURGICAL SERVICES WHICH IS NONREFUNDABLE WITH CANCELLATION.

WE ACCEPT CASH, CHECK, VISA, AND MASTERCARD.

INSURANCE

We do accept assignment on your insurance benefits. We must have your insurance information to do any insurance billing. In event that your insurance company does not pay, we reserve the right to transfer balances to your responsibility. We will be happy to assist you by providing you with claim forms and an explanation of benefits from your primary insurance after your balance with us is satisfied.

Please be aware that some of the services provided may not be considered reasonable and necessary under your health plan.

All copays and deductibles are due at the time of treatment unless prior billing arrangements have been made. If your insurance requires a referral, we request that you bring it with you at the time of your visit.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans.

This assignment will remain in effect until revoked by me in writing. A copy of the Assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges. I hereby authorize Clinical Care Associates-New Leaf Plastic and Reconstructive Surgery to release all information necessary to secure payment.

Signature Patient/Legal Guardian: _____

Patient: _____ SSN: _____ Date: _____

MEDICARE GUIDELINES

I authorized any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I permit a copy of this request for payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature Patient/Legal Guardian: _____

USUAL AND CUSTOMARY RATES

Clinical Care Associates is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT AND MINOR PATIENTS

Adult patients are responsible for payment at time of service. Minor patients must be accompanied by a parent or legal guardian who is responsible for the minor. Payment for services provided to minors is due at time of service.

MISSED APPOINTMENTS

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of 50% of a normal office visit.

FORMS COMPLETION

There will be a \$15.00 charge for items for which the physician and/or staff are required to complete including by not limited to the following items:

- a. Letter of Medical Necessity
- b. Family Medical Leave Forms
- c. Disability Forms
- d. Application for handicapped parking permits and or license
- e. Prior authorization of medications through an insurance company

Thank you for understanding our FINANCIAL POLICY. Please let us know if you have any questions or concerns.

I have read the FINANCIAL POLICY. I understand and agree to this policy.

Signature Patient/Legal Guardian: _____

