

Name: _____ Marital Status: S / M / W / D
(Last Name) (First Name) (Middle Initial) (Nickname)
 SS#: _____ Date of Birth: _____ Age: _____ Sex: M / F
 Mailing Address: _____ City, State, Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 E-mail Address: _____
 Physical Address (if different from above): _____
 City, State, Zip: _____
 Employer Name: _____
 Employer Address: _____ City, State, Zip: _____
 Spouse Name: _____ SS#: _____
 Date of Birth: _____ Spouse Employer: _____ Phone: _____

Did a physician refer you to us? Doctor's Name _____
 City, State of Doctor's Office _____

If Patient is under 18 years of age OR Insurance is under Parent/Guardian

Father/Legal Guardian Name: _____
 SS#: _____ Date of Birth: _____
 Address: _____ City, State, Zip: _____ Phone: _____
 Father's/Guardian's Employer: _____ Phone: _____
 Mother/Legal Guardian Name: _____
 SS#: _____ Date of Birth: _____
 Address: _____ City, State, Zip: _____ Phone: _____
 Mother's/Guardian's Employer: _____ Phone: _____
 Person Responsible for Payment, if other than patient: _____
 Relationship to Patient: _____
 Address: _____ City, State, Zip: _____ Phone: _____

Insurance Information

Primary Insurance Company: _____
 Address: _____
 City, State, Zip: _____ Phone: _____
 Policy# or ID#: _____ Group#: _____
 Subscriber Name: _____
 Relationship to Patient: _____
 Secondary Insurance Company: _____
 Address: _____ City, State, Zip: _____
 City, State, Zip: _____ Phone: _____
 Policy# or ID#: _____ Group#: _____
 Subscriber Name: _____
 Relationship to Patient: _____

Is this visit Work Related? Yes / No If yes, please complete the following section.

Date of Injury: _____ Contact at Work: _____
 Company Name: _____
 Address: _____ City, State, Zip: _____ Phone: _____
 Workers Comp Insurance Company: _____
 Address: _____ City, State, Zip: _____ Phone: _____
 Contact Person & Claim #: _____

Additional Information - Page 2

What prompted you to call us for an appointment? (Please check all that apply)

Physician Referral _____ Hospital _____ Website _____ Internet Search _____
Billboard _____ Newspaper _____ TV _____ Radio _____ Magazine _____
Yellow Pages _____ Family Member _____ Friend _____ Other _____

Please complete this section if you are covered under Medicare.

Are you employed: Yes / No Retirement Date _____
Is your spouse employed: Yes / No Retirement Date _____

Is this visit due to an accident? Yes / No

Auto _____ Non-Auto _____ Date of Injury _____ Time of Day _____ State _____

Authorization to Release Information

According to office policy, test results or release of medical information will be provided to the patient only. If you would like your information to be made available to someone else, please specify below who information may be released other than yourself.

Name & Relationship _____

I understand that Plastic & Hand Surgery Associates, PLLC (PHSA) may release to my insurance company, managed care, organization, State or Federal agencies, and third party administrators and/or Workers Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also understand that PHSA may utilize a fax machine to transmit any or all records pertaining to my medical care or insurance reimbursement. I understand that faxing my medical records may increase the risk of accidental disclosure. I also understand that it may be necessary for PHSA release all or part of my medical records to any consulting entity that may be involved in my care. I understand and acknowledge that PHSA may use and disclose my records under state and federal law for the purposes described in the Notice of Privacy Practices, in some cases without the requirement of authorization. Nonetheless, I authorize PHSA to use and disclose my medical records for all necessary purposes under state and federal law and regulations.

(Signature)

I consent to the photographing or televising of the appropriate portions of my body, for medical, scientific, educational or marketing purposes, provided my identity is not revealed by the pictures. This includes, but is not limited to, testing facilities, consulting physicians, outpatient facilities and website.

(Signature)

Financial Policy-Assignment

I hereby assign payment of benefits directly to PHSA, otherwise payable to me for services described. I understand that I am fully responsible for the deductible, co-pay and coinsurance amounts, non-covered charges and any and all balances not covered under a contractual write off agreement. My carrier's failure to pay does not release me from this responsibility. I also agree that if my account is turned over to a collection agency, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

(Signature)

Notice of Privacy Practices

I have received the Plastic & Hand Surgery Associates, PLLC Notice of Privacy Practices explaining the uses and disclosures of my health information.

*Patient/Guarantor Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement. For example: We may disclose medical information about you to doctors, nurses or other healthcare professionals involved in your care. For example, your doctor will need to know if you are allergic to any medicines. The doctor may share this information with pharmacists and others caring for you.

We may also disclose information to other professionals providing your health care. For example, we may need to tell a specialist about your medical conditions if we refer you to a specialist so you may receive the proper care.

Disclosure: We may disclose and/share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances. If you have health insurance, we request payment from your health insurance plan for the services we provide. For example, we may need to give your health plan information about your visit, your diagnosis, procedures, and supplies used so that we can be compensated for the treatment provider. However, we will not disclose your health information to a third party payer without your authorization except required by law. We may also tell your health plan about your recommended treatment to get their prior approval, if that is required under your insurance plan. For example, if you need surgery, we will call your health plan to make sure the surgery is covered and will be paid for by the health plan.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. For example, we may use your health information to review the quality of services you receive or to provide training to our staff.

Required by Law: We may use or disclose your health information when we are required by law to do so. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and/or Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voice mail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, a record of these disclosures is not kept; therefore it would not be available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Confidential Communication: You have the right to request to receive confidential communications by alternative means or at alternative locations. We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. We will not request an explanation from you as the basis for the request. Requests must be made in writing to our Privacy Officer.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Plastic and Hand Surgery Associates, PLLC

Phone: (601) 939-9999 Fax: (601) 939-0590

Address: 2550 Flowood Drive, Suite 200, PO Box 321433, Flowood, MS 39232

MEDICAL HISTORY

Name _____ Marital Status _____ Age _____ Occupation _____

Is your problem work related? ___ Yes ___ No Date of Injury _____

What doctor referred you to this office? _____ Phone # _____

What is the reason for today's visit? _____

Have you consulted any other physician about this problem? Yes ___ No ___ Who _____

Date of Last Physical? _____ Describe your general health: (circle) Excellent Good Fair Poor

Usual Blood Pressure _____ Height _____ Weight _____

List previous operations or admissions to the hospital: additional space of reverse side

Operation	Year	Doctor	Hospital	Complications (yes/no)

Have you ever had: (circle yes or no)

Arthritis	Yes	No	Glasses	Yes	No	Nausea (recent)	Yes	No
Asthma	Yes	No	Blurring Vision	Yes	No	Vomiting (recent)	Yes	No
Blood or Bleeding Disorders	Yes	No	Snoring	Yes	No	Reflux	Yes	No
Cancer	Yes	No	Breathing Problems	Yes	No	Prostate Problems	Yes	No
Sleep Apnea	Yes	No	Difficulty Hearing	Yes	No	Frequent Urination	Yes	No
Stomach Ulcers	Yes	No	Thyroid Disease	Yes	No	Difficulty Urinating	Yes	No
Hypertention	Yes	No	Diabetes	Yes	No	Broken Bones	Yes	No
Heart Disease	Yes	No	Chest Pain	Yes	No	Back Pain	Yes	No
Lung Disease	Yes	No	Rapid Heart Beat	Yes	No	Depression	Yes	No
Kidney Disease	Yes	No	Shortness of Breath	Yes	No	Migrane Headaches	Yes	No
			Cough (recent)	Yes	No	Seizures	Yes	No

Medications You Are Now Taking:

Are You Allergic to (circle Yes or No)

penicillin Yes No
 sulfa Yes No
 aspirin Yes No
 codeine Yes No
 latex allergy Yes No

List Any Other Allergies:

Do You Use:

Alcohol _____ How Much Per Day? _____ Tobacco _____ How Much Per Day? _____

Signature _____ Relationship to Patient _____ Date _____