ETPS
East Tennessee Plastic Surgery

Date ____________________________

GENERAL INFORMATION

Name (First, Middle, Last)____Sex M F DOB____-____-____Age____

Mailing Address____

City/State/Zip____

Street Address (if different than above)________________________________ Email:______________________

Home Phone (______)______________________________ Cell (______)______________________________

Social Security #__________________________________ Marital Status_________________________________

Patient's Employer____________________________________ Work Phone (______)____________________

Spouse (or parents if minor) Name____

Spouse's Employer__________________________________ Work Phone (______)_______________________

Emergency Contact (other than spouse): Name____

Phone Number (______)__________________________ Relationship to Patient_________________________

Who referred you to this office? (Doctor/Other)____

1. Insurance ____ Policy Holder's DOB ____________________

Policy Holder's Name ___________________________________Policy Holder's SS# ______________________

2. Insurance ____ Policy Holder's DOB ____________________

Policy Holder's Name ___________________________________Policy Holder's SS# ______________________

CONTACTING YOU

There may be occasions in which our office needs to contact you concerning your appointment, diagnostic testing results, or billing problems or any other situation relating to your visit at our office. Please read and answer the following questions:

East Tennessee Plastic Surgery has permission to contact the number(s) checked below as well as send and/or receive information such as test results, appointments, pictures, and other information pertaining to me or to anyone answering the telephone or on an answering machine.

Home _________ Cell _________ Text ________ Work _________

East Tennessee Plastic Surgery has my permission to email me about any information pertaining to my visits and/or any special services or promotions currently being offered at the office.

Yes _________ No __________ Email ______________________________________

PRIVACY POLICY

I have had the opportunity to review the privacy policy and have been offered a written copy of this policy.

Signature ____ Date ________________________

Primary Care Physician and Office Number ______________________________

List all other physician you have seen in the last three years ______________________________

List known medical problems ______________________________

List current medications – prescription and non-prescription, with dosages ______________________________

____

Nutritional supplements: Turmeric: Y N Fish Oil: Y N Flax Seed: Y N Vitamin E: Y N Other: ____________

Are you allergic to any medications? ______________________________ Allergic to latex? Y N

List any prior surgeries ______________________________

Do you take aspirin? Y N Prescribing physician of aspirin ______________________________

Do you use tobacco? Y N How much? ____________ Do you drink alcohol? Y N How much? ____________

GENERAL AUTHORIZATION – ALL PATIENTS PLEASE READ AND SIGN

ASSUMPTION OF RESPONSIBILITY: the undersigned agrees, whether he/she signs as an agent or as a patient, that in consideration of services to be rendered to the patient named above he/she obligates themselves and agrees to pay upon demand to the above named provider all charges for such services and incidental incurred by said patient. Should the account be referred for collection, the undersigned shall pay all reasonable frees and collection expenses. All delinquent accounts to bear interest at the legal rate. It is understood that bills are payable upon presentation.

Signature ______________________________ Date ____________________

ALL INSURANCE PATIENTS PLEASE AND SIGN

ASSIGNMENT OF INSURANCE BENEFITS: I/We hereby guarantee payment of all charges incurred for the account of the above said patient from the date of first treatment until discharge or termination of treatment, and hereby assign any hospital insurance benefits, insurance sick benefits, or injury benefits payable because of liability of a third party payable to or for the above said patient unless accounts for said patient have been paid in full.

Signature ______________________________ Date ____________________

ALL COSMETIC PATIENTS PLEASE READ AND SIGN

A $500 nonrefundable deposit is required to schedule surgery. The deposit is transferable and will remain transferable for a period of 12 months. If you cancel surgery with less than two weeks notice, your deposit will be forfeited. The remaining surgery balance is due two weeks before your surgery. We accept cash, checks, or credit cards (Visa, MasterCard, Discover, and American Express). We also accept Care Credit (ask us which plan). Any refunds on credit cards will be assessed a 10% refund fee. East Tennessee Plastic Surgery will NOT file health insurance or provide information for the patient to file health insurance on any procedure or surgery that is paid for as cosmetic by the patient. I have read and understand the above information regarding payments to East Tennessee Plastic Surgery.

Signature ______________________________ Date ____________________

MEDICARE PATIENTS PLEASE READ AND SIGN

(Medicare extended payment request one-time authorization) I request that payment of authorized Medicare benefit be made to East Tennessee Plastic Surgery for any services furnished to me by that provider. I authorize any holder of medical information about me to release to Health Care Financing Administration (now CMS Centers for Medicare and Medicaid Services) and its agents any information needed to determine these benefits or the benefits payable for related service. (MEDIGAP PATIENTS - if applicable), I also request that payment of authorized Medigap benefits be made on my behalf to above listed provider and authorize release of medical information required to determine.

Signature ______________________________ Date ____________________