Plastic Surgery Associates of Valdosta
230 Northside Drive, Valdosta, GA 31602
229-242-3002 Phone 229-242-0644 Fax

Name _____
(first) (Middle) (Last)
Address _____ Apt # _____ or Lot # _____

City _____ State _____ Zip _____
Cell Phone _____ Alternate Phone _____

Our office utilizes text message appointment reminders. Do you wish to receive appointment reminders via text message? ( ) Yes ( ) No

Social Security # _____ Date of Birth _____ Marital Status ( )S ( )M ( )D ( ) W
( ) Male ( ) Female Race _____ Ethnicity _____
Do you have email? ( ) Y ( ) N Would you like to be added to our mailing list for specials and news? ( ) Y ( ) N
Email Address _____
Are you employed? ( ) Y ( ) N Name of Employer _____ Occupation _____
Address of Employer _____
Spouse's Name _____ Employer _____ Occupation _____

If patient is a minor please provide employment information for responsible party.

Responsible Party (for patients under 18)
Name: _____ Date of Birth: _____ Phone: _____

Do you have insurance? ( ) Y ( ) N
**If your insurance is NOT in your name, we MUST have the following information:

Primary Insurance: _____ Is this an exchange plan: ( ) Y ( ) N
Group Insurance Employer Name: _____
Policy Holder's Name: _____ Policy Holder's Phone#: _____
Policy Holder's Date of Birth: _____ Policy Holder's Relationship to Patient: _____
Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance: _____ Is this an exchange plan: ( ) Y ( ) N
Group Insurance Employer Name: _____
Policy Holder's Name: _____ Policy Holder's Phone#: _____
Policy Holder's Date of Birth: _____ Policy Holder's Relationship to Patient: _____
Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

I understand that I am responsible for all charges. I will furnish this office with all information necessary to bill by insurance. Any balance after insurance has paid or denied is due by me. I agree that if it becomes necessary to forward by account to a collection agency, I will also be responsible for the reasonable cost of collection, to include attorney fees. I understand that my insurance benefits and referral requirements are my responsibility and that all co-payments and co-insurance are due at the time of service.

I authorize payment of medical benefits to physician for these services and all future claims and I authorize the release of any medical information necessary to process this claim and all future claims.

_____ _____
Signature Date

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Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Patient Name _____ **Date** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Plastic Surgery Associates of Valdosta may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Plastic Surgery Associates of Valdosta has a detailed document call the **'Notice of Privacy Practices.'** It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Plastic Surgery Associates of Valdosta will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Plastic Surgery Associates of Valdosta to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Plastic Surgery Associates of Valdosta has taken action relying on this consent.

Consent for Communications

You have the right to request that we restrict how protected health information about you is used or disclosed. Most patients have family members and friends that occasionally become involved in their care. (For example, your spouse calls to confirm your appointment time; OR your adult child calls with questions about your medications.) Please list any restrictions to the information you have regarding how we can communicate with those you have listed below. (Example: Appointments only, financial matters only; Medications only, etc. If there are no restrictions, please list "NONE" beside their name.

Please list below any persons you will allow us to talk with about you. (If you prefer we do not speak with anyone, please write "NO ONE" across this section.

Name	Relationship to You	Phone Number	Restrictions (See instructions above.)

_____ _____

Signature (Patient or Legal Custodian/Authorized Representative) Date

_____ _____

Relationship to Patient if signed by another party Date