Chase Plastic Surgery
Lawrence J. Chase, M.D.

PATIENT INFORMATION

Name: _____ Preferred Name: _____

Date of Birth: ____/____/____ Sex: M / F Marital Status: Married Single Other

Mailing Address: _____ City _____ State _____ Zip____

Street Address: _____ City: _____ State_____Zip____

Prefered Phone: ( ) _____ Alternate Phone: ( ) _____

Employer: _____ Employer Phone: ( ) _____

RESPONSIBLE PARTY INFORMATION (If different from patient)

Name: _____ Date of Birth: ____/____/____

Relationship to Patient: (Circle One) Spouse Father Mother Other:_____

Mailing Address: _____ City:_____State:_____Zip____

Preferred Phone: ( ) _____

Employer: _____ Employer Phone: ( ) _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____

Relationship to Patient: (Circle One) Spouse Father Mother Other:_____

Home Phone: ( ) _____ Mobile Phone: ( ) _____

INSURANCE INFORMATION

1) Primary Insurance Company: _____

ID No. _____ Group No. _____

Policy Holder: _____ Date Of Birth: ____/____/____

Relationship to Insured: (Circle One) Self Spouse Child Other

2) Secondary Insurance Company: _____

ID No. _____ Group No. _____

Policy Holder: _____ Date of Birth: ____/____/____

Relationship to Insured: (Circle One) Self Spouse Child Other

Method of Payment: (Circle One) CASH CHECK CREDIT CARD

(CONTINUED ON BACK)

MEDICAL INFORMATION RELEASE

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of Chase Plastic Surgery and that Chase Plastic Surgery may release all or portions of my medical records to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or workers compensation carriers. I further acknowledge that Chase Plastic Surgery may disclose my patient information to referring or treating health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, films/images, and other clinic information deemed necessary by Dr. Chase or representative. I understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with Chase Plastic Surgery's privacy policy.

Patient/Responsible Party Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby consent to medical treatment, diagnostic and laboratory tests, and other procedures, which the physician may deem advisable in treatment of my case)or as legal guardian for patient). Chase Plastic Surgery will determine the proper disposition of any tissues, parts, or body fluid consistent with the state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Patient?Responsible Party Signature: _____ Date: _____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I hereby authorize any benefits due to me to be paid directly to Chase Plastic Surgery, 321 N. Mall Dr. Bldg N, St.George, UT 84790. I understand and agree that I am financially responsible of any deductible amounts, co-insurance,non-covered services or services deemed as "not medically necessary" by my insurance carrier. I agree that I am responsible for satisfying and consitions necessary for insurance and health benefits.

I agree that if I do not have insurance I will pay 100% of services rendered each visit or make payment arrangements in advance.

A finance charge of 18% per year or 1.5% per month may be added to any amount for which payment has not been received within 60 days from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of $25.00 for each check or other instrument tendered by me but returned to this facility. Additional service charges may be levied for accounts placed with third party collection agencies, or failure to make necessary co-payments at the time of service.

It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs for collection of this account.

In consideration for medical services rendered, I acknowledge that I have received notice of this financial policy and agree to pay for said medical services according to such terms.

Patient / Responsible Party Signature: _____ Date: _____

MEDICARE PATIENT AGREEMENT
(Required by Medicare for all Medicare claims)

_____

Entitlee's Name Medicare Subscriber Number

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to Chase Plastic Surgery, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits of the benefits payable for related services.
This authorization is in effect until I choose to revoke it in writing.

Signature: _____ Date: _____

Employee Signature: _____ **Date:** _____

ACKNOWLEDGMENT

PLEASE INITIAL

_____ I have received a Written Explanation of Arbitration and I have been verbally encouraged to read both the Written Explanation and the Arbitration Agreement.

_____ I have had the right to ask questions, I have been verbally encouraged to ask any questions, and I have had all my questions answered.

_____ I understand that any claim I might have must be resolved through the dispute resolution process in the Arbitration Agreement instead of having them heard by a judge or jury.

_____ I understand that I can decline to enter into the Arbitration Agreement and still receive health care.

_____ I have received a copy of the Arbitration Agreement.

_____ I understand that I can rescind the Arbitration Agreement within 10 days of signing it.

_____ _____

Date Name of Patient (please print)

_____

Signature of Patient or Patient's Representative

A copy of the Arbitration Agreement and the Written Explanation of Binding Arbitration were provided to _____

on this _____ day of _____ 20____.

_____ _____

Date Signature Physician or Authorized Agent

WRITTEN EXPLANATION OF BINDING ARBITRATION

A binding arbitration agreement requires a patient to submit all future medical malpractice claims to arbitration instead of having the claim heard in court by a judge or jury.

An arbitrator is a person chosen to resolve disputes after hearing the information presented by both sides. You select an arbitrator, your doctor selects one, and you and the doctor agree on a third arbitrator. In the event the parties do not agree, the third arbitrator will be selected by the other two arbitrators from a court-issued list of arbitrators.

You pay for the fees and expenses of your arbitrator, the doctor pays for his or her arbitrator, and the fees and expenses of the third arbitrator are shared equally.

You have the right, at your expense, to be represented in arbitration by an attorney.

By choosing arbitration, you may also have the right to require mediation. Mediation occurs before arbitration. Mediation is a process by which a neutral person tries to help the parties reach a mutually agreeable resolution of their dispute. The cost of mediation is shared equally.

- The arbitration agreement is renewed each year unless it has been canceled in writing before the renewal date.
- You have the right to have all of your questions about arbitration answered.
- You have the right to rescind the agreement within ten (10) days of signing the agreement.
- You have the right to decline to enter into the agreement and still receive health care.

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ AGE: _____ HEIGHT: _____ WEIGHT _____

PRIMARY/FAMILY DOCTOR: _____ REFERRED BY: _____

ALLERGIES:

☐NONE/No known allergies ☐Adhesive tape ☐Anesthesia ☐Aspirin ☐Codeine
☐Iodine/Shellfish/Contrast Dye ☐LATEX ☐Morphine ☐Penicillin ☐Sulfa Drugs
☐Other: _____

MEDICATIONS: List any medications you are currently taking (Include any over the counter medications, herbs and supplements)

PREFERRED PHARMACY: _____

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

MEDICAL HISTORY: Have you ever had any of the following?

☐**NONE of the problems listed** ☐**CAD coronary artery disease** ☐**drug/alcohol abuse** ☐**migraines/headaches**
☐**malignant hyperthermia** ☐**cancer** ☐**fibromyalgia** ☐**neuropathy**
☐**anemia** ☐**chest pain** ☐**heart disease** ☐ **pulmonary embolism**
☐**arthritis conditions** ☐**CHF congestive heart failure** ☐**hypertension** ☐ **seizure disorder**
☐**asthma/shortness of breath** ☐**depression** ☐**infection problems** ☐**cigarette smoker**
☐**bleeding/clotting disorder** ☐**diabetes** ☐**kidney problems** ☐**thyroid**
☐**hepatitis/HIV/TB** ☐**eating disorder** ☐**swallowing disorder**

SURGICAL HISTORY: Please list any hospitalizations, surgeries, fractures, or major illnesses

TYPE OF SURGERY	YEAR OR DATE	DOCTOR

SIGNATURE: _____ **DATE:** _____