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_____

Preferred Phone: ( ) _____ Alternate Phone: ( ) _____

E-mail address: _____

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: _____

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

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

2) Secondary Insurance Company: _____

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

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

(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:** _____

HIPAA OMNIBUS RULE

Patient Acknowledgment of Receipt of Notice of Privacy Practices and Consent/Limited Authorization and Release Form

CHASE PLASTIC SURGERY/ LAWRENCE J. CHASE, M.D. P.C.

Patient Name: _____ DOB: _____ Date _____

I _____, authorize the following parties may have access to my personal health information from this office. **If you do not list anyone, we will be unable to communicate with anyone including your spouse. We will be unable to leave messages or even verify you are our patient with anyone but you.**

Name: _____ DOB: _____

Relationship: _____ Phone: _____

Name: _____ DOB _____

Relationship: _____ Phone: _____

Name: _____ DOB: _____

Relationship: _____ Phone: _____

The following protected health care information (check One):

___Entire medical record for specific date(s) of service: _____

___ONLY the following specific information: _____

List any restrictions: _____

Re-disclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure.

Right to Revoke: Authorization will remain in effect unless revoked in writing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy to revoke this authorization, I will provide Chase Plastic Surgery with a written revocation.

Right to Inspect: I understand that I have the right to inspect the health information that I have authorized to be used or disclosed by this authorization form.

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

Photocopy: A photocopy of this authorization, including a copy that is received by fax or electronically transmitted, shall be considered as effective and valid as the original.

Signature of Patient or Legal Representative: _____

Printed Name of Patient: _____ **Date:** _____

Office: _____

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:_____

ARE YOU OR HAVE YOU EVER BEEN UNDER PAIN MANAGEMENT: ☐ YES ☐ NO

(IF YES) NAME OF DOCTOR_____

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

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:**_____