JOSEPH PLASTIC SURGERY

(PLEASE PRINT)

PATIENT INFORMATION SHEET

Date: _____

_____
Social Security Number

Age: _____

Patient's Name: _____ Date of Birth: _____
Last First Middle

Mailing Address: _____
Number Street City State Zip

Sex: M or F Marital Status: _____

Home Phone No: _____ Cell No.: _____

Occupation: _____ Employer: _____

Work Phone No: _____ Address: _____

Emergency Contact other than spouse/Phone: _____

Name of Parent or Spouse/Please circle: _____ SS #: _____

Occupation: _____ Employer: _____

Work Phone No: _____ Address: _____

Referred by: _____

Reason for this visit: _____

Have you ever been treated elsewhere? _____ By Whom? _____

E-mail: _____

INSURANCE INFORMATION

Insurance Co. _____

Group or Employer _____

Policy # _____

Insured Person _____

Insured SS # _____

Mail Claims to:

_____

_____

_____

WORKER'S COMP OR 2ND CARRIER

Insurance Co. _____

Group or Employer _____

Policy # _____

Insured Person _____

Insured SS # _____

Mail Claims to:

_____

_____

_____

ACCIDENT INFORMATION

Date of Accident: _____ Time: _____ Describe how accident occurred: _____

_____

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.

RELEASE INFORMATION - I, the below named patient, do hereby authorize the physician examining and/or treating me to release any third payor (such as an insurance company or governmental agency) any medical information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to the physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services. Any services for which assignment is not accepted, are acknowledged to be my full and complete financial responsibility. If payment is not received from your insurance co. within 60 days from the date of billing, payment will be expected from you.

RESPONSIBILITY FOR ACCOUNT - I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my insurance policy. I understand that my portion of all fees are due at the time treated unless previous arrangements have been made. Any amounts which are 90 days past due will be eligible to be turned over to a collection agency, unless previous arrangements have been made. I agree to pay all collection costs and attorneys fees for collection whether or not suit is filed. All delinquent accounts bear interest at the legal rate. There will be a $25.00 charge for any returned check.

SIGNATURE _____ DATE _____

PATIENT, POLICYHOLDER OR
RESPONSIBLE PARTY - RELATIONSHIP

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH

Name _____

Address _____
Street Address City State Zip Code

I consent to the taking of photographs by Dr. Brian Joseph or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Brian Joseph.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that photography is a necessary part of planning and evaluating plastic surgery. I authorize that the taking of photographs at the direction of my surgeon and under such conditions as may be approved by him. These photographs will be used solely for education purposes and will be kept confidential. I also authorize Dr. Joseph to use the aforementioned images for Direct Patient Care, Medical Education Teaching, News Media, Institutional Promotion/ Advertising, Educational Publications/Videos, and Electronic Publishing without compensation.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Brian Joseph.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on my action taken prior to my revocation. I do understand that this authorization does not expire.

I release and discharge Dr. Brian Joseph, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature (Patient or Parent / Legal Guardian of Patient) Date