THE PLASTIC SURGERY GROUP, P.C.

PATIENT REGISTRATION

DATE:____________________

PATIENT NAME:____SEX(M)______(F)____ M/S/D:______________

STREET ADDRESS:____

TOWN:____STATE:___________________ZIP CODE_________________

HOME PHONE#:_______________________________________BUSINESS PHONE #.: _______________________________

CELL PHONE #: _______________________________________E-MAIL ADDRESS : _______________________________

PATIENT'S AGE:________________________DATE OF BIRTH_________________PATIENT SS#____________________

WHO REFERRED YOU TO OUR OFFICE:____

ADDRESS:____

FAMILY DOCTOR/PEDIATRICIAN:_______________________________________PHONE #:_______________________

ADDRESS: ____

IN CASE OF EMERGENCY PLEASE NOTIFY:____

RELATIONSHIP TO PATIENT:_______________________________________PHONE #:_______________________

PATIENT'S OR GUARDIAN'S EMPLOYER:____

ADDRESS:____PHONE #:_______________________

REASON FOR VISIT:____DATE OF ONSET/ACCIDENT: _____________

ACCIDENT DESCRIPTION:____

HOW / WHERE INJURY OCCURRED: ____

WAS PATIENT INJURED ON THE JOB ? (YES)_____(NO)____ IN AN AUTO ACCIDENT?(YES)________(NO)_____

(IF ON THE JOB INJURY OR NO FAULT, PLEASE COMPLETE INFORMATION ON REVERESE SIDE)

INSURANCE # 1

NAME OF INSURANCE CARRIER:____

ADDRESS:____

NAME OF POLICY HOLDER:____________________________________NAME OF EMPLOYER PROVIDING COVERAGE:___________________________

POLICY HOLDER'S SS#_________________________ POLICY HOLDER'S DATE OF BIRTH:________________SEX: (M)___________(F)___________

POLICY ID # :____GROUP#:__________________PLAN#:___________________

INSURANCE # 2

NAME OF INSURANCE CARRIER:____

ADDRESS:____

NAME OF POLICY HOLDER:____________________________________NAME OF EMPLOYER PROVIDING COVERAGE:___________________________

POLICY HOLDER'S SS#_________________________ POLICY HOLDER'S DATE OF BIRTH:________________SEX: (M)___________(F)___________

POLICY ID # :____GROUP#:__________________PLAN#:___________________

<u>**IF YOUR INSURANCE REQUIRES A REFERRAL, IT IS YOUR RESPONSIBILITY TO FURNISH US WITH IT PRIOR TO SEEING THE DOCTOR. FAILURE TO DO SO WILL RESULT IN THE PATIENT BEING RESPONSIBLE FOR THE BILL.**</u>

THE PLASTIC SURGERY GROUP, P.C.

SELF-PAY: (Must be completed if you have no insurance)

RESPONSIBLE PARTY'S NAME:______________________________ SS#:______________________

STREET ADDRESS:____

TOWN: ______________________________ STATE:______________ ZIP CODE:____________

EMPLOYER NAME: ________________________ ADDRESS:______________________________

I.D. RECEIVED: (to be completed by receptionist) ______________________________________

FOR ON THE JOB INJURY:

DATE OF ACCIDENT: __________ TIME: ___________ AM PM TOWN WHERE ACCIDENT TOOK PLACE______________________

DESCRIPTION OF ACCIDENT: ____

EMPLOYER:__________________________________ SUPERVISOR:______________________

INSURANCE COMPANY: ________________________ ADDRESS:__________________________

PHONE #: __________________________________ CONTACT: __________________________

POLICY #:________________ CARRIER CASE #:________________ WCB CASE #:______________

ARE YOU STILL WORKING? (YES)__________ (NO)_______ LAST DATE WORKED:____________

FOR AUTOMOBILE ACCIDENT: (Please supply receptionist with copy of insurance ID card)

DATE OF ACCIDENT:_______ PATIENT WAS: DRIVER:_____ PASSENGER:_____ PEDESTRIAN:______ WORKING AUTO_______

NAME OF POLICY HOLDER: ______________________________ PHONE #:____________________

INSURANCE COMPANY:___________________________ ADDRESS:_________________________
PHONE #:_____________________________________ CONTACT:__________________________
POLICY #:___________________________________ FILE #: ____________________________

INSURANCE PAYMENT ORDER & AUTHORIZATION TO RELEASE INFORMATION:
I HEREBY AUTHORIZE MY INSURANCE COMPANY(S) KNOWN BY THE NAME(S) OF ____________________ TO PAY DIRECTLY TO THE PLASTIC SURGERY GROUP, P.C., BENEFITS DUE ME OUT OF INDEMNITY UNDER THE TERMS OF MY POLICY.
IF I RECEIVE PAYMENT FROM THE INSURANCE COMPANY, I AM RESPONSIBLE FOR FORWARDING ALL PAYMENTS WHICH I HAVE RECEIVED, ALONG WITH A COPY OF THE EXPLANATION OF BENEFITS TO THE PLASTIC SURGERY GROUP P.C. I UNDERSTAND THAT I AM RESPONSIBLE FOR PROMPT PAYMENT OF ANY PORTION OF THE CHARGES NOT COVERED BY INSURANCE, INCLUDING DEDUCTIBLES, CO-INSURANCE OR COPAYS. IN THE EVENT, THAT MY ACCOUNT HAS TO BE REFERRED FOR LEGAL ACTION, ANY AND ALL REASONABLE COLLECTION AND/OR ATTORNEY FEES AND INTEREST WILL BE ADDED TO THE ENTIRE BALANCE.

I HEREBY AUTHORIZE THE PLASTIC SURGERY GROUP, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIER AND/ OR EMPLOYERS CONCERNING ILLNESS AND TREATMENT RECEIVED BY ME FOR THE PURPOSE OF PROCESSING MY CLAIM(S) FOR MEDICAL SERVICE:

INSURED NAME:______________________________

LEGAL SIGNATURE: ___________________________ DATE:____________________

650 NORTHERN BLVD
GREAT NECK NY 11021
(516) 466-7000
(516) 466-9024 FAX

242 MERRICK RD
SUITE 302
ROCKVILLE CENTRE NY 11570
(516) 536-5858
(516) 536-6119 FAX

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ERIC S. MAGER, M.D.,F.A.C.S. ROBINDER P. SINGH, M.D.

MEDICAL HISTORY FORM

PATIENT NAME:______________________________ DATE:__________

PHARMACY: ______________________________ TEL: __________

PHARMACY ADDRESS: ______________________________

PAST MEDICAL HISTORY:

General Health : Good ___________ Fair ___________ Poor _________

If not "Good", please explain :

____

____

____

HEIGHT: _____ WEIGHT: ______WEIGHT LOSS: _____ GAIN: ______ IN PAST YEAR: _______lbs.

HOW LONG AGO WAS YOUR MOST RECENT CHECK-UP?______________________

NAME & ADDRESS OF YOUR DOCTOR:______________________________

____

PREVIOUS SURGERY (Please list)

Operation	Year	Hospital	Doctor	Local or General Anesthesia?

PREVIOUS ILLNESSES (Please List):______________________________

____

____

ARE YOU CURRENTLY BEING TREATED FOR ANY ILLNESS OR CONDITIONS? If so, please list:

____

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ________ NO _______ if yes, Please list:

____

Continued on back

CURRENT MEDICATIONS (Please list all medications you are now taking and their dosages, including birth control pills, diuretics or water pills, blood pressure or heart medication, pain medications, or any other prescribed or over the counter medications): ____

____

____

WHAT IS YOUR APPROXIMATE DAILY CONSUMPTION OF THE FOLLOWING:

COFFEE OR TEA: _____________ TOBACCO: ____________ ALCOHOL: ________________
OTHER INTOXICATING OR MIND ALTERING DRUGS (SPECIFY): _____________________

PERTINENT PRE-OPERATIVE INFORMATION:

Have you ever reacted badly to being put to sleep for surgery?	**No _____Yes _____**
Has any member of your family ever reacted badly to being put to sleep for surgery?	**No _____Yes _____**
Have you required large amounts of anesthetic for medical or dental procedure?	**No _____Yes _____**
Have you ever had a bad reaction to local anesthetic(Novacain, etc?)	**No _____Yes _____**
Are you allergic to adhesive tape?	**No _____Yes _____**
Are you allergic to suture material?	**No _____Yes _____**
Have you ever had Scarlet fever or Rheumatic Fever?	**No _____Yes _____**
Do you have high blood pressure?	**No _____Yes _____**
Do you bleed unusually easily (from cuts, surgery, tooth extractions, etc)?	**No _____Yes _____**
Do you bruise easily?	**No _____Yes _____**
Have you ever had a transfusion for surgery?	**No _____Yes _____**
Are you a slow or poor healer?	**No _____Yes _____**
Do you form large scars or keloids?	**No _____Yes _____**
Have you ever taken steroid medications, cortisone, or ACTH?	**No _____Yes _____**
Do you have shortness of breath with walking?	**No _____Yes _____**
Do you have or have you had significant emotional problems?	**No _____Yes _____**
Are you pregnant?	**No _____Yes _____**

FAMILY HISTORY:

Give age and State of Health for each:

Mother: ______________________________

Father: ______________________________

Brother(s) ______________________________

Sister(s) ______________________________

Children: ______________________________

____

____

____

HAS ANY RELATIVE HAD:

Tuberculosis:	**No _____Yes _____**
Cancer:	**No _____Yes _____**
Diabetes:	**No _____Yes _____**
Epilepsy:	**No _____Yes _____**
Heart Disease:	**No _____Yes _____**
High Blood Pressure:	**No _____Yes _____**
Blood or Bleeding Disorders:	**No _____Yes _____**
Asthma or Lung Disease	**No _____Yes _____**

Signature of patient or other: ______________________________________ Date: _________________

(If “other” please indicate relation): ___________________________________

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PATIENT NAME : ______________________________

PHARMACY NAME : ______________________________

PHARMACY ADDRESS: ______________________________

PHARMACY TEL: ______________________________

UNIVERSAL CLAIM FORM

Member’s Name (Last) (First) (Initial) (from ins. Card)
Policy#:
Group#:

Home Address
Home Tel #:
Business Tel #:

Name of Patient
Patient’s SS#:
Patient’s Birth Date:

Was injury or condition related toL
Patient’s Employment? ____(YES) _____(NO)

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THE PLASTIC SURGERY GROUP, P.C.

ROBINDER P. SINGH, M.D.

AUTHORIZATION FOR THE TAKING AND RELEASE OF PHOTOS

I, the undersigned patient, hereby consent to allow the doctors of **The Plastic Surgery Group, P.C.** to take, and/or release clinical photographs of me. I understand that these images may be used for any or all of the following purposes.

My surgical planning
Resolution of my insurance claim(s)
Patient and/or public education
Marketing / Promotional (including website)

If I have any exceptions to the above they are listed as follows:

____

____

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

With the exception of any particular items indicated by me on this form, I consent to the above stated of said photographs.

Signature ____________________________ Date: ______________

Witness: ____________________________ Date: ______________

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The estimated cost of services that your healthcare professional may bill you is available upon request.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED.

Effective April 14, 2003

The Privacy of your medical information is important to us. You may be aware that U.S. government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Harriet Piltz, Administrator is in charge of privacy matters at our office. You can contact her at (516) 466-7000 if you desire further information, or have any questions or concerns.

Use and disclosure of protected information.

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. Example, if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York Laws, such as restriction on disclosures of information concerning HIV/AIDS")

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. Example, under your health plan, we are required to provide then with diagnosis code for your visit and a description of the services rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you. Or written authorization by you. Example, our accountant may see your name, dates of treatment and procedure codes during audits of our books : we may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We May use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. required by the law
2. required for public health purposes;
3. required by the law to report child abuse;
4. where required by the health oversight agency for oversight activities authorized by law, such as Department of Health Office of professional Discipline or Office of Professional Medical Conduct.
5. required by law in judicial or administrative proceedings;
6. required by law enforcement purposes by law enforcement official;
7. required by a coroner or medical examiner;
8. permitted by law to a funeral director;
9. permitted by the law for organ donation purposes;
10. permitted by law to avert a serious threat to health or safety;
11. permitted by law and required by military authorities if you are a member of armed forces of United States;
12. [research purposes(if applicable to our practice, see details at 45 CFR & 164.512(1))]

New York States law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State Law with respect to such information.

We may contact you by mail or phone, at you residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable request, in writing , for us to use alternative methods of communicating with you in a confidential manner. Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

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Rights that you have.

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree such restriction .

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information,. Such request must be in writing , and must state the reason for the requested amendment. We will notify you as to whether we agree to disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you , or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR & 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law [or for research or public disclosure made before April 14,2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file complaint with us. Complaint should go directly to Harriet Piltz, Administrator at 650 northern Boulevard great Neck NY 11021.

No retaliatory action will be taken against you for any complaint you may make.

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I wish to designate the following person(s) to be able to speak on my behalf and have access to my Protected Health Information:

1. ____
2. ____
3. ____
4. ____

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have been provided with a copy of **The Plastic Surgery Group, P.C.**'s privacy notice.

____
Signature

____
Print Name

____
Date