Southwest Plastic Surgery Center
Patient Registration Information

Chart # ________________ Date ________________

❒ **Milton M. Rowley, M.D.**
❒ **Jane M. Rowley, M.D.**

When registering, please present proof of insurance, Medicare and/or Medicaid. Payment is expected at the time of service, unless special arrangements have been made. If you wish to speak with the bookkeeper, please inform the receptionist when this form is completed and returned to the front desk.

PLEASE FILL THIS FORM OUT COMPLETELY

PATIENT INFORMATION

Name ________________ Age ________
Date of Birth ________________ Sex ________
Address ________________
City ________________ State ________ Zip ________
Phone ( ) ________________ Marital Status ________
Drivers License # ________________ State ________
Social Security # ________________
Employer ________________
Address ________________
Phone ( ) ________________ Student Y N
**Cell# ________________ or ________________

INSURANCE INFORMATION

WE DO NOT ACCEPT MEDICAID FOR BREAST REDUCTIONS

MEDICARE # ________________
MEDICAID # ________________ **State** ________

PRIVATE CARRIER/MANAGED CARE

Company ________________
Address ________________
City ________________ State ________ Zip ________
Phone ( ) ________________
Group # ________________
Subscriber ID # ________________
Is this plan through an employer? ________________
If so, which one ________________
Name on Card ________________
Cardholder's Date of Birth ________________

SECONDARY INS - OR SUPPLEMENT POLICY

Company ________________
Address ________________
City ________________ State ________ Zip ________
Phone ( ) ________________
Group # ________________
Subscriber ID # ________________
Name on Card ________________ DOB: ________________

REASON FOR CONSULTATION, PLEASE BE SPECIFIC:

____
____

PATIENTS SPOUSE/GUARDIAN, IF APPLICABLE

Spouse/Guardian ________________
Relationship ________________
Address (if different) ________________
City ________________ State ________ Zip ________
Employer ________________ Phone ( ) ________________

RESPONSIBLE PARTY (if other than patient)

Name ________________
Address ________________
City ________________ State ________ Zip ________
Phone ( ) ________________
Social Security # ________________
Employer ________________
Address ________________
City ________________ State ________ Zip ________

EMERGENCY CONTACT (Not living with patient)

Name ________________
Address ________________
City ________________ State ________ Zip ________
Phone ( ) ________________ or ( ) ________________
Relationship to patient ________________

Method of payment ❒ **Check** ❒ **Cash** ❒ **Credit Card**

Referred by ________________
City of Referring Physician ________________
Phone # for Referring ________________ Date of Injury ________
(Fill out for Injury only)

Animal Bite ________ Auto Accident ________________
Other ________________

WE DO NOT ACCEPT WORKERS COMPENSATION CASES

DRUG ALLERGIES: ________________
____
____

My present Age ____________ Today's Date ____________

Maternal History

Have you ever been pregnant? ❑ Yes ❑ No
If yes, how many times? ________ How many children do you have? ________

Are you pregnant now? ❑ Yes ❑ No Are you planning to have more children? ❑ YES ❑ NO

Do you smoke? ❑ Yes ❑ No How much? ________pkg/day Quit smoking When? ________

Do you take aspirin in any form (Bufferin, Anacin, etc.)? ❑ Yes ❑ No Last time taken? ________

Do you drink alcohol? ❑ Yes ❑ No If YES, comment on the following:

Are you allergic to any pills, drugs or medicines? ❑ Yes ❑ No ____________

Have you ever had a bad reaction to a **GENERAL** anesthetic? ❑ Yes ❑ No ____________

Have you ever had a bad reaction to a **LOCAL** anesthetic? ❑ Yes ❑ No ____________

Do you have a Latex allergy? ❑ Yes ❑ No ____________

Have you or anyone in your family ever had Malignant Hyperthermia? ❑ Yes ❑ No ____________

Do you have acetylcholinesterase deficiency? ❑ Yes ❑ No ____________

Do you have high blood pressure? ❑ Yes ❑ No ____________

Do you have bleeding tendencies? ❑ Yes ❑ No ____________

Do you form large scars or keloids? ❑ Yes ❑ No ____________

Do you have frequent infections or boils? ❑ Yes ❑ No ____________

Have you ever had any significant emotional problems, or received psychiatric care? ❑ Yes ❑ No ____________

Have you seen other plastic surgeons about the SAME problem which brings you here? ❑ Yes ❑ No ____________

Past History

Have you ever had any serious illness of the following? (Circle if YES)

1. Head Injury
2. Eyes: Excess tearing, Dry Eyes, Double vision, Loss of vision, Blurring of vision
3. Ears: Loss of hearing, Dizziness
4. Nose: Difficult breathing, Bleeds, Previous Injury
5. Breasts: Lumps, Biopsy
6. Lungs: Pneumonia, Asthma, Emphysema, Shortness of breath
7. Heart: Previous attacks, Chest pain with exertion, High blood pressure, Rheumatic fever, Heart murmur
8. Abdomen: Jaundice, Ulcer, Weight Loss, Indigestion/Heartburn
9. Kidney infection
10. Anemia
11. Reproduction
12. Nervous
13. Extremities: Phlebitis, Swollen legs and ankles, Varicose veins
14. Miscellaneous: (You and/or family) Cancer, Thyroid disease, Diabetes
15. Height _______ Present Weight ________
    Any recent weight loss/gain ❑ Yes ❑ No
    If yes, how much? ______________________
    Over what period? ______________________

If any circled, please explain: ____

____

SERIOUS INJURIES (Please list)

TYPE	YEAR	AFTER EFFECTS

PREVIOUS SURGERY (PLEASE List):

OPERATION	**YEAR**	**COMPLICATIONS**

MEDICATIONS AND DRUGS (Please include dosage and how often) Please list ALL medications you are now taking (including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, blood thinners, aspirin, etc.

I verify that the information is complete and accurate:

Patient Signature: ______________________________ Date: ________________

DOCTOR SIGNATURE: ______________________________ Date: ________________

SOUTHWEST PLASTIC SURGERY CENTER
4/10/03

CONSENT FOR USE DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I understand that as part of my health care, Southwest Plastic Surgery Center originates and maintains medical records describing my health history, symptoms, examination and test results, diagnoses, treatment, financial and demographic information, as well as any plans for future care or treatment. Southwest Plastic Surgery Center also originates and maintains billing records. I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment;
- Communications between Southwest Plastic Surgery Center and health care professionals that act under the direction of Southwest Plastic Surgery Center and participate in my diagnosis, evaluation or treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting healthcare operations, including: the evaluation of health care services, appropriateness and quality of health care treatment and the qualifications of health care practitioners.

I have been provided with a copy of Southwest Plastic Surgery Center's *Notice of Privacy Practices* that provides information about how Southwest Plastic Surgery Center uses and discloses Protected Health Information about me. I understand that I have the following rights and privileges:

- The right to review the *Notice* prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations. Southwest Plastic Surgery Center is not required to agree to requested restrictions, but is bound to any restrictions agreed to.

I understand that as provided in the *Notice of Privacy Practices*, the terms of the Notice may change. If they do, I may obtain a revised copy from the Privacy Official by calling 806/792-3715.

I understand that I may revoke this consent in writing, except to the extent that Southwest Plastic Surgery Center has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, Southwest Plastic Surgery Center may refuse to treat me. I wish to restrict the use or disclosure of my health information as follows:

____

____

____

I understand that my confidential information may be released to the following individuals:

____

____

____

____
Signature of Patient or Representative

____
Date

_________________________________ _________________________
Patient Name | Patient Identification Number

_________________________________ _________________________
Name of Representative (if applicable) | Relationship

Restrictions to use and disclosure of health information: □ Accepted □ Denied

_______________________ ________________ ______________
Signature of Employee | Title | Date

For Office Use Only

[ ] Consent received by ________________________ on ____________________
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on ___________________________

SOUTHWEST PLASTIC SURGERY CENTER

MILTON M. ROWLEY, M.D.
JANE M. ROWLEY, M.D.

FINANCIAL POLICY

A brief explanation of our financial policies are outlined below. Please review the part that applies to you. If you have any questions or specific financial needs, please feel free to discuss them with the bookkeeper.

PRIVATE OR COMMERCIAL INSURANCE
Patients who carry medical insurance should remember that services are rendered and charged to the patient. As the patient, you are responsible for fees arising from any services provided. We cannot render services on the assumption that all charges will be paid by an Insurance company or third party. Please expect to provide the office with a copy of your insurance cardAt the minimum, patient should expect to pay the remaining deductible amounts and co-insurance payments as described in their insurance contract. Some surgical procedures require a larger down payment. The bookkeeper will inform you if a down payment is required.

In the case of an accident, all charges are considered the patient's responsibility. Any necessary payment arrangements or prior arrangements should be discussed with the bookkeeper on the first visit to the office. If litigation is involved, we will file your insurance. If there is a balance due, payment is expectedupon billing. We do not wait for payment upon settlement of pending suits. If you have any further questions, feel free to discuss them with the bookkeeper.

WORKMAN'S COMPENSATION
We do not accept workman's compensation injury cases.

MEDICARE
As a participating provider, we will file your Medicare and Medicare supplement Insurane for services covered by Medicare. Please provide our office with a copy of your Insurance cards. You will be billed for any remaining billable amounts after we have received payment from Medicare and yur Medicare supplement**Medicare does not cover cosmetic procedures.**

MEDICAID
We do not accept Medicaid for services not covered by Medicaid. Please provide our office with a copy of your mostecent Medicaid identification form at each visit. It is the patient's responsibility to inform us if your eligibility status changes. **MEDICAID DOES NOT COVER COSMETIC PROCEDURES.**

COSMETIC SURGERIES
The bookkeeper or office manager will be glad to discuss fees for cosmetic procedures prior to scheduling the procedure. We observe a policy of payment in advance of all cosmetic procedures.

THE UNINSURED PATIENT
We recognize that there are occasions when surgical care is needed by a patient who does not carry health insurance. Uninsured patients should be aware that they are responsible for all charges at the time of services. If necessary, payment plans can be established. Arrangements must be made with the bookkeeper when services are rendered, or in the case of an accident, on the first follow-up visit to our office.

COLLECTION POLICY
An account is considered delinquent and eligible for legal action after 60 days from the date of service, If payment is not received from an insurance company within 60 days, the patient is expected to either contact our office and the insurance company and/or pay the balance in full. If an account has to be referred to collection, the patient is responsible for all fees and costs which are incurred in the collection process. All patient's with accounts that have been referred for collection will be on a CASH ONLY basis until the past due bill is paid in full.

I have read and understand the above financial policy.

SIGNATURE__________________________________ DATE __________________________

Milton M. Rowley, M.D.
Jane M. Rowley, M.D.

ACKNOWLEDGMENTS AND AGREEMENTS

I realize that in my assignment of insurance benefits I am not released from my responsibility for all charges related to services rendered to me by Milton M. Rowley, M.D. or Jane M. Rowley, M.D.

I authorize Milton M. Rowley, M.D. or Jane M. Rowley, M.D. to release any medical information regarding services performed to my insurance company or my personal physician.

I hereby authorize my insurance company to pay any and all benefits due to me as described in my policy contract directly to Southwest Plastic Surgery Center.

A photographic copy of this authorization is as valid as the original. This is valid indefinitely.

____________________	____________________	____________________
Signature	Witness	Date

PHOTOGRAPHIC CONSENT

I hereby give permission to Milton M. Rowley, M.D. and Jane M. Rowley, M.D. to take necessary clinical photographs of my (please specify area) ____________________ with the understanding that such photographs ar e for clinical purposes and are confidential. All photographs will remain the property of the doctors.

Patients Signature ____________________

Parents Signature ____________________

Date ____________________