NEWMAN, MD PLASTIC SURGERY

(870) 425-6398

Patient Information as of ________________ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ____
First Middle Last

Address ____
Street & Apt # City State Zip

Home Phone ________________ Cell Phone ________________ Other Phone ________________

Any restrictions for contacting you? ☐ No ☐ Yes E-mail ______________________

Contact Restrictions: ____

Age ______ Birthdate ___/___/___ SS# ___-___-___ Gender

Marital Status ☐ Single ☐ Married to: ________________ ☐ Other: ________________

Patient's Employer ________________ Occupation ________________

Work Phone ________________ Ext: ______ Is it okay to call you at work? ☐ Yes ☐ No

Address ____
Street & Suite # City State Zip

PRIMARY CARE PHYSICIAN: ______________________

How did you hear about ? (Mark all that apply)

☐ TV News ☐ TV Ad ☐ Phone Book ☐ Magazine ☐ Newsletter ☐ Seminar ☐ Salon ☐ Web

☐ Friend/Relative: ________________ ☐ Doctor: ________________ ☐ Other: ________

If you were referred by a specific person*, may we thank them? ☐ Yes ☐ No

Emergency Contact
(Not in your household) ______________________ Phone #: ________________

I understand that office visit charges are payable on the day of service is rendered. I authorize Newman, MD Plastic Surgery to bill my insurance company for treatment. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

SIGNATURE____

* $25 "Newman Dollars" credit will be applied to current patient accounts for new patient referrals. Credit good for 6 months.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Newman, MD Plastic Surgery for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Newman, MD Plastic Surgery. I understand that diagnosis or treatment of me by Dr.   may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Newman, MD Plastic Surgery is not required to agree to the restrictions that I may request. However, if Newman, MD Plastic Surgery agrees to a restriction that I request, the restriction is binding on Newman, MD Plastic Surgery . .

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr.   or Newman, MD Plastic Surgery has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Newman, MD Plastic Surgery's Notice of Privacy Practices prior to signing this document. The Newman, MD Plastic Surgery's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Newman, MD Plastic Surgery. The Notice of Privacy Practices for Newman, MD Plastic Surgery is also provided **200 N. College Street, Mountain Home, AR 72653.** This Notice of Privacy Practices also describes my rights and the Newman, MD Plastic Surgery's duties with respect to my protected health information.

I hereby authorize Newman, MD Plastic Surgery to use and/or release the above-named individual's protected health information (i.e., medical information or PHI), for medical reasons only. This authorizes Newman, MD Plastic Surgery to request my health records.

Newman, MD Plastic Surgery reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Newman, MD Plastic Surgery's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Newman, MD Plastic Surgery

Patient Name:
Procedure Date:

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, , authorize Dr Newman. and/or Newman, MD Plastic Surgery, representative(s), to take photographic documentation of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please **initial** in the boxes marked Yes or No for each item)

Yes	No	Medium
		in the office **photo album** for prospective patients.
		in office **seminars** for prospective patients.

I understand that:

1. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to **Newman, MD Plastic Surgery.** A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. If I do not revoke this authorization, it shall not expire.

2. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

3. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law. I release and discharge Dr. and/or Newman, MD Plastic Surgery from all liability, including liability for negligence, that in any way arises out of: any and all rights that I may have or may have had in the photographs that I have authorized to be used and disclosed in this Authorization. This Authorization is made as a voluntary contribution in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand its terms. For perspective patients, your identify is never released or associated with your photopraphs.

Patient is a minor years of age, and we, the undersigned, are the parents or guardian of the patient and do hereby consent for the patient.

Signature ______________________________ Date ________________

Witness ______________________________

Patient Initials: ________

Newman MD Plastic Surgery

200 N College Street | MOUNTAIN HOME AR, 72653 | (870) 425-6398

Written Financial Policy

Thank you for choosing Newman MD Plastic Surgery. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

<u>You may choose from these payment options:</u>

- Cash, Check, Visa, MasterCard, American Express, Discover Card or Care Credit Cards.

We offer a 5% courtesy accounting adjustment to patients who pay for their surgery with cash prior to completion of care. The 5% adjustment is for surgeries only.

Please provide a copy of your driver's license and insurance cards upon completion of paperwork. Co-Pays are due at check in. Unless otherwise noted on insurance card, co-pays are $50 for specialty physicians. Cosmetic and Self-Pay Consults are $100 and due upon check-in. If your insurance deductible has not been met, the deductible amount is required two weeks prior to surgery date. A $250 non-refundable cancellation fee of $250 will be charge on all surgeries cancelled with less than two weeks notice.

For patients with insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. Yet, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees. If and when your insurance carrier provides payment for your benefit, we will refund any duplicate payment made by you directly to you. In the event of balance not covered by insurance, we work with each individual to set up appropriate payment plans to reduce the financial stress to your household. Newman MD Plastic Surgery charges $25 for returned checks. We charge 15% interest on all past due accounts.

In the event that a balance is outstanding for more than 90 days, I agree Newman MD Plastic Surgery, or any collection/servicing agency retained to collect balance due may contact me by phone, cellular device, mail and email.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you want or need.

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Patient, Parent or Guardian Signature Date

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Patient Name (Please Print)