pediatrix | PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH

☐**New Patient**
☐**New Insurance**

What is your primary language? ☐**English** ☐ **Spanish** ☐**Other**_____

Patient Information		
Name Last:	First Name:	Middle Initial:
Ethnicity: ☐Hispanic ☐Not Hispanic	Race: ☐Asian ☐Black ☐White ☐Other	
Email:		
Address:	*Phone* Home: Work: Cell: Email:	
City: Zip:	Date of Birth:	
Occupation:	Social Security #:	
Employer: Employer Address:	Marital Status: M D W S ☐ ☐ ☐ ☐	
Name Referring MD/Phone Address:	Emergency Contact/Phone/Address:	

Insurance Information	
Patient's relationship to Insured ☐ Self ☐ Spouse ☐ Child	☐ Self ☐ Spouse ☐ Child
NAME OF PRIMARY INSURANCE COMPANY:	NAME OF SECONDARY INSURANCE COMPANY:
☐HMO ☐PPO ☐ POS ☐EPO ☐Other	☐HMO ☐PPO ☐ POS ☐EPO ☐Other
Address:	Address:
Insured's Name:	Insured's Name:
Phone Home: Work:	*Phone* Home: Work:
Social Security #: Date of Birth:	Social Security #: Date of Birth:
Insured's Employer:	Insured's Employer:
Insured Employer Address/Phone:	Insured Employer Address/Phone:

pediatrix | PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH

Group No.: Effective Date:	Group No.: Effective Date:
Policy No:	Policy No:

I hereby assign to this Practice, my physician or other healthcare professionals involved in my care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available, to pay for all services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. I understand that I am responsible for all charges (hospital and/or physician) until the bills are paid in full and for the balance of charges not covered by insurance.

Signature_____Date_____

YOU MUST BE PREPARED TO PAY YOUR COPAY AND DEDUCTIBLE AT THE TIME OF YOUR APPOINTMENT TO AVOID A DELAY IN SEEING THE PHYSICIAN

pediatrix | PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH

CONSENT FOR TREATMENT
AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

PARTICIPATING INSURANCE – I hereby give consent to **PEDIATRIX PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH** to provide whatever treatment they may deem necessary to me or my dependent, _____. I hereby request payment of authorized benefits and/or any insurance benefits to be paid directly to **PEDIATRIX PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH** for any service furnished to me by **PEDIATRIX PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH**. I authorize **PEDIATRIX PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH** and staff to release to my insurance carrier and its agents, any information concerning healthcare, advice, or treatment provided to me or my dependent _____, that is needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for charges not covered by the insurance policy, and should it become necessary to collect the charges through an attorney or other collection process, I shall be responsible for all costs.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed name of Patient or Authorized Representative Date

pediatrix | PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1. _____

2. _____

3. _____

4. _____

___ Yes ___No The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

The practice staff have my permission to leave messages concerning treatment (i.e., Lab Results) on my: (Please check all that apply)

__□ Home Voice Mail or Answering Machine Home Phone number: _____

__□ Cell phone Cell phone number: _____

__□ Work Voice Mail Work phone number: _____

__□ **NO INFORMATION:** I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

_____ _____

Print Name of Patient *Print Name of Authorized Representative

_____ _____

Patient/Authorized Representative Signature Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

o Parent/legal guardian □ Power of Attorney

*Evidence of authority must be provided and on file with the practice.

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of my electronic health record, **PEDIATRIX PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH** will transmit my prescriptions electronically as permitted, to the pharmacy that I delegate as my primary pharmacy provider. Additionally, **PEDIATRIX PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH** will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health record.

E-Prescribing greatly reduces medication errors and enhances patient safety. Features of our ePrescribe program include:

- Formulary and benefit transactions- Provides us with information about which drugs are covered by the drug benefit plan.
- Medication history transactions- Provides us with information about medications you are already taking.
- Fill status notification- Sends us an electronic notice that your prescription has been picked up.

By signing this consent form you are agreeing that we can ePrescribe for you and request your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

☐ I hereby provide informed consent to enroll me in the ePrescribe program.

☐ I decline this option. I do not give permission for access to the above information.

Pharmacy Information

Pharmacy Name: _____

Address: _____

Phone: _____

Fax: _____

_____ _____

Signature of Patient or Legal Representative **Date**

pediatrix | PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to **privacy_officer@mednax.com** or a letter to:

Chief Privacy Officer MEDNAX Services,
Inc. 1301 Concord Terrace

Sunrise, FL 33323

By signing this form, you are only acknowledging that you have been provided our Notice.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Print Name of Patient/Authorized Representative

pediatrix | PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH

AUTHORIZATION FOR OBTAINING AND DISLOSING PROTECTED HEALTH INFORMATION

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**

Provider's Name:	**Recipient's Name:**
Provider's Address:	**Recipient's Address:**

Provider's Phone Number:	**Provider's Fax Number**	**Recipient's Phone Number**	**Recipient's Fax Number**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure: Media Social Media
Other (explain)_____

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
Intake Form Chart Notes Consultation Report Laboratory Results Operative Report Procedure Note		Diagnostic tests Echo Report EKG Stress Test Special Test/Therapy Ultrasound Report		Monitoring Report All PHI in medical record Itemized bill: Other: Other: Other:	

I understand that:

I may refuse to sign this authorization and that it is strictly voluntary.
My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken in reliance on this authorization prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
If the requester or receiver is not a health plan, health care provider, healthcare clearing house or business associate of such health plan, health care provider or health care clearing house the released information may no longer be protected by federal privacy regulations and may be redisclosed.
I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
I may receive a copy of this form after I sign it.

Section B: The request of PHI is for the purpose of marketing or for the sale of PHI

Will the recipient receive direct/indirect payment in exchange for using/ disclosing this information for marketing?	Yes	No
If yes, describe:		
Will the recipient receive financial or in-kind compensation in exchange for the sale of this information?	Yes	No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Indicate authorized representative's authority to act on the patient's behalf: (circle one)

o Parent/legal guardian
o General power of attorney
o Limited power of attorney
o Other (Please describe): _____

pediatrix | PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH

AUTHORIZATION FOR THE USE OR RELEASE OF PHOTOGRAPHS
(All Subjects Must Sign)

Subject to the terms and conditions contained in this form, I hereby expressly authorize **PEDIATRIX PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH** to use or disclose for non-treatment purposes photographs/images/videos taken of _____.

1. **The Practice** must answer the following statements:

   Photographs may be used for one or more of the following purposes (check all that apply):

   Media request _____ (e.g., television spots, newspaper and magazine articles)

   Marketing _____ (e.g., informational brochures and mailings, newsletters and handouts)

   Advertising _____ (e.g., TV, Newspapers, Magazines and Posters)

   Medical education _____ (e.g., medical students, physicians and other ancillary professions)

   Medical research _____ (e.g., case studies and academic presentations)

2. **Patient or responsible party** must review the following statements:

   a. I expressly authorize the following (initial all that apply):

      i. The use of my and/or my child's name in connection with the photographs, images and/or videos: Initials: _____

      ii. The disclosure of my and/or my child's medical condition and related treatment in connection with the photographs, images and/or videos: Initials: _____

   b. Upon request, I am entitled to receive a copy of this form after I have signed it.

   c. I understand that the Practice will provide medical treatment, if applicable, regardless of whether or not I sign this form.

   d. I understand that I may revoke this authorization at any time by notifying the Practice in writing at: Compliance Department, 1301 Concord Terr., Sunrise, FL 33323. If I revoke this authorization, I understand that it will not apply to any actions taken by the Practice before it received the revocation.

   e. I understand that this authorization will expire ten (10) years after I execute this form, unless I revoke it in accordance with paragraph (d) above or I specify another expiration date or event (if applicable, specify alternate expiration date: _____).

   f. I understand that the Company may only use and disclose the photographs, images and/or videos and related health information in accordance with this specific authorization. However, such information may be subject to further disclosure by third parties who are not bound by this authorization.

3. I agree that subject to the following limitations, the Company may select and utilize the photographs, images, and/or videos that best suit the uses and disclosures authorized in Section 1.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Name

_____

Witness

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION