COMMONWEALTH
FACIAL PLASTIC SURGERY

Patient Information

Referring Physician _____ Primary Care Physician _____

Patient's Full Name_____

Date of Birth_____/_____/_____ Age _____ Sex: ☐ Male ☐ Female Social Security # _____

Address_____ Apt. # _____

City_____ State_____ Zip code_____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Email Address _____Patient's Employer _____

Preferred Method of Contact ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

Pharmacy Name _____ Pharmacy Number_____

Race_____ Ethnicity_____

Language_____

Spouse's Name_____ Date of Birth_____/_____/_____

Spouse's Social Security # _____ Spouse's Phone _____

Spouse's Employer

_____

Responsible Party

If you are providing the information above for a patient under the age of 18 years old, please complete this section below:

Father/Guardian's Name_____

SSN_____

DOB_____/_____/_____Phone(____)_____ Relationship to Patient _____

Address (If different from above)

_____

Employer_____ Work Phone(____)_____

Mother/Guardian's Name_____

SSN_____

DOB_____/_____/_____Phone(____)_____ Relationship to Patient _____

Address (If different from above)

_____

Employer_____ Work Phone(____)_____

Insurance Information

Insurance Company_____ Policy ID#_____ Group#
_____
Policy Holder's Name_____DOB_____/_____/
_____
Address _____Phone_____Relationship to
Patient_____
Secondary Insurance Company _____ Policy ID#_____ Group#
_____
Policy Holder's Name_____DOB_____/_____/
_____
Address _____Phone_____ Relationship to
Patient_____
Is today's visit pertaining to a motor vehicle accident or a workman's comp injury? □ Yes □ No
If you answer yes please complete the following information:
Insurance Company
Name_____
Agent Name/Contact Name_____ Phone
(____)_____
Claims/Billing
Address_____
Claim#_____ Date of Accident or
Injury_____

Patient Acknowledgement of Financial Responsibility

I hereby authorize Commonwealth ENT Specialists, P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Commonwealth ENT Specialist, P.C. of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

_____ _____
Patient's Signature (or responsible party) Date

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

_____ _____
Signature Date

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

Consent For Use Or Disclosure of Patient Information For The Purposes of Treatment, Payment, And Healthcare Operations

I hereby consent to Commonwealth ENT using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Commonwealth ENT using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

_____ _____

Patient's Signature (or responsible party) Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

Patient's Consent for Provider to Disclose PHI to Authorized Persons

I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the person indicated below.

Persons to Whom Disclosure May be Made. Provider may disclose my PHI to the following persons:

Name	**Relationship**	**Contact #**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Purpose of Disclosure - The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

Expiration of Authorization - This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

Conditioning of Treatment - Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

Redisclosure by Recipient - I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.

Acknowledgment of Reading and Agreement – I have read and understand this authorization.

_____ _____

Patient Name or Representative Date

_____

If a Representative Signs, state the Representative's Authority