COMMONWEALTH
FACIAL PLASTIC SURGERY

This form must be completed (front and back)

PATIENT INFORMATION

What Physician requested this consultation: _____

Patient's Primary Care Physician: _____

Patient's Full Name _____

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

Patient's Home Address _____ Apt. # _____

City_____ State_____ Zip Code _____

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

Home Email _____ Patient's Employer _____

Spouse's Full Name_____ Date of Birth _____/ _____/_____

Spouse's Social Security #_____ - _____ - _____ Spouse's Work Phone (_____)_____

Spouse's Employer _____

RESPONSIBLE PARTY

If you are providing the information above for a patient under the age of 18 yrs. old, please complete the 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 Holder ID# _____ Group# _____

Policy Holder Name _____ DOB _____/ _____/_____

Address _____ Phone (_____) _____ Relationship to Patient_____

Secondary Insurance Company _____ Policy Holder ID# _____ Group# _____

Policy Holder 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 fill out 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 _____

SPECIFIC INFORMATION RELEASE (if applicable)

I request and authorize Commonwealth ENT Specialists, P.C. to disclose protected health care information to the individual(s) listed below.

A. Name(s): _____ Contact # _____

_____ Contact # _____

_____ Contact # _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding 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 _____