LAUGHLIN
Plastic Surgery

Laughlin Plastic Surgery, LLC
166 Defense Highway, Suite 101
Annapolis, MD 21401
410-224-2020

Name: _____ Age: _____ Date of Birth: _____Sex: F M

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ SS#: _____

Street Address: _____ City: _____ Zip: _____

Reason for Today's visit: _____How did you hear about us? _____

Marital Status: Single Married Divorced Widowed

Emergency Contact: _____Relationship: _____Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Employer: _____ Occupation: _____

Did you receive a copy of the HIPPA notice? Yes ____ No____ Do you give permission to leave a voicemail? Yes ___ No ____

Insurance Info:

Primary Health Insurance: _____ ID#: _____

Group#: _____ Subscriber: Self _____ Spouse _____ Other _____

Subscriber's Name: _____ DOB: _____

Secondary Health Insurance Name: _____ ID#: _____

Group #: _____ Subscriber: Self _____ Spouse _____ Other _____

Subscriber's Name: _____DOB: _____

All patients are required to complete our registration form, provide us with a valid medical insurance card and a photo ID, as well as new insurance cards as they become available. We accept assignment of insurance benefits as a courtesy to our patients; however the balance is your responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be your responsibility. Please be aware that some services provided may not be covered and may not be considered medically necessary, under Medicare and other insurances. Patients will be responsible for payment in full at the time of visit, unless valid insurance is presented. All copayments are to be paid at the time services rendered.

I HAVE CAREFULLY READ AND UNDERSTAND AND AGREE TO THE OFFICE POLICY OF LAUGHLIN PLASTIC SURGERY, LLC.

_____ _____

Signature of Patient or Parent/Legal Guardian (if under 18) Date

Medical History Questionnaire
(Confidential Information)

Patient's Name: _____ Date: _____

Reason for Visit: _____

Height: _____ Weight: _____

Do you smoke or use any nicotine replacement product? _____ If so, how much per day? _____

Medical History: Please check the following

High Blood Pressure……yes____no____

Bleeding Disorder…….yes____no____

Anemia…….yes____no____

Liver Disease…….yes____no____

Heart Disease……yes____no____

Psychiatric Illness……yes____no____

HIV…….yes____no____

Skin Disease……..yes____no_____

Thyroid Disease……..yes____no_____

Lung Disease…….yes____no_____

Tuberculosis……..yes____no_____

Shortness of Breath..yes____no_____

Hepatitis……yes____no_____

Diabetes…….yes____no_____

Please list any other medical history the doctor should be aware of:

_____

Please list all previous surgeries, as well as cosmetic:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Please list any complications or problems you experienced during or following the above procedures:

_____

Family History: (serious illnesses; cancer, etc)

_____

Medical History Questionnaire (cont'd)
(Confidential Information)

MEDICATIONS: Please list medications you currently take, including appetite suppressants, vitamins, etc.

_____

_____

Do you take any Aspirin or any Aspirin-containing compound? _____If yes, explain below:

_____

_____

Do you have any **ALLERGIES and/or SENSITIVITIES** to the following medications:

Penicillin……..yes_____no_____

Sulfa……yes_____no_____

Codeine……yes_____no_____

Latex……..yes_____no_____

Other Antibiotics (list)……yes_____no_____

_____

Aspirin……..yes_____no_____

Xylocaine…….yes_____no_____

Adhesive tape……..yes_____no_____

Tetanus Toxix……yes_____no_____

Any other allergies not listed above: _____

_____

Do you wear eyeglasses or contacts? _____

Primary Physician: _____ Date of last check-up? _____

Phone #: _____

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410-224-2020 ~ 410-224-2021 (Fax)

ASSIGNMENT OF BENEFITS

I, _____, understand that services rendered to me by Laughlin Plastic Surgery, LLC/C. Daniel Laughlin, M.D. are my financial responsibility and that the provider will bill my insurance company. I authorize my insurance company to pay my benefits directly to Laughlin Plastic Surgery, LLC/C. Daniel Laughlin, M.D. and I understand that I will be fully responsible for any amount allowed and not paid by insurance company. I am also responsible for any Deductible, Copay and/or Co-insurance.

If my account is turned over to a collection agency or taken to court, I agree to pay any collection fees, reasonable legal fees (25%), court cost and other expenses incurred as a result of said collection or court date.

I authorize the provider to release any information necessary to adjudicate my claims.

I also understand that should my insurance company send payment to me, I will forward the payment to the office in a timely manner.

I certify that the information I have provided with regard to my insurance coverage is current and correct. I agree to continually provide current and accurate health insurance information should any changes occur. I agree to notify the office of any updated insurance information prior to any services being rendered.

I authorize the Laughlin Plastic Surgery, LLC/C. Daniel Laughlin, M.D. to initiate a complaint or file an appeal to my insurance company and/or the insurance commissioner on my behalf and I personally will be active in the resolution of any claim delays, unjustified reductions or denials.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The Notice contains a patient's rights section described your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES** **NO**

May we leave a message on your answering machine at home or on your cell phone? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

If YES, please name the members allowed:

_____

This consent was signed by _____
(PRINT NAME)

Signature: _____

Witness: _____