455 Patroon Creek Blvd, Suite 101, Albany, NY 12206
Telephone: (518) 438-0505 | Fax: (518) 438-4517

PATIENT INFORMATION

Last Name: ____________ Suffix: ______ First Name: ____________ Middle Initial: ______

Date of Birth: ____________ Marital Status: ____________

Sex: Female / Male / Non-Binary / Other

Address: ________________________

City: ____________ State: ____________ Zip Code: ____________

Home #: ____________ Cell #: ____________ Work #: ____________

Social Security #:____________Employer:____________Student: Yes / No

Preferred Language (optional):____________Ethnicity (circle one): Hispanic / Other

Race (circle one): Caucasian African American Asian American Indian Other: ____________

Appointment Reminder: [ ] Email [ ] Text [ ] Voicemail (circle one): Home / Mobile

Email Address:____________Would you like to receive our e-newsletter?: Yes / No

Primary Care Physician: ____________ Phone #: ____________

Referring Physician: ____________ Phone #: ____________

Contact in case of emergency: ________________________

Relationship:____________Phone #: ____________

Pharmacy Preference: ____________ Address: ____________ Phone #: ____________

Primary Insurance:____________Subscriber #: ____________

Group #:____________Copay: ____________

POLICYHOLDER INFORMATION (please complete this section if different from the patient information above)

Last Name: ____________ First Name: ____________ Middle Initial: ______

Address:____________City: ____________

State: ______ Zip Code: ______ Social Security #: ____________ Date of Birth: ____________

Relationship to Patient: ____________ Employer: ____________ Phone #: ____________

Secondary Insurance:____________Subscriber #: ____________

Group #:____________Copay: ____________

POLICYHOLDER INFORMATION (please complete this section if different from the patient information above)

Last Name: ____________ First Name: ____________ Middle Initial: ______

Address:____________City: ____________

State: ______ Zip Code: ______ Social Security #: ____________ Date of Birth: ____________

Relationship to Patient: ____________ Employer: ____________ Phone #: ____________

Is injury work related?: Yes / No (If yes, please fill out additional information worksheet)

Is injury related to car accident?: Yes / No (If yes, please fill out additional information worksheet)

PLEASE COMPLETE REVERSE SIDE

I HEREBY CONSENT TO THE FOLLOWING:

Authorization

I authorize The Plastic Surgery Group/Plastic Surgery Associates, LLP to release all medical records pertaining to medical history, services rendered or treatment for me or my dependents for insurance claims.

I authorize payment of benefits to the Plastic Surgery Group/Plastic Surgery Associates, LLP.

I promise as guarantor for the above patient, to pay for medical services at the time of my service, unless prior arrangements have been made.

I understand that I am financially responsible for all charges incurred, whether or not they are covered/paid by my insurances.

Permission for Taking Photographs

I hereby consent that photographs may be taken of me or the names patient by The Plastic Surgery Group/Plastic Surgery Associates, LLP in connection with the medical care and treatment received.

I **give / do not give** (circle one) permission for my photographs to be used for educational purposes.

Consent to Release and HIPAA Acknowledgment

I hereby authorize The Plastic Surgery Group/Plastic Surgery Associates, LLP to discuss my medical and payment information with:

1. ______________________________ Relationship:______________________________
2. ______________________________ Relationship:______________________________
3. ______________________________ Relationship:______________________________
4. ______________________________ Relationship: ______________________________

I acknowledge that I have received a copy of The Plastic Surgery Group/Plastic Surgery Associates, LLP's Notice of Privacy Practices. This notice describes how The Plastic Surgery Group/Plastic Surgery Associates, LLP may use or disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____ ______________________________

Patient/Guardian Signature Date