GAUTHIER
PLASTIC SURGERY

PATIENT INFORMATION

NAME:_____
(Last) (First) (Middle) (Mother's Maiden Name)

ADDRESS:_____ E-MAIL: _____

CITY, STATE, ZIP:_____

HOME PHONE: (_____)_____ CELL / PRIMARY PHONE: _____

SEX:_____ AGE: _____ RACE:_____ DATE OF BIRTH: _____

MARITAL STATUS:_____ SOCIAL SECURITY: _____

EMPLOYER NAME & ADDRESS:_____

EMPLOYER PHONE: (_____)_____ OCCUPATION: _____

EMPLOYER STATUS (FULL / PART TIME / RETIRED): _____

SPOUSE NAME: _____

SPOUSE EMPLOYER & ADDRESS: _____

EMPLOYER PHONE: (_____)_____ SPOUSE OCCUPATION: _____

EMPLOYER STATUS (FULL / PART TIME / RETIRED): _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE: (_____)_____

ADDRESS: _____ RELATIONSHIP: _____

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN ABOVE

NAME:_____ HOME PHONE: (_____)_____
(Last) (First) (Middle)

ADDRESS:_____ CITY, STATE, ZIP: _____

RELATIONSHIP TO PATIENT:_____ SOCIAL SECURITY: _____

EMPLOYER NAME & ADDRESS:_____

EMPLOYER PHONE: (_____)_____ OCCUPATION: _____

ONLY IF WORKER'S COMPENSATION

EMPLOYER:_____ EMPLOYER PHONE: (_____)_____

ADDRESS:_____

WORKER'S COMP INSURANCE CARRIER:_____

ADDRESS:_____ PHONE: (_____)_____

CLAIM #: _____ WC VERIFICATION: _____ DATE OF INJURY: _____

PRIMARY INSURANCE

INSURANCE CARRIER:_____ EMPLOYER:_____

ADDRESS:_____ ID #: _____

CITY, STATE, ZIP:_____ GROUP # / NAME: _____

NAME OF POLICYHOLDER: _____ DOB: _____

RELATIONSHIP TO PATIENT:_____ SOCIAL SECURITY #: _____

MEDICAID / MEDICARE #:_____ STATE: _____

SECONDARY INSURANCE

INSURANCE CARRIER: _____

ADDRESS: _____ ID#: _____

CITY, STATE, ZIP: _____ GROUP # / NAME: _____

RELATIONSHIP TO PATIENT: _____ SS#: _____

PRIMARY CARE PHYSICIAN: _____

PHONE: (_____)_____ ADDRESS: _____ CITY, STATE, ZIP: _____

REFERRING PHYSICIAN (IF DIFFERENT THAN PRIMARY):_____ SELF OR NOT REFERRED (CIRCLE)

PHONE: (_____)_____ ADDRESS: _____ CITY, STATE: _____

HOW DID YOU HEAR ABOUT US? (CIRCLE)

FRIEND INSURANCE INTERNET MAGAZINE NEWSPAPER PATIENT PHYSICIAN TV-RADIO

UNKNOWN YELLOW PAGES OTHER_____

TODAY'S DATE: _____/ _____/ _____

GAUTHIER
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INFORMATION FOR CASE HISTORY FILE

(PLEASE PRINT) DATE: _____

PATIENT'S NAME:_____ AGE: _____ DOB: _____

OCCUPATION:_____ REFERRED BY: _____

PRESENT PROBLEM (Reason for consultation with Dr. Gauthier):_____

_____

DATE OF LAST COMPLETE MEDICAL CHECK-UP:_____ PHYSICIAN: _____

DID MEDICAL CHECK-UP INCLUDE ELECTROCARDIOGRAM?: Yes☐ No☐ CHEST X-RAY?: Yes☐ No☐

PAST MEDICAL HISTORY

_____

_____

_____

PREVIOUS SURGERY HISTORY

OPERATION	DATE OF SURGERY	SURGEON

HAVE YOU HAD SIGNIFICANT COMPLICATIONS OR ADVERSE EFFECTS AS A RESULT OF THESE OPERATIONS?: Yes☐ No☐

IF YES, PLEASE EXPLAIN: _____

_____

PLEASE LIST ALL MEDICATIONS AND DRUGS YOU ARE TAKING AT THIS PRESENT TIME:

_____ _____ _____

_____ _____ _____

_____ _____ _____

ARE YOU ALLERGIC TO ANY MEDICATIONS?: Yes☐ No☐ IF YES, PLEASE LIST MEDICATIONS YOU ARE ALLERGIC TO:

_____

PLEASE LIST ANY SERIOUS ILLNESSES YOU HAVE HAD:

_____

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISORDERS OR ILLNESSES? (PLEASE CIRCLE)

BRAIN (INCLUDING STROKES AND EPILEPSY)	FACE (PARALYSIS)	INTERNAL DISORDER
LUNGS (INCLUDING ASTHMA)	NOSE, SINUS, THROAT	BLOOD
ENDOCRINE OR DIABETES	ARMS OR LEGS	EARS
HEART OR BLOOD VESSELS	NERVOUS SYSTEM	LIVER
EYES (INCLUDING GLAUCOMA AND DRYNESS)	BREASTS	STOMACH
REPRODUCTIVE SYSTEM	URINARY SYSTEM	BONES OR JOINTS

PERTINENT PRE-OPERATIVE INFORMATION (PLEASE CIRCLE YES OR NO)

HAVE YOU EVER REACTED BADLY TO ANESTHESIA?	YES	NO
ARE YOU ALLERGIC TO ADHESIVE TAPE?	YES	NO
ARE YOU ALLERGIC TO SUTURE MATERIAL?	YES	NO
DO YOU HAVE HIGH BLOOD PRESSURE?	YES	NO
HAVE YOU EVER HAD RHEUMATIC FEVER?	YES	NO
DO YOU BLEED UNUSUALLY EASILY?	YES	NO
ARE YOU A SLOW OR POOR HEALER?	YES	NO
DO YOU FORM LARGE SCARS OR KETOIDS?	YES	NO
DO YOU HAVE FREQUENT INFECTIONS OR BOILS?	YES	NO
DO YOU HAVE ANY SKIN DISEASE?	YES	NO
HAVE YOU TAKEN STEROID MEDICATIONS? (CORTISONE)	YES	NO
DO YOU HAVE SHORTNESS OF BREATH WITH WALKING?	YES	NO
DOES YOUR RELIGION PROHIBIT BLOOD TRANSFUSION?	YES	NO
HAVE YOU EVER HAD PSYCHIATRIC CARE?	YES	NO
DO YOU SMOKE? (PKG / DAY)	YES	NO
DO YOU DRINK ALCOHOL?	YES	NO

SIGNATURE OF PATIENT_____

RELATIONSHIP TO PATIENT _____

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AUTHORIZATION FOR MEDICAL TREATMENT & FINANCIAL RESPONSIBILITY

1. CONSENT

I authorize my physician and other physicians who may attend me, their assistants, including those employed by Stephen Gauthier, MD to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may include emergency services and other special services ordered by my physician. In consenting to treatment, I have not relied on any statements as to results. I further authorize my physician or associated staff to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any bones, organs, tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis B, & C, and HIV. I also agree to update this office of any related information and health history that may change over the course of my care.

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, or related entities, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

- Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
- The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
- Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.

3. MEDICARE/OTHER INSURANCE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by our office. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

I (or my representative) certify that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand, accepts the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

4. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by our office, all physicians and services, I authorize direct payment to Stephen Gauthier, MD of all insurance benefits applicable to these medical services, which are now or which shall become due and payable. In addition, I hereby authorize payment to our office of applicable insurance benefits for medical and/or surgical services rendered by physicians or representatives for whom the entity is authorized to bill and collect.

I understand that Stephen Gauthier, MD may utilize facilities or other services in our out of my insurance network. Fees or other concerns associated with such interactions should be addressed with that entity directly. Certain ancillary services (i.e. lab work or pathology) or facilities that are routinely out-sourced by the practice may not be partially or fully covered by my insurance. We can never guarantee that other consultants or services will be covered by my insurance plan. I understand that I should contact my insurance for further information. I also understand that if my insurance plan has specific restriction on such services, I need to make a written request in advance of care for special accommodations. I some cases, based on the restrictions of the insurance plan, accommodations cannot be made and an out of pocket cost may be incurred if care is to be provided. We may on occasion utilize facilities or services in which it has direct interest or ownership.

Patients who request evaluation for a medical condition through insurance will be billed based on a standard fee schedule. It is noteworthy that the actual fee paid is often significantly reduced due to contractual agreements. Those conditions deemed medically indicated, which are generally covered by insurance, will be billed based on a pre-determined fee schedule. Cosmetic consultation fees and other associated discounts are only applicable for visits for cosmetic conditions. This practice reserves the right at any time to cancel, not renew, or re-negotiate any health plan based on contract terms.

5. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the patient by Stephen Gauthier MD, the undersigned agrees, whether he/she signs as patient or guarantor, to pay Stephen Gauthier, MD and related facilities for all services ordered by the physician, or requested by the patient and/or the patient's family. If the requirements for referral, second opinion, pre-certification of care, hospitalization, or surgery as otherwise outlined by the insurer, benefit plan or other payer, have not been fully followed, the patient/or guarantor agrees to be personally responsible for all charges incurred. We intend to provide timely invoices, but due to the complexities of medical billing, delays may occur. Please contact this practice or the billing company if there is concern about the invoice. Patients may request, or may be required, to file their own insurance claims. If the patient/or guarantor fails to pay within a timely manner or payment is invalid or insufficient, then extra charges will be incurred, and a collection agency will be utilized.

6. FINANCIAL POLICY

You are responsible for payment of all medical treatment and related services provided by this practice. As a service and out of consideration to you, this office will, in most cases, file insurance claims for applicable covered services. You are responsible for any deductibles or co-payments and any non-covered services incurred. You agree to pay these fess regardless of your interpretation of information provided from our staff or physician, and you agree to be responsible for interpreting the complexity of your own health plan.

If you are being seen for cosmetic reasons, we do require that you have insurance, in the event of any unforeseen circumstances (i.e. lab work, pathology, hospitalization).

7. RELEASE OF INFORMATION TO FAMILY AND FRIENDS

I authorize the following persons (or class of persons) to receive my protected health information: _____

_____

HIPPA-NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been provided the opportunity to receive a copy for review only of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared, I acknowledge, Dr. Gauthier, this practice and other staff may use and share my confidential health information with others in order to treat me, and to arrange for payment of my bill and for issues that concern our operations and responsibilities.

Initials of patient or person authorize to sign HIPAA for patient _____

_____ _____

SIGNATURE OF PATIENT OR PERSON DATE PATIENT'S RELATIONSHIP TO PERSON

_____ _____

SIGNATURE OF GUARANTOR DATE PATIENT'S RELATIONSHIP TO GUARANTOR

_____

SIGNATURE OF WITNESS DATE

GAUTHIER
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PERMISSION FOR PHOTOGRAPHY

I hereby voluntarily grant permission to Dr. Gauthier and/or his or her designated representatives to take and use clinical photographs with the understanding that such photographs are for confidential, clinical record purposes, and that all photographs remain the property of the doctor.

Occasionally, such photographs are used for teaching purposes, research, medical publications, medical, as well as public education and for patient information and education and for patient information and education.

I will / will not (circle one) permit the use of my photographs for such ethical professional purposes.

_____ _____

SIGNATURE DATE

_____

BIRTHDAY

_____ _____

WITNESS DATE