SEIDEL PLASTIC SURGERY

Dr. Steven Seidel
Dr. Morgan Martin

Primary Physician: _____ Date: _____

Patient Name: Last _____ First _____ Middle _____

Address: _____

City: _____ State: _____ Zip: _____ _____

Date of Birth: _____ Social Security #: _____

Primary phone: _____ Secondary phone: _____

Email: _____

Sex: _____ Race: _____ Marital Status: _____ Retired: _____ Employed: _____ Student: _____

Employer: _____ Employer Phone: _____

Person Responsible for account: _____ Relationship: _____ _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

Spouse's Name: _____ Employer: _____ Phone: _____

Relatives or friends that are patients: _____

Drug Allergies: _____

Present Medications: _____

_____

_____

Major Medical Problems: _____

Insurance Policy Information

Insurance Company (primary): _____

Policy Holder's Name: _____ Birthdate: _____/_____/_____

Employer: _____

Contract #: _____ Group # _____

Relationship of patient to policy holder: _____

Insurance Company (secondary): _____

Policy Holder's Name: _____ Birthdate: _____/_____/_____

Employer: _____

Contract #: _____ Group # _____

Relationship of patient to policy holder: _____

Referred by: _____

CONSENT FOR TREATMENT- I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of x-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION- I authorize Seidel Plastic Surgery to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to any on the job injury.

ASSIGNMENT OF BENEFITS- I hereby authorize payment directly to Seidel Plastic Surgery of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed Seidel Plastic Surgery charges for these services. I understand that I am financially responsible to Seidel Plastic Surgery for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF PAYMENT- For services furnished by Seidel Plastic Surgery I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney fees. I agree to pay 27% of the unpaid and past due principal balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable to such additional reasonable court costs and attorney's fees as may be determined by a court.

SIGNATURE: _____ DATE: _____

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PLASTIC
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Privacy Notice

Seidel Plastic Surgery is dedicated to protecting the privacy of each and every patient.

It is your right to receive quality care without concern that your personal health information will be shared or disclosed to others. Your medical information is protected by law and will only be used in treatment, payment and healthcare operation scenarios. Employees of Seidel Plastic Surgery and affiliated business associates have signed confidentiality statements and contractual agreements to follow the policies and procedures of our practice in protecting your privacy.

While disclosures of personal health information to doctors, nurses and specialists is often necessary for treatment, your medical information will not be sold to any outside agency or pharmaceutical company nor will it be released for any reason other than treatment, payment, healthcare operations or when required by state or federal laws without your written authorization.

You have to right to access and request changes to your medical records, find out what disclosures have been made and request restrictions on uses and disclosures of your health information

Signature_____

Date_____

Names of those we may release your medical information to:

_____	_____
Name	Phone Number and relationship
_____	_____
Name	Phone Number and relationship
_____	_____
Name	Phone Number and relationship