CHARLOTTE
PLASTIC SURGERY.

Date ________________________ Chart # ________________________ Doctor _____________________

Last Name ____________________________ First Name __________________________ Middle Initial ____

Is this your legal name? ( ) Yes ( ) No If no, please give legal name ____

DOB __________________________ Age __________ Sex ( ) Male ( ) Female

Social Security # ______________________________ Marital Status ( ) Single ( ) Married ( ) Divorced ( ) Widow

Address ____

City ____ State ________ Zip Code __________________

Provide your email address so we may notify you of specials ____

Reason for Consult ____
____

Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number ________________________ Cell Telephone Number __________________________

_______ OK to leave message with detailed information
_______ Leave message with call back numbers only

______ OK to leave message with detailed information
______ Leave message with call back numbers only

Work Telephone Number _________________________
_______ OK to leave message with detailed information
_______ Leave message with call back numbers only

Other
______ OK to mail information to home address
______ OK to email information

Emergency Contact Information:

Name _________________________________ Relationship__________________________ Phone __________________

How did you hear about us? Please check **all** that apply:
( ) Dr ______________ ( ) Another Patient ____________________ ( ) Family/Friend ( ) Magazine/Newspaper
( ) Yellow Pages ( ) TV/Radio ( ) Web ( ) Hospital ( ) Spa/Salon/Gym ( ) Other _______________

see other side

HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE

Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment related to my health care. In that case, Charlotte Plastic Surgery will disclose only information that is directly relevant to the person's involvement with my health care or payment.

Print Name:______________________________ ☐ Health Information ☐ Billing Information

Relationship:______________________________

Print Name:______________________________ ☐ Health Information ☐ Billing Information

Relationship:______________________________

With five board certified surgeons at Charlotte Plastic Surgery, all of your questions will be answered by a knowledgeable and trained physician. In order to find the right fit for you, we offer the opportunity to speak to any or all of the Charlotte Plastic Surgery physicians.

Financial Statement: If you decide to have procedures performed or services rendered which are non-covered procedures or services under your insurance policy, you agree to pay Charlotte Plastic Surgery directly for those charges in advance.

Acknowledgement of Charlotte Plastic Surgery's Notice of Privacy Practices:

By signing my name below I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP) and that I have read (or had the opportunity to read if I so chose) and understand the NPP and agree to its terms.

____
Name of Patient (Print)

____
Signature / Date

____
Witness signature / Date