

Plastic Surgery Specialists, Inc

Personal Information

Patient Name _____ Sex: M F

Age _____ Date of Birth _____ Social Security Number _____

Address _____
(Street) (City) (State) (zip)

Home phone (____) _____ Other phone(____) _____

E-mail _____

Employer _____ Marital Status S M D W

We may release medical information to the following people:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Insurance Information

Insurance Carrier _____ Subscriber _____

Subscriber DOB _____ Subscriber SS# _____

Subscriber Employer _____

Consent for Use and Disclosure of Medical Information for Treatment, Payment and Health Care Operation.

I authorize the release of my health information regarding services rendered by the practice to my insurance company or any government payer or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also authorize the Practice to release medical information about me to other health providers for treatment purposes. In addition, if the patient is a minor child, I as a parent or guardian, authorize the release of medical information to the child's other parent or the person(s) that I have listed above as being responsible for the medical bill. I understand that this authorization to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes or for purposes of subsequent treatment. Further, this authorization is valid for the disclosure of medical information contained in hard copy or electronic form (e-mail) and facsimile. Finally, I understand that the Practice may use and/or disclose certain information about me in order for it to carry out its various health care operations. This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately except to the extent that the Practice has taken action in reliance upon my consent. I hereby assign to the Practice all payments for medical services rendered to my dependents or myself. I understand that I am responsible to any amount not covered by my insurance.

Authorized Signature: _____ **Date** _____

Relationship to patient: _____

Dr. Pan is an investor in Butler County Medical Center. At times, Dr. Pan refers patients to Butler County Medical Center in connection with their care and treatment.