SEIDEL
PLASTIC
SURGERY

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:

_____

_____

Past Surgeries:

_____

_____

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 understand that payment is due at the time of service. "I agree to pay collection fees of 33 1/3% of the unpaid balance at such time that my account is placed with a collection agency. I further agree that I am responsible for all costs associated with the collection of my account, including but not limited to postage costs, and all credit card processing costs. In the event my account is referred to an attorney for collection, I agree to be liable for attorney's fees of 33 1/3% of the unpaid balance, and all costs of court. I also authorize my employment location and status to be verified for the purpose of processing my bill for payment."
I authorize the use of the phone numbers and other contact information I provide, including my cellular number and any future number assigned to me, for calls, texts, emails, to include automated dialers, to contact me regarding my care and my account by this medical provider and this medical provider's business associates.

Responsible Party Signature: _____
DATE: _____

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. Your personal health information is protected by law and will be used only 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 disclosure 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 without your written authorization for any reason other than treatment, payment, healthcare operations or when required by state or federal laws.

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

This privacy notice is subject to change.

Signature_____

Date_____

Please list names of those to whom we may release your medical information. If someone is not on this list we CANNOT release any medical information about you, this includes spouses.

_____ Relation to patient:_____
(Name & phone number)

_____ Relation to patient:_____
(Name & phone number)

_____ Relation to patient:_____
(Name & phone number)