

REGISTRATION

(please print)

JOHN H. BROWN, MD
Plastic and Reconstructive Surgery

PART 1.

Patient _____ Sex ____ M ____ F
Address _____
City _____ State _____ Zip _____
Soc Sec. # _____ Birth date _____ Marital Status _____
Home Phone _____ Work _____ Ext. _____
Cell Phone _____ Preferred Contact Home ____ Work _____ or Cell _____
Emergency Contact _____ Relationship _____
Home _____ Work _____ Cell _____
If Patient is a minor: Name of Parent or Guardian _____
Student ____ Full-time ____ Part-time Employment Status: ____ Full-time ____ Part-time
Occupation _____ Name of Employer _____
Employer Address _____ Business Phone _____
Referring Doctor _____ Primary Care Physician _____
Who may we thank for your referral? _____

Part 2.

Do you have medical insurance? ____ NO ____ YES If Yes,
Primary Insurance Company _____ Name of insured _____
Address _____ Employer _____
Insured Date of Birth _____ Insured Soc. Sec. # _____
Phone # _____ Relationship to Patient _____

Secondary Insurance Company (if any) _____ Name of insured _____
Address _____ Employer _____
Insured Date of Birth _____ Insured Soc. Sec. # _____
Phone # _____ Relationship to Patient _____

Part 3.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
(Name of insurance company)
and assign directly to Dr. John H. Brown, MD all medical benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the
doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on
all my insurance submissions.

X _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to
Dr. John H. Brown, MD for any services furnished me by that physician. I authorize any holder of medical information
about me to release to the Health Care Financing Administration and its agents any information needed to determine
these benefits or the benefits payable for related services. I understand my signature requests that payment be made
and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in line
9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature
authorizes releasing of the information to the insurer or agency shown.

X _____ Date _____

HEALTH HISTORY

Name _____

Age _____ Birthdate _____ Height _____ Weight _____

Reason for visit:

IF MEDICAL CONDITION IS DUE TO AN INJURY, PLEASE COMPLETE AN INJURY FORM AVAILABLE AT THE FRONT DESK.

Family Doctor _____

Allergies _____

Do not smoke? _____ If so, how much _____

List medications you are currently taking:

Preferred Pharmacy: _____

Circle any of the following over-the-counter medications you have taken in the past 10 days:

Advil Aspirin Bufferin Ibuprofen Motrin Arthritis Medication

Other _____

Past Medical History: (Illnesses, Injuries, Hospitalizations, Surgeries)

Check if your blood RELATIVES have or had any of the following conditions:

_____ Cancer	_____ Heart Disease	_____ Epilepsy
_____ Diabetes	_____ High Blood Pressure	_____ Kidney Disease
_____ Stroke	_____ Emotional Problems	_____ Tuberculosis

Check if YOU have or had any of these symptoms in the past year:

_____ Dizziness	_____ Numbness	_____ Weight gain or loss
_____ Chest pain	_____ High Blood Pressure	_____ Breast pain or lump
_____ Diabetes	_____ Sinus problems	_____ Bruise easily
_____ HIV positive	_____ Change in moles	_____ Sore that won't heal
_____ Depression	_____ Hearing problems	_____ Visual Problems
_____ Bleeding problems after previous surgeries		

Signature _____

Date _____

John H. Brown, MD
Plastic and Reconstructive Surgery

Part 1.

I have received a copy of the Notice of Privacy Practices for Greenville Plastic Surgery Assoc., LTD.

_____ Date _____
Signature of Patient

_____ Date _____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign)

Relationship of Patient Representative to Patient

Part 2.

I permit Greenville Plastic Surgery Assoc., LTD to contact me via mail or the telephone number(s) I have authorized below, regarding my treatment, appointments, account, and other necessary communication. In the event that I cannot be reached directly, I give my authorization for Greenville Plastic Surgery Assoc., LTD to leave a message on my voice mail, answering machine, or with any individual who answers any of the telephone numbers I have listed.

Home _____ Work _____ Cell _____

I further authorize Greenville Plastic Surgery Assoc., LTD to discuss my medical condition and care with the following person(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Patient _____ Date _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

- Treatment - Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
- Payment – Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
- Health Care Operations – Your health information may be used as necessary to support the day-to-day activities and management of GREENVILLE PLASTIC SURGERY ASSOC., LTD. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
- Law Enforcement – Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
- Public Health Reporting – Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.
- Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

- Appointment reminders – Your health information will be used by our staff to send your appointment reminders.
- Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health – related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Greenville Plastic Surgery Assoc., LTD Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting one of our Receptionists or our Privacy Officer. Your requests will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

**Privacy Officer
Greenville Plastic Surgery Assoc., LTD
53 North Main Street
Greenville, PA 16125**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

**Privacy Officer
Greenville Plastic Surgery Assoc., LTD
53 North Main Street
Greenville, PA 16125
724-588-2330 or 1-800-225-2330**

Effective Date

This Notice is effective on or after April 1, 2003