AMBULATORY PLASTIC SURGERY CENTER ASSOCIATES CHTD.

Patient Information ***To maintain compliance with the changes in health care and the electronic medical record, we are required by Meaningful Use Criteria to ask for the following information using the Centers for Medicare and Medicaid terminology.***

Name: _____

Mailing Address: _____

City:_____ State:_____Zip Code:_____

Preferred Email Address: _____

I expressly permit the Ambulatory Plastic Surgery Center Associates, Chtd, Michael P. Vincent, MD, FACS, and /or Practice Fusion.com (our EMR) to contact me using my preferred email as listed above. This will allow email reminders for appointments, applicable preventative care information, and your notice that you should be able to access your electronic medical record within 4 business days.

Home Phone:_____Cell:_____Work:_____

Preferred Method of Contact (please circle): Home Cell Work All

Birthdate:_____Age:_____Gender:_____Marital Status:_____Preferred Language:_____

Race (circle one): 1) American Indian or Alaskan native 2) Asian 3) Black or African American
4) White 5) Native Hawaiian or other Pacific Islander 6) Decline to Specify

Ethnicity (circle one): 1) Hispanic or Latino 2) Non-Hispanic or Latino 3) Decline to Specify

Employer:_____Occupation:_____

Reason for Visit:_____Who Referred You:_____

Date of Injury:_____Worker's Comp?: Yes No Auto Accident?: Yes No

Emergency Contact

Name:_____Relationship:_____

Home Phone:_____Cell:_____Work:_____

Insurance Subscriber if other than self: Primary / Secondary (circle one or both)

Name:_____Relationship:_____

Birthdate:_____Home Phone:_____Cell/Work:_____

Assignment of Benefits/Authorization for Treatment

I hereby authorize treatment and authorize the provider of medical services to release information regarding these services for treatment, payment, and healthcare operations. Please refer to the Notice of Privacy Practices for specific information regarding this practice's use of protected healthcare information. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges incurred by me not covered by my insurance which include all legal and or collection fees.

Signature:_____Date:_____

******PLEASE SIGN ABOVE: Patient or Authorized Representative (over 18 years of age) ******