PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____ **(First)**_____ **(MI)** _____

Preferred Full Name (if different from above): _____ **Patient Social Security Number**: _____

Address: _____ **Marital Status:** _____

City, State, Zip: _____ **Home**: _____ **Cell**: _____

Occupation:_____ **Work Phone**: _____

E-Mail Address:_____ **Date of Birth**: _____

Gender: ☐ Female ☐ Male ☐ Wish not to disclose

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic ☐ Wish not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Wish not to disclose ☐ Other not listed _____

Preferred Language: ☐ English ☐ Spanish ☐ Other not listed_____

Referred by Doctor: _____ **Family/Friend:** _____ **Other:**_____

PCP Name: _____ **PCP Phone**: _____

Pharmacy Name: _____ **Address:** _____ **Phone:** _____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self ☐ Check here if address and telephone information is same as patient

Responsible party name: (Last)_____ (First)_____ (MI) _____

Date of birth:_____ ☐ Female ☐ Male Responsible Party Social Security Number:___-___-____ Phone #: _ Address: ____

City, State: _____ ZIP:_____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Emergency Contact Phone #:

_____

Do you have a living will? ☐ Yes ☐ No ☐ Guardian _____

Emergency contact relationship to patient:

_____

Address_____ City_____ State_____ Zip_____

Home phone#:_____ Cell Phone#: _____ Work Phone#: _____ Ext._____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, photos and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, photos and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked

to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Patient Last Name (Printed) Patient First Name (Printed) MI Date of Birth

Is this visit related to any (past, current or future) litigation proceedings? Yes / No

Any appointment related to any type of litigation or any attorney involvement MUST be authorized by our office prior to your appointment. If this has not been done, please ask to speak with someone before being seen

Is this visit the result of an accident?

Work: _____Date of injury: _____Claim# _____
Auto: _____Date of injury: _____Claim# _____

Patient/patient representative signature **Date**

FINANCIAL AGREEMENT

- I acknowledge, that as a courtesy, Panama City Plastic Surgery may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge Panama City Plastic Surgery may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Panama City Plastic Surgery any insurance or other third-party benefits available for health care services provided to me. I understand Panama City Plastic Surgery has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Panama City Plastic Surgery, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Panama City Plastic Surgery by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Panama City Plastic Surgery or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Panama City Plastic Surgery and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Panama City Plastic Surgery and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature **Date**

Raymond A. Mockler, M.D., FRCS(C)
Panama City Plastic Surgery

Welcome To Our Practice

Our goal is to provide an exceptional healthcare experience. We believe that in the interest of best healthcare practices a copy of our policies and procedures is being provided to you in order to avoid unwanted communication errors or misunderstandings of what is expected in a healthy Doctor-Patient relationship.

WAIT TIMES

Your time is valuable and that every patient has unique needs that may require more time than planned. We will make every effort to provide proper care and minimize your in office wait time. Unforeseen emergencies/surgeries that take longer than anticipated may arise and cause a delay or rescheduling of your appointment. We will exhaust efforts to accommodate your schedule and notify you as soon as we are aware of the delay.

LATE ARRIVAL

It is our policy that if you are more than 15 minutes LATE arriving to your scheduled appointment, you may encounter longer wait time or a need to have your appointment rescheduled. Please call our office prior to your appointment if you anticipate a delay in your arrival time.

PHYSICIAN AND HMO REFERRALS

It is the responsibility of the patient to obtain and provide a valid referral from your Primary Care Physician (PCP) and to ensure that our office staff has them PRIOR to your appointment. Failure to do so may result in insurance denial of your visit and payment/financial responsibility directly transferred to the patient as a result.

MEDICATIONS

Prescriptions for narcotics are only issued for acute post-operative pain management

Women, please immediately notify Dr. Mockler and/or his staff if you are or you should become pregnant while taking any prescribed medications from Dr. Mockler.

Notify Dr. Mockler and/or staff of any narcotics prescribed to me by other physicians and/or their assistants while under Dr. Mockler's care. All prescription history is verified through external sources including Florida Drug Monitoring

Program. I understand that without a valid photo ID, I cannot be given any prescriptions.

I agree that I will not sell or share any medications/narcotics prescribed to me by Dr. Mockler and understand that the prescribed medications/narcotics are only for the present care I am receiving from this office.

I have no suicidal or homicidal thoughts and further agree to surrender any and all medications to this office, another healthcare provider or a law enforcement officer should I consider harming myself or others.

FORM COMPLETION

- Due to the high volume of form completion requests, please submit your forms in a timely manner. The fee must be paid prior to the forms being returned, faxed or mailed by our office.
- The patient information portion MUST be completed by the patient PRIOR to processing
- Once we receive your form(s) and signed authorization to release your medical information, please allow **5-7 business days** for processing.
- There will be a charge of $5.00 per page for the completion of the following forms:

Disability **FMLA** **Supplemental Insurance** **Return to Work** **Medical Hardship Letter**

Signature of patient or personal representative: _____ Date: _____

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth

NOTICE OF PRIVACY PRACTICE/CLINICS

_____**(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name		Relationship		Contact Number	
1:						
2:						
3:						

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

COMMUNICATIONS ABOUT MY HEALTHCARE

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature **Date**

Patient Last Name (Printed) Patient First Name (Printed) MI Date of Birth

Allergies	
Name	Reaction

Medications			
Name	Dose / Strength	Frequency	Prescribing Physician

Surgical History		
Date	Name of Surgery	Surgeon

Hospital Stays	
Date	Reason

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge

Signature of patient or personal representative: _____Date: _____

Patient Last Name (Printed) Patient First Name (Printed) MI Date of Birth

Past Medical History

o Alcoholism/substance abuse o Anemia o Asthma o Arthritis o Bipolar disorder o Diabetes o Bladder infection o Crohn's disease/Ulcerative Colitis	o High cholesterol o HIV/AIDS o Chronic kidney disease o Lupus o Obstructive sleep apnea o Osteoporosis o Osteopenia o Psoriasis o Eczema o Psychosis o Schizophrenia o Rheumatoid disease	o COPD/chronic bronchitis o Depression/anxiety o Emphysema o Epilepsy/seizures o Fibromyalgia o Headaches/migraines o Heart disease o Prior heart attack o Hemorrhoids o Hepatitis o Hiatal hernia/GERD o Thyroid disorder	o Chronic knee pain o Chronic back pain o Chronic neck pain o Chronic shoulder pain o High blood pressure o Shingles o Stroke o Tuberculosis o Other: _____ o _____ o _____ o _____

Social History

Tobacco Use: Have you ever used a tobacco product?	Yes / No	Type and amount: Quit Date:
Have you had a flu shot?	Yes / No	Date:
Have you had a pneumonia vaccine?	Yes / No	Date:
Have had a drink containing alcohol in the past 12 months?	Yes / No	Number of drinks _____ Daily / socially / rarely Type of alcohol:
Have you used drugs (other than medial reasons) in the last 12 months?	Yes / No	Type: _____ Daily / socially / rarely
Do you exercise?	Yes / No	How often:

Family History

	Alive / Deceased	Age	Medical concerns/conditions
Mother			
Father			
Maternal Grand Mother			
Maternal Grand Father			
Paternal Grand Mother			
Paternal Grand Father			
Sister			
Brother			
Other			

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge

Signature of patient or personal representative: _____ Date: _____

Patient Last Name (Printed) | Patient First Name (Printed) | MI | Date of Birth

Are you currently experiencing any of the following?
(Circle all that apply)

Review of Systems	
General	fever - chills - fatigue - weight loss – loss of appetite – feeling tired
Ear, Nose, Throat	nose bleeds – sinus problems – sinus discharge – ringing in ears – sore throat – swollen glands – blocked ear headaches – hearing loss – sores in mouth
Eyes	eye sensitivity – change in vision or loss of vision – eye pain – redness of the eyes
Endocrine	heat or cold intolerance – excessive thirst – excessive urination
Cardiac	palpitations – chest pain – fluttering of the heart – shortness of breath w/ exertion shortness of breath w/sleeping
Respiratory	chest congestion – wheezing – difficulty breathing – shortness of breath – cough – coughing up blood pain – snoring
Gastrointestinal	appetite changes – nausea – constipation – diarrhea – heartburn – vomiting – stomach pain – vomiting blood
Hematology	prolonged bleeding – bruise easily – leg swelling – arm swelling
Breast	lump – discharge – tenderness – pain
Skin	hives – rash – itching – yellowing of the skin
Vascular	pain in legs after exertion – swelling of legs
Urinary	frequent – urgency – difficulty starting or stopping – incontinence – pain/burning with urination – blood in urine
Musculoskeletal	muscle weakness – muscle stiffness – joint pain – joint stiffness
Psychiatric	depression – anxiety – sadness – difficulty sleeping
Neurologic	numbness/tingling – headache – burning – fainting – tremors – loss of memory – difficulty walking – dizziness weakness – nerve pain
Allergy	cough/congestion – runny nose – itching eyes

Women Only	
• Could you be pregnant?	Yes / No
• Number of pregnancies:	
• Number of children:	
• Did you breastfeed?	Yes / No
• Date of most recent mammogram:	

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge

Signature of patient or personal representative: _____ Date: _____

AUTHORIZATION TO USE PHOTOS / VIDEOS / DIGITAL IMAGES

I, _____, hereby authorize Panama City Plastic Surgery and Raymond A. Mockler, MD, its successors and assigns, the right to use its photographs / videos and/or digital images of me for the purposes listed below. These photographs / videos and/or digital images were captured on _____and include photos of: _____.

The usage of these photographs, videos and/or digital images will be limited to (select all that apply):

☐ Medical purposes related to case
☐ Scientific purposes, including seminars and medical articles
☐ Digital or printed materials for patients to view in the office(s)
☐ Digital or printed materials to be included in our practice's newsletter to be sent to current or prospective patients
☐ Digital images to be included in our practice website
☐ Digital images to be uploaded to the broader Internet to be viewed by the public

Panama City Plastic Surgery and Raymond A. Mockler, MD need not approach me again for authorization to use these photos, videos and/or digital images unless the usage differs from that listed above and this authorization will remain in place indefinitely unless I ask Panama City Plastic Surgery and Raymond A. Mockler, MD to terminate use of these photos, videos and/or digital images, in writing and communicated to Panama City Plastic Surgery and Raymond A. Mockler. If I terminate authorization, which I may do at any time, I recognize that it will likely take a reasonable time period to accomplish. For example, to remove such pictures from a web site, Panama City Plastic Surgery and Raymond A. Mockler, MD will need to coordinate with a third-party webmaster.

Termination of prospective use of photos, videos and/or digital images may have no effect on prior distribution-such as the case with medical journals. A published journal, for example, cannot be "recalled."

Further, please note that once photos, videos and/or digital images are used for any of the authorized purposes above, that information may no longer be protected by HIPAA.

Providing authorization is entirely voluntary and will not affect our commitment to treatment by our practice.

To the extent allowed by law, I hold Panama City Plastic Surgery and Raymond A. Mockler, MD harmless from any liability related to use of these photos, videos and/or digital images for the purposes outlined above. I further hold Panama City Plastic Surgery and Raymond A. Mockler, MD harmless for any third-party use of these photos unrelated to direct, immediate, and negligent proximate action by Panama City Plastic Surgery and Raymond A. Mockler, MD.

This release and authorization do not conflict with any existing commitments on my part.

I understand that Panama City Plastic Surgery and Raymond A. Mockler, MD are not obligated to make use of its rights set forth herein.

I understand that I do not have any intellectual property rights in or to these images. Copyright to photos, videos and/or digital images is retained by Panama City Plastic Surgery and Raymond A. Mockler, MD.

Patient Signature _____ Date/Time_____

Witness Signature _____ Date/Time _____