Garcia Plastic and Hand Surgery

Please fill out these forms **COMPLETELY.**

PERSONAL INFORMATION

Patient Name: First___________________________ MI________Last __________________________________

Address:_____________________________________City_________________State________ Zip ___________

Phone home:______________________ cell:_________________________ work:_______________________

Date of Birth: __________________________ Age: ________________ Sex: Male Female

SS#:______________________________ Marital Status (please circle) Single Married Divorced Widowed

Email Address: ____

Your Employer:____ Occupation: _________________________

Employer's Address:____

Primary Care Physician (name & phone): ____

Which provider requested this consultation? (name & phone):____

EMERGENCY CONTACT INFORMATION

Name: ____ Relationship to you: ________________________

Phone home:_________________________work:_________________________ cell:____________________

Address:____

Employer:_____________________________________Employer's Address:____________________________

INSURANCE INFORMATION (please fill out completely)

Primary Medical Insurance Plan: ____

Subscriber's Name:____________________________________ Relationship to you:______________________

Subscriber's Date of Birth:________________________________ SS#:__________________________________

Subscriber's Employer:____

Secondary Medical Insurance Plan:____

Subscriber's Name:____________________________________ Relationship to you:______________________

Subscriber's Date of Birth:_________________________________ SS#:_________________________________

Subscriber's Employer:____

Is this a Worker's Compensation Claim? Yes or No

This signature authorizes us to release and obtain medical information electronically, verbally and in writing for medical history and insurance purposes, to bill your insurance and have benefits assigned to our practice. By signing this, you certify the information on this form is correct, you agree to the exchange of medical information and that you understand you are financially responsible for any uncovered medical charges.

Signature of person responsible for this account: ____

Relationship to patient: ________________________________Today's Date:____________________________

Date: ______________________________

Garcia Plastic and Hand Surgery

Allergies: None

____
____
____

Your Medications: None

____
____
____
____

Your Surgical History: None

____
____
____

Hospital Admissions (what for): None

____
____
____
____

Your Medical Problems: (please circle)

□ Abnormal EKG □ Anemia □Anxiety
□ Arthritis □Asthma □BleedingDisorder
□ Blood Clots □Cancer □Dementia
□ Diabetes □Fibromyalgia □Glaucoma
□ Gout □Heart Disease □Heart Murmur
□ High Blood Pressure □ High Cholesterol
□ Kidney Disease □ Liver Disease □Lung Disease
□ Lyme Disease □Melanoma □Multiple Sclerosis
□ Pacemaker □ Palpitations □Parkinson's
□ Stomach problems □Stroke□Skin Cancer
□ Prostate Disease □Sleep Apnea □None

Family History of:

□ Cancer □ Diabetes
□ Heart Disease □ High Blood Pressure
□ Kidney Disease □ Stroke □ None

History of or current usage of:

Current Smoker? __________ Amount/day_________
Have you ever smoked? ___________
Current Alcohol Use? Amount/week ________
Past Alcohol Use? ________________________
Any marijuana use past or present? ____________
None

Hand Dominance: (circle one) Left Handed Right Handed Ambidextrous

Pharmacy: ______________________________Address:____

Our office uses electronic medical records to share and obtain medical information and prescription information.

Other Physicians involved in your health care: (cardiologist, oncologist, etc) None

____
____

Weight: ______________________ Height: ____________________________

Patient Name: ____
Date of Birth: ________________________________ Age: __________________________

JUAN C. GARCIA, MD, FACS

HIPAA PRIVACY INFORMATION

□ I have reviewed the HIPAA Privacy Statement

May we leave Appointment Information on:

□	Home Phone?	Yes	No
□	Mobile Phone?	Yes	No
□	Work Phone?	Yes	No
□	With another person?	Yes	No
□	Send via mail?	Yes	No
□	Send via E-mail?	Yes	No
□	Other____		

May we leave Medical Information on:

□	Home Phone?	Yes	No
□	Mobile Phone?	Yes	No
□	Work Phone?	Yes	No
□	With another person?	Yes	No
□	Send via mail?	Yes	No
□	Send via E-mail?	Yes	No
□	Other____		

HIPAA Contact Instructions:

Person(s) Authorized to Communicate With:

____________________________________ ___________________ __________________________

First and Last Name Relationship Phone Number

_____________________________________ ___________________________

Patient Name (print) Date of Birth

_____________________________________ ___________________________

Signature of Patient or Personal Representative Date Signed

____

Signature of Witness

GARCIA PLASTIC AND HAND SURGERY

Financial Policy

We are here to assist you in providing information to your health insurance company so that payment may be made according to the coverage you have purchased. Please keep in mind that **NOT ALL SERVICES ARE A COVERED BENEFIT OF ALL PLANS** and that your insurance coverage is an agreement between you and your insurance company. If you do not understand your coverage, please contact your insurance carrier or, if your insurance coverage is provided through your employer, contact your benefits administrator at work.

If your insurance requires that you pay an office copay, it is due when you check in for your appointment. Failure to pay your copay will result in your appointment being rescheduled.

As a courtesy, we will file claims with your primary and secondary insurance (if applicable) providing we have your Assignment of Benefits (see below) and **current and accurate** insurance information from you. However, payment for services at Garcia Plastic and Hand Surgery is ultimately the **patient's responsibility**.

ALWAYS BRING YOUR INSURANCE CARDS. WE WILL NEED A COPY.

Once we have received a response from your insurance(s), an itemized statement will be sent to you. You have 30 (thirty) days from the statement date to pay your account in full. If you have questions concerning insurance payment or denial of your claim, you should **first contact your insurance provider** to obtain further information. After you have contacted your insurance provider, if you still have questions, please call our billing office at (518) 793-0475.

ANY ACCOUNT BALANCE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY MAY RESULT IN THE PATIENT AND ASSOCIATED FAMILY MEMBERS BEING TERMINATED FROM THE PRACTICE.

For the convenience of our patients, Garcia Plastic and Hand Surgery accepts payment in the following forms: Cash/Check/Visa/MasterCard/Money Order.

Note: the person's signature on this form will be responsible for payment.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS:
I have read and agree to the terms and conditions set forth above. I understand that I am responsible for and agree to pay all charges regardless of insurance coverage or pendency of claims. I authorize the release of all medical information necessary to process my health insurance claim and request payment of benefits be made to Garcia Plastic and Hand Surgery. A photocopy of this agreement shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

Patient Signature: ____ Date:__________________________
(Parent or Legal Guardian if minor)

I agree to reimburse Garcia Plastic and Hand Surgery the fees of any collection agency, which may be based on a percentage at a maximum of 33% of all debt, and all costs, and expenses, including reasonable attorneys' fees, Garcia Plastic and Hand Surgery incurs in such collection efforts.

Patient Signature: ____ Date:__________________________
(Parent or Legal Guardian if minor)