PATIENT DEMOGRAPHIC INFO

(Circle One) New Patient/ Established Patient Date: _____

Last Name: _____ First Name: _____ MI _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Date of Birth: ____/____/____ SS#: ____-____-____

Email Address: _____

(If Minor) Parent's Name: _____ DOB ____/____/____

Employment

(Circle One) Retired/Employed/Unemployed/Disabled

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____-_____

Emergency Contact

Name: _____ Address: _____ Phone: (_____) _____-_____

Insurance Information

Is this visit related to accident? YES or NO If yes, please explain: _____

Is this visit a Workman's Compensation Claim? Yes or NO if yes, please provide the following information.

Employer: _____ Industrial Carrier: _____

Claim Number: _____ Case Manager: _____ Date of Injury: ____/____/____

Primary Insurance Information

Ins. Co. _____ ID# _____ Group # _____

Claims Address: _____ City: _____ St: _____ Zip: _____

Secondary Insurance Information

Ins. Co. _____ ID# _____ Group# _____

Claims Address: _____ City: _____ St: _____ Zip: _____

How did you hear about the practice? (circle one)

Internet/Google_____ **Friend/Family**_____ **Doctor Referral (who?)**_____

Insurance Company_____ **Facebook**_____ **Other**_____

SUN HEALTHCARE & SURGERY GROUP, INC
1815 ARNOLD DR
MARTINEZ, CA 94553
(925) 979-8313 F# (925) 954-6959

THE SUN HEALTHCARE & SURGERY GROUP, INC

(HIPAA RELEASE FORM)

Name: _____ Date of Birth: ____/____/_____

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

Name	Phone	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ Information not to be released to anyone other than medical professionals directly involved in my care.

This Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call: ☐ Cell _____ ☐ Home _____ ☐ Work _____

OK to message me electronically via ☐ Text _____ ☐ E-Mail _____

If unable to reach me:

☐ you may leave a detailed message on ☐ cell ☐ home ☐ work

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____ between (time) _____

1. **Legal Relationship Between Facility and Physician:** The undersigned recognizes that any and all physicians and/or surgeons, including but not limited to radiologists, pathologists, anesthesiologists and emergency room physicians furnishing services to the patient at the Facility are independent contractors, and are not, in any way, employees of the Facility. Their fees are not included as a part of the Facility bill.
2. **Release of Information for Reimbursement:** To the extent necessary to obtain reimbursement, the Facility may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any of the Facility's charges, included but not limited to, insurance companies, healthcare service plans, workers' compensation carriers, social security administration and per review organizations. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending you text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

   The undersigned have read this disclosure and agree that the lender/Creditor and its agents may contact me/us as described above.
3. **Financial Agreement:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Facility in accordance with the regular rates and terms of the Facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.
4. **Assignment of Insurance Benefits:** The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the Facility of any insurance benefits otherwise payable to the undersigned for services rendered at a rate not to exceed the Facility's usual and customary charges. It is agreed that payment to the Facility, pursuant to this authorization, by an insurance company/ Health Care Service Plan shall discharge said insurance company/ Health Care Service Plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for all charges not covered by this assignment, or for not cooperating with requests for information by the insurance company/ Health Care Service Plan.
5. **Health Care Service Plans:** The Facility has contracted with multiple Health Care Service Plans. It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service Plan limit, reduce or deny coverage of medical services at the Facility. It is also the responsibility of the undersigned to verify if the Facility is within their covered Network _____.
   Initials

   The undersigned agrees that he/she is obligated to reimburse the Facility for any deductible, co-payments, coverage penalties, or for any service rendered which is not a covered benefit of his/her Health Care Service Plan at the Facility. For on-emergency Services, it is the patient's responsibility to ensure his/her Plan has authorized the requested services at the Facility. The undersigned agrees that denial of payment for lack of an authorization for non-emergent services will be considered a denial for a non-covered benefit, and payable by the undersigned.

☐ Unable to sign

The undersigned acknowledges he/she has read and understands the Financial Agreement, Assignment of Insurance Benefits, Health Care Service Plan obligation and all other applicable provisions above and received a copy thereof, and is the patient, the patient's legal representative or is duly authorized as the patient's general agent to execute the above and accept its terms.

SIGNATURE: PATIENT, LEGAL REPRESENTATIVE, AGENT	DATE/TIME	RELATIONSHIP TO PATIENT	WITNESS

☐ Unable to sign

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative: I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, Health Care Service Plan obligation, and all other applicable provisions above.

FINANCIALLY RESPONSIBLE PARTY	DATE/TIME	WITNESS

☐ Unable to sign

The Sun Healthcare & Surgery Group, Inc

FINANCIAL AGREEMENT

SUN HEALTHCARE & SURGERY GROUP, INC.
NOTICE OF PRIVACY PRACTICES

At the practice of Sun Healthcare and Surgery Group, your privacy is a very important part of our mission. Muir Plastic Surgery and its staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your health care information. Additionally, the team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPPA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2008.

As of April 14th, 2008, we are required by law to offer you a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI).

Your PHI, also known as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals you contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this State and the Nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

The "Notice of Privacy Practices" details the following:

- How we may use/disclose your PHI to carry out treatment, payment, or health care operations
- How you may request copies of your healthcare information
- How you may verify the accuracy of this information
- How you may request an accounting of certain external disclosures in your PHI.

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for the permitted uses, including disclosures via fax.

Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below.

"I have been offered a "Notice of Privacy Practices" by the office of Muir Plastic Surgery and I fully understand and accept the terms of this consent."

Signature (Patient, Parent, or Guardian)_____

Date ____/____/_____

PRIVACY POLICY

SUN HEALTHCARE & SURGERY GROUP, INC.
1815 ARNOLD DR
MARTINEZ, CA 94553

PATIENT MEDICAL HISTORY FORM

Date:

Patient Name: _____ D.O.B.: _____

Gender: _____ Ethnicity: _____ Preferred Language: _____

Height: _____ Weight: _____

Smoker: Yes / No Packs per Day: _____

Alcohol: Yes / No Drinks per Day/Week: _____

Recreational Drug Use (please specify): _____

_____

Primary Care Physician: _____ PCP Phone: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

_____

_____

Allergies

Are you Allergic to any of the following?	Yes / No	Severity (Mild, Moderate, Severe)	Reaction
Aspirin			
Penicillin			
Codeine			
Local Anesthetics			
Acrylic			
Metal			
Latex			
Sulfa			
Other:			

O I have no known drug allergies. _____
Initials

[redacted]

Diagnosed Medical Problems:_____

_____

_____

_____

Would you like online access to your Electronic Medical Records? O Yes O No

If yes, please provide your e-mail address: _____

Medication List

Please include all medications, including over the counter medications, herbs, vitamins, and supplements.

MEDICATION NAME	STRENGTH	DIRECTIONS

Please use the back of this page if more room is needed.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is MY responsibility to inform The Sun Healthcare & Surgery Group, Inc. of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____