

**GUNN PLASTIC SURGERY CENTER**  
**PATIENT DEMOGRAPHIC INFORMATION**  
**(Please Complete Entire Form)**

Patient's Full Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip Code

Home Phone \_\_\_\_\_ Business \_\_\_\_\_ Cell \_\_\_\_\_

Social Security Number (Last 4) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Sex: (Circle One) Male Female Other \_\_\_\_\_

Marital Status: (Circle one) Married Single Separated Divorced Widowed Partnered

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Employer \_\_\_\_\_

Referred By \_\_\_\_\_ Email Address \_\_\_\_\_

Please tell us how you heard about our office. \_\_\_\_\_

If accident or illness, give date \_\_\_\_\_ Were you in an auto accident? YES NO  
Were you injured on the job? YES NO Were you seen in a hospital? YES NO

\*\*\*\*\*

Responsible Party  
Person Responsible for payment if other than above \_\_\_\_\_  
Relationship of Patient to Responsible Party: Self Spouse Child Dependent Other \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Date of Birth of Responsible Party \_\_\_\_\_

\*\*\*\*\*

Emergency Contact  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

\*\*\*\*\*

Insurance Information Primary	Secondary
Insurance Company Name _____	_____
Name of Policy Holder _____	_____
Relationship to Patient _____	_____
Policy # and Group # _____	_____
Insured's Date of Birth _____	_____
SSN of Policy Holder _____	_____

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Authorization to pay benefits to physician: I hereby authorize payment directly to Laura A. Gunn, M.D of any surgical and/or medical benefits, if any, otherwise payable to me for the Physician's services. Authorization to release medical information: I hereby authorize Laura A. Gunn, M.D to release any information acquired during the course of my examination and treatment to expedite insurance claims.

Laura A. Gunn, M.D files insurance claims as a service to her patients; however, **the patient is responsible for their copayment at the time of check in** and all balances on their account until paid in full. The information listed above is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



## USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**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.**

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client of ours, facts about you must be used and disclosed to other parties for treatment, payment, and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records;
- Diseases spread person to person, such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)
- Drug and alcohol abuse/Psychiatric diagnosis and treatment records;
- Medical history/treatment process & Laboratory test results;
- Data from the OASIS data set (home health); any other facts.

We may release the above to:

1. Your insurance company, Medicare, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;
2. Any person from a program or an insurance company, who performs billing, quality and risk tasks, such as insurance auditors and state risk management.
3. Any hospital, nursing home, or other health care facility where you may have testing done or to which you may be admitted
4. Any assisted living or personal care facility where you live; and any doctor providing your care.
5. Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc. State and Federal agencies acting on behalf of programs, Medicare/Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc. OR Other healthcare people to start treatment.

We are allowed to use or disclose facts about you without consent in the following situations;

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly Inferred from the situation. We are required by law to provide treatment and we are unable to obtain;
3. Where the use or disclosure is required by law; for certain public health activities, such as reporting births, deaths, injuries, diseases, etc.; where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect, or domestic violence reports.
4. Health care oversight activities; certain legal administrative proceedings, certain research purposes & certain law enforcement purposes; to coroners, medical examiners and funeral directors in certain situations (hospice/home health).
5. To avoid a serious threat to health and safety; for specialized military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions and custodial situations; and for Workers' Compensation Purposes.

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict, or forbid the disclosure in the following situations;

1. The use of a directory of people served by us (clinic schedules, patient schedules)
2. To a family member, friend or other person you choose, who may assist in your care or payment for care.

**YOUR RIGHTS-**You have the right, subject to certain conditions, to;

1. Request restrictions on certain uses and disclosures of facts about you by filling out our request form. However, we are not required to agree to the requested restrictions.
2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
3. Inspect and copy protected health data by filling out our form or amend protected health data by filling out our request form. Receive a list of disclosures made of your protected health data by filling out our request form.
4. Obtain a paper copy of this notice upon request, if you agreed to receive this notice by email, fax, or website.

**COMPLAINTS-**You may complain to us and the Secretary of the U.S Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed in writing with us and must state the specific incident(s) including date, what happened and the details of the incident.

**\*\*NO SHOW AND CANCELLATION POLICY- IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT WITH ANYONE IN OUR OFFICE, PLEASE CANCEL WITHIN 24 HOURS OF THE SCHEDULED TIME OR YOU WILL BE CHARGED A \$50 NO SHOW/ LATE CANCELLATION FEE.\*\***

Please note that any unpaid balance turned over to collections will result in a \$25 late fee.

**\*\*The patient is responsible for their copayment at the time of check-in and all balances on their account until paid in full.\*\***

**ACKNOWLEDGEMENT-**I have read this Notice or have had it explained to me. I understand this Notice and have had a chance to ask questions about any matters I do not understand.

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**SIGNATURE**

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**DATE**

# GUNN PLASTIC SURGERY PARTY RELEASE

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize **Gunn Plastic Surgery and Associates** to release protected health information about the above patient in the following manner and/or to selected person(s) when requested.

**Gunn Plastic Surgery and Associates** uses the following for appointments, reminders and changes, form completion, electronic statements, billing notifications, lab results, referral details, prescriptions and refills, other medical recommendations, and may request follow up regarding previous visits with your other providers.

EMAIL ADDRESS (provided by patient on demographic sheet) \_\_\_\_\_ Yes \_\_\_\_\_ No

MOBILE PHONE/HOME/WORK TEXT AND/OR  
VOICEMAIL (provided by patient on demographic sheet) \_\_\_\_\_ Yes \_\_\_\_\_ No

**FOR EMAIL AND/OR TEXT COMMUNICATION, I UNDERSTAND THAT IF INFORMATION IS NOT SENT IN AN ENCRYPTED MANNER THERE IS A RISK IT COULD BE ACCESSED INAPPROPRIATELY. I STILL ELECT TO RECEIVE EMAIL AND/OR TEXT COMMUNICATIONS AS SELECTED ABOVE.**

Other person(s) we may contact regarding your medical information and/or financial information, please list below:

_____	_____	_____
Name	Phone Number	Relation
_____	_____	_____
Name	Phone Number	Relation
_____	_____	_____
Name	Phone Number	Relation

**PATIENT RIGHTS:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization.

**NOT SIGNING MAY AFFECT TREATMENT AS OUR ABILITY TO CONTACT PATIENT IS HINDERED**

This authorization will remain in effect until revoked by the patient or until expiration of 1 year following date signed.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date