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: ○ Male ○ Female ○ Other: _____

Marital Status: ○ 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	_____	_____

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: _____ - _____ - _____

GUNN PLASTIC SURGERY CENTER, 300 CRUTCHFIELD STREET, DURHAM, NC 27704 Tel. 919-471-3406

Patient's Full Name _____ Date of Birth _____-_____-_____

Sex: ○ Male ○ Female ○ Other: _____

Family History: ○ Diabetes ○ Heart Disease ○ Stroke ○ Other _____

Personal History

(If you answer yes to any questions, please explain in the space provided)

To be completed by GPS staff.

Height _____ BP _____ Temp _____
Weight _____ HR _____ O2Sat _____

Yes	In the past	No		
○	○	○	Do you consume alcohol?	Daily Intake _____
○	○	○	Do you consume caffeine? (coffee, tea, soft drinks)	Daily Intake _____
○	○	○	Do you use Tobacco? (cigarette, pipe, cigar, snuff)	Daily Intake _____
○	○	○	Are you allergic to any medications? Latex allergy?	_____
○		○	Do you take any medications? List Current Medications	_____
				_____
○	○	○	Do you take aspirin? (Bufferin, BC, Goodies, Anacin)	Daily Intake _____
○	○	○	Allergies to local anesthetics? (Novacaine, Xylocaine, etc.)	_____
○	○	○	Do you have allergies to tape, soaps, solutions, etc.?	_____
○	○	○	Previous hospitalizations	_____
○	○	○	Previous operations?	_____
○	○	○	Do you have children?	How Many _____
○	○	○	Have you ever had problems with anesthesia or surgery?	_____
○	○	○	Have you had previous allergy treatment?	_____

Do you or have you ever had a history of the following? (If you answer yes to any questions, please explain in the space provided)

Yes	In the past	No		
○	○	○	Gastroesophageal reflux or ulcers?	_____
○	○	○	Psychiatric problems?	_____
○	○	○	Heart attack, angina, or chest pain?	_____
○	○	○	Blood pressure problems?	_____
○	○	○	Cardiac pacemaker?	_____
○	○	○	Neurological disease? (fainting, convulsions, etc.)	_____
○	○	○	Back problems? (numbness or weakness in arms or legs)	_____
○	○	○	Hepatitis or yellow jaundice?	_____
○	○	○	Cancer?	_____
○	○	○	Kidney disease, stones, cystitis?	_____
○	○	○	Diabetes?	_____
○	○	○	Thyroid disease or goiter?	_____
○	○	○	Anemia or low blood?	_____
○	○	○	Asthma, lung infections?	_____
○	○	○	Sleep Apnea?	_____
○	○	○	Frequent headaches?	_____
○	○	○	Arthritis?	_____
○	○	○	Are you currently pregnant? *If yes, how far along?*	_____
○	○	○	Excessive bleeding when cut?	_____
○	○	○	Bruising easily?	_____
○	○	○	Slow healing wounds?	_____
○	○	○	Keloids or excessive scarring?	_____
○	○	○	Family/personal history of blood clots?	_____
○	○	○	Hives or allergic skin reactions?	_____

I certify that the above information is accurate and correct to the best of my knowledge and I have not withheld information concerning my medical history.

Patient Signature (Parent/ Guardian if minor) _____ Date: _____ - _____ - _____

GUNN PLASTIC SURGERY PARTY RELEASE

Patient's Full 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

NOTICE OF PRIVACY PRACTICES

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 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__- WE ASK THAT YOU PROVIDE OUR OFFICE A MINIMUM OF 48 HOURS' (2 BUSNESS DAY) NOTICE SHOULD YOU NEED TO CANCEL OR RESCEDULE YOUR APPOINTMENT. IF APPOINTMENT IS CANCELED OR RESCHEDULED WITHIN THE 48 HOURS (2 BUSINESS DAY) OF APPOINTMENT TIME, OR A NO-SHOW, YOU WILL BE ASSESSED A $50 NO SHOW/ LATE CANCELLATION FEE.

REFUNDS: If original payment is made with a charge/debit card, there will be a 3% fee per transaction for refund if approved.
If original payment is made with Care Credit, the fee for refund if approved will be determined at that time.

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.

Signature _____ Date _____