BODY THE ORIGINAL GARAGE PLASTIC SURGERY & MEDICAL SPA

Date: _____

PATIENT INFORMATION:

Title: (Mr., Mrs., Ms.) First Name: _____ Middle Initial: _____ Last Name: _____

Sex: ___Male___ Female Date of Birth____-____ - ____Age: ____ Social Security No.: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Tel.:( ) _____ Bus. Tel.: ( ) _____ Cell Tel.: ( ) _____

Email: _____

Physician: _____ Address: _____

Whom may we thank for referring you to us?: _____

Who will be responsible for your account? Relation: ❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ _____

Name: _____ Soc. Sec.#: _____ Home Tel.: ( ) _____

Street: _____ City: _____ State: _____ Zip: _____

Employer: _____ Tel.: ( ) _____

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single Spouse's Name: _____

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Spouse's Employer: _____

Ethnicity: ❑ Caucasian ❑ African American ❑ Native American ❑ Asian Other: _____

❶ INSURANCE COMPANY:

Name: _____

Address: _____

_____

Phone ( ) _____

_____

Group No.: _____

Group Name: _____

INSURED PARTY:

Name: _____

Relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Sex: ❑ M ❑ F Date of Birth: _____

Street _____

City, State, Zip: _____

Phone ( ) _____

S.S. No.: _____ ID No.: _____

❷ INSURANCE COMPANY:

Name: _____

Address: _____

_____

Phone ( ) _____

_____

Group No.: _____

Group Name: _____

INSURED PARTY:

Name: _____

Relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Sex: ❑ M ❑ F Date of Birth: _____

Street _____

City, State, Zip: _____

Phone ( ) _____

S.S. No.: _____ ID No.: _____

RELEASE OF PERSONAL HEALTH INFORMATION:

Including yourself, and your physician, who else would you like us to release your confidential medical information to (if they request it)?

Name: _____ _____

_____ Signature: _____

CONTINUED ON REVERSE SIDE

Friend or Relative (other than spouse) to leave message with in case of emergency:

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

FEES AND PAYMENTS:

We make every effort to keep down the cost of your plastic and reconstructive surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have medical insurance, we will be glad to file your claim for you.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

The clinic expects payment of accounts within 30 days following the date they were billed. A FINANCE CHARGE is computed on account balances unpaid 60 days after the first billing at PERIODIC RATE OF 1.25% PER MONTH (ANNUAL PERCENTAGE RATE OF 15%). **If all attempts to collect payments due the clinic fail, the patient or guarantor will be responsible for attorney fees and costs that are incurred for the collection of the debt.**

Please be informed: The Physicians of Sioux Falls Center for Plastic and Reconstructive Surgery have an ownership interest in the Sioux Falls Specialty Hospital.

AUTHORIZATION AND ASSIGNMENT:

This signature on file is my authorization for the release of information necessary to process my claim and/or secure payment. I hereby authorize payment directly to Dr. Richard J. Howard or Dr. Thomas C. Howard of the insurance benefits otherwise payable to me. This assignment will remain in effect until removed by me in writing.

HIPAA Notice of Privacy Practices

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to suppose the operation of the physician's practice, and any other use required by law. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. Your protected health information will be used, as needed, to obtain payment for your health care services. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the right to inspect and copy your protected health information. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. You may have the right to have your physician amend your protected health information. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

☐ I hereby acknowledge and agree to all above statements.

Print Name	Signature of Patient or Responsible Party	Date