PATIENT INTAKE FORM MR#_____

Patient Name: Last First Middle
Date of Birth / / Age Sex ☐Male ☐Female
Social Security Number (SS#)
Street Address
City State Zip
Email Address
Would you like to receive emails regarding periodic special offers and news from our practice? ☐Yes ☐No
How did you hear about Dr. Jarrell?
☐Website ☐ Radio ☐ Newsletter ☐ Seminar ☐Salon
☐Friend/Relative ☐Doctor ☐Other

Home Phone Mobile Work
Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
Race ☐American Indian ☐ Asian ☐ African American ☐Caucasian ☐ Unreported/Refused to report ☐Undefined
Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐ Unreported ☐ Refused to Report Undefined
Language Preference
Employer
Spouse's Name DOB / / SS#
Spouse's Employer Work Phone
Emergency Contact Relationship
Emergency Contact Number

DISCLOSURE OF PROTECTED HEALTH INFORMATION

According to office policy, test results or release of medical information including, but not limited to, appointment times, lab results, etc., will be provided to the patient only. Please specify below whom information may be release to other than yourself. I grant my permission to Jarrell Plastic Surgery to release any and all medical information to the person(s) listed below.
Patient Signature:_____

Name Relationship Name Relationship
Name Relationship Name Relationship
May we leave message at your: ☐Home Answering Machine ☐Cell Phone ☐Work Voice Mail ☐ Email

Preferred Notification Method: ☐ Phone ☐Email/Text Message ☐Both

FINANCIAL INFORMATION

Person Responsible for Payment Relationship to Patient
Street Address (if different from above)
City State Zip
Home Phone Mobile Work

IF THE PATIENT IS A MINOR/STUDENT

Father's Name/Legal Guardian
Address (if different from above)
City State Zip
SS# DOB / /
Home/Cell# Work#
Employer

Mother's Name/Legal Guardian
Address (if different from above)
City State Zip
SS# DOB / /
Home/Cell# Work#
Employer

PLEASE COMPLETE ALL SECTIONS MR#_____

Primary Insurance Name			Subscriber's Name		
Relationship to Patient	DOB	/ /		SS#	
Secondary Insurance			Subscriber's Name		
Relationship to Patient	DOB	/ /		SS#	

COMPLETE THIS SECTION IF YOU ARE COVERED UNDER MEDICARE

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assists us in the correct billing of these services, please answer the following questions.

Are you employed? ☐Yes ☐No	Is your spouse employed? ☐Yes ☐No
If retired, list date of retirement / /	If retired, list date of retirement / /
Please list details employer information on front of form	Please list details employer information on front of form.
Please complete health plan information on front of form	Please complete health plan information on front of form

ADVANCE DIRECTIVE

Do you have a Living Will? ☐Yes ☐No

Please provide Jarrell Plastic Surgery with a copy of your file. Jarrell Plastic Surgery does not honor Advance Directives/Living Wills and our policy is as follows: Regardless of any advanced directive, if an adverse event occurs during your treatment at this office, we will initiate resuscitative or other stabilizing measures and transfer you to the nearest hospital for further evaluation. At the hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance to your wishes, Advance Directive, or Health Care Power of Attorney. Your agreement with this policy by your signature does not revoke or invalidate any current health care power of attorney.

AUTHORIZATION

I authorize Jarrell Plastic Surgery to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Centers for Medicare and Medicaid Services, Third Party Administrators, and/or Workers Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I am aware that the practice has a Notice of Privacy Practices that contains a section on Patient Rights. I have been given the opportunity to review this notice.

I also authorize Jarrell Plastic Surgery to utilize a fax machine or secure email to transmit any or all the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing or secure emailing of my medical records may increase the risk of accidental disclosure of my medical records. I am aware that most standard email/text does not provide a secure means of communication. There is some risk that any protected health information contained in email/text may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax is always an alternative that is available to you. I grant permission to Jarrell Plastic Surgery to release all or part of my medical records to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians and outpatient facilities. I am aware that I may request restrictions concerning the use of my personal medical information and that my request may not be able to be fulfilled and I will be notified if my request is denied. I request that payment of Medicare, Third Party Administrators for services furnished to me or on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Jarrell Plastic Surgery and my third-party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court cost.

Signature of Patient or Responsible Party/Insured Date

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