PLASTIC SURGERY CENTER OF ST. JOSEPH, INC.

Michael D. De Priest, M.D., F.A.C.S.
2111 N. Woodbine • St. Joseph, MO 64506 • (816) 364-6446 • FAX (816) 364-5320

DATE: _____

PATIENT INFORMATION

NAME _____
LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER DATE OF BIRTH AGE

CIRCLE ONE OR BOTH

RACE
1-WHITE
2-BLACK OR AFRICAN AMERICAN
3-AMERICAN INDIAN/ALASKAN NATIVE
4-ASIAN
5-NATIVE HAWAIIAN/PACIFIC ISLANDER
6-OTHER
7-MULTI-RACIAL (two or more races)
9-UNKNOWN

ETHNICITY 1-HISPANIC OR LATINO 2-NEITHER HISPANIC OR LATINO

ADDRESS CITY STATE ZIP COUNTY

HOME PHONE SEX MARITAL STATUS REFERRED BY

PRIMARY CARE PHYSICIAN

EMPLOYED BY EMPLOYER'S ADDRESS OCCUPATION BUS. PHONE

SPOUSE'S NAME DATE OF BIRTH SOC. SEC. # EMPLOYED BY

NEAREST RELATIVE/FRIEND NOT LIVING WITH YOU RELATIONSHIP PHONE

HOW CAN WE REACH YOU IN AN EMERGENCY? _____

PATIENT MEDICAL INFORMATION

Reason for Visit _____

MEDICAL HISTORY: *Circle any of the following conditions*

High Blood Pressure	Asthma	Cancer	Hives
Poor Wound Healing	Ulcers	Diabetes	Pacemaker
Excessive Bleeding When Cut	Anemia	Hay Fever	Seizures
Overgrowth Scars (Keloids)	Eczema	Tuberculosis	Kidney Disease
Reaction to Local Anesthestic	HIV +	Thyroid Condition	Liver Disease
Reaction to General Anesthestic	AIDS	Hepatitis A B C	Heart Disease

Herbs: *(Please List)* _____

_____

Current Medications: *(Please List)* _____

_____

Do You Take Aspirin? ❑ Yes ❑ No **Do You Take Arthritis Medication?** ❑ Yes ❑ No

Allergies to Medications: *(Please List)* _____

_____

Please List All Surgeries and the Approximate Year _____

_____

_____

Please List Any Significant Medical Illnesses or Problems _____

_____

DO YOU SMOKE? _____ IF YES, HOW MUCH? _____ HOW MANY YEARS? ___
DO YOU DRINK ALCOHOL? _____ IF YES, HOW MUCH? _____ HOW MANY YEARS? ___

MICHAEL De PRIEST, M.D., F.A.C.S.
PAYMENT AND INSURANCE PROCEDURES

The Consultation Fee is to be paid the day of your first appointment. All payments are expected at the time services are rendered including the dressing change and office visit charges.

INSURANCE

We file your insurance claims as an additional service for you. We do not determine the amount of coverage you will receive. This is done by your insurance company. Any question you may have concerning your insurance benefits should be directed to your insurance representative.

Very few companies will pay the full amount of the surgical fee. For that reason, we ask that your deductible be paid at the time your surgery is scheduled. If this is not feasible, you can make payments in which case the deductible amount is due at the end of a 2 month period. Please advise us what your deductible is at that time.

DEDUCTIBLE: $_____

I do hereby understand that in the case that my insurance company **NOT** pay my surgery fees in full, I am duly responsible for the balance of my account, to be paid upon receipt of my statement. Interest on account balances over 30 days will accrue at a rate of 1½% per month (annual rate of 18%). I understand should I default on payment of my account, relative financial information may be shared with your collection agency for purposes of collecting owed monies.

I hereby authorize payment of medical benefits and release of information requested to **MICHAEL D. De PRIEST, M.D.**

X_____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I authorize **MICHAEL D. De PRIEST, M.D.** to disclose complete information concerning his medical findings and treatment of the undersigned from the initial office visit until date of the conclusion of such treatment, to those individuals who, in **MICHAEL D. De PRIEST, M.D.'s** sole determination, are required to receive such information for the purpose of *medical treatment, medical quality assurance and peer review.*

X_____ _____

PATIENT'S SIGNATURE **DATE**

SUPPLEMENTAL INSURANCE CONSENT

We want you to receive the best reimbursement possible from your health insurance. As a service, we will fill out insurance forms for you. Please **READ** and **SIGN** below.

I authorize release of information to any and all insurance companies. I authorize payment direct to **MICHAEL D. De PRIEST, M.D.** I understand that I am responsible for my bill. I authorize use of this form on all my insurance submissions and authorize you to act as my agent in helping me obtain payment from my insurance companies.

X_____ **DATE** _____

LIFETIME CONSENT

I request that payment of my authorized Medicare benefits be made either to me or on my behalf to **MICHAEL D. De PRIEST, M.D.** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X_____ _____

NAME OF BENEFICIARY (PATIENT'S NAME) **PATIENT'S MEDICARE NUMBER**

DATE SIGNED _____