

**PATIENT INFORMATION**

PLEASE PROVIDE PHOTO ID AND INSURANCE CARDS

PATIENT FULL NAME \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

MARRIED SINGLE WIDOWED DIVORCED

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

NEAREST RELATIVE \_\_\_\_\_ PHONE \_\_\_\_\_

**SPOUSE/PARENT INFORMATION**

NAME \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IS THIS A WORK COMP CLAIM? YES / NO (VERIFICATION REQUIRED)

IS THIS DUE TO AN AUTO ACCIDENT? YES / NO (VERIFICATION REQUIRED)

**PRIMARY INSURANCE**

INSURANCE COMPANY NAME \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECONDARY INSURANCE**

INSURANCE COMPANY NAME \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

METHOD OF PAYMENT: (CIRCLE ONE) CASH CHECK CREDIT CARD

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PATIENT REGISTRATION INFORMATION**

PATIENT NAME \_\_\_\_\_ AGE: \_\_\_\_\_ M F

REFERRED BY: \_\_\_\_\_ FAMILY DOCTOR \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

DRUG/LATEX ALLERGIES: \_\_\_\_\_

PRESENT MEDICATIONS (including aspirin) \_\_\_\_\_

PREVIOUS SURGERIES \_\_\_\_\_

MEDICAL HISTORY: PLEASE CHECK	YES	NO
HEART ATTACK/ANGINA	( )	( )
HIGH BLOOD PRESSURE	( )	( )
MALIGNANT HYPERTHERMIA	( )	( )
DIABETES (PLEASE CIRCLE insulin pills)	( )	( )
CIGARETTE SMOKER	( )	( )
PNEUMONIA/EMPHYSEMA/LUNG PROBLEMS	( )	( )
BLEEDING/ CLOTTING DISORDER	( )	( )
THYROID (PLEASE CIRCLE high low)	( )	( )
HEPATITIS	( )	( )
HIV POSITIVE/AIDS EXPOSURE	( )	( )
SUBSTANCE DEPENDENCY (PLEASE CIRCLE drugs alcohol)	( )	( )
TUBERCULOSIS (TB)	( )	( )
EATING DISORDER	( )	( )
SWALLOWING DISORDER	( )	( )
CANCER (SPECIFY _____)	( )	( )
CHRONIC HEALTH CONDITION	( )	( )
SPECIFY: _____		
OTHER: _____	( )	( )

I AUTHORIZE EVALUATION AND TREATMENT BY DR.CHASE. ALL INFORMATION PROVIDED IS TRUE. I GIVE MY PERMISSION FOR PHOTOGRAPHS TO BE TAKEN.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Lawrence J. Chase, M.D. Chase Plastic Surgery  
321 North Mall Drive, Bldg N  
St George Utah 84790**

**NOTICE OF PRIVACY PRACTICE** \_\_\_\_\_

Print Patient Name

**As part of your medical care this office will protect your health information. Your medical and health information is personal. We will maintain confidentiality of your health information. We may be asked to release information for treatment purposes, payment for services, or health care operations (maintaining standards of care and quality improvement).**

**There may be cases where we are required to disclose health information without your signed authorization to report public health problems, to protect victims of abuse, neglect or domestic violence; for health oversight activities such as investigations, audits and inspections; for litigation; for workman's compensation claims or when required by law or court order.**

**Other disclosures require written requests to release health information. Authorizations may be revoked at any time with a written statement.**

**You have the right to:**

- \*Request restrictions on how your health information is used and shared, all requests will be considered but we are not required to agree with restrictions .**
- \*Inspect a copy of your health information including medical and billing records with written authorization.**
- \*Request corrections/additions to your health information in writing.**
- \*Contact the privacy officer at this office.**
- \*Receive a copy of this notice.**

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**Date**

**Patient signature**

**Staff**

*updated 4-14-03*

Financial Policy  
Chase Plastic Surgery  
Lawrence J. Chase, M.D., P.C.

1. Each patient is responsible for his/her own bills
2. As a courtesy, this office will submit claim forms to your insurance carrier. In order to facilitate claims processing, we request that you provide all insurance policy information or changes to our office. We will submit claims to your primary insurance a maximum of two times, if needed. If you have secondary insurance, we will be happy to submit it. We will submit one time only to your secondary insurance.
3. Payment of all co-payments or deductibles is requested at the time services are rendered. If your insurance carrier pays you directly, we will be glad to prepare the bill for you, and ask that you pay at the time of service or prior to the surgery. We will be happy to arrange a payment schedule for you. Patients who do not have insurance are asked to pay 100% of services rendered each visit or to make payment arrangements in advance. If insurance payments, co-payments, etc. paid to our office exceed the balance owed on your account an appropriate refund will be made.
4. At times you may be asked to contact your insurance carrier regarding payment of your claim. We have had problems with many insurance companies. You have more influence with your insurance company than we have.
5. We request that monthly payments be made on all accounts with outstanding balances. A bill becomes delinquent after 60 days. If payment arrangements need to be made for your account, please contact our billing company.

6. A service fee of \$25.00 will be charged on all returned checks, in conjunction with Utah State Law.  
AUTHORIZATION TO RELEASE INFORMATION: I/WE HEREBY AUTHORIZE Lawrence J Chase, M.D., P.C. to release any medical information that may be necessary for either medical care or in processing applications for financial benefit, including but not limited to Rehabilitation Service, Social Security Administration, and Worker's Compensation. I hereby authorize examination and any other medical services deemed necessary. I authorize the release of any medical information required by my insurance company for services furnished to me by this provider.

I agree to assume full financial responsibility for all charges by this practice, even if my insurance company does not cover these services. I authorize any insurance proceeds paid on my behalf be paid directly to this practice. I understand and agree to pay a finance charge of 18% per year or 1 ½ % per month on any unpaid balance to begin 60 days from the date of service. I further understand and agree to pay all attorneys' fees, court costs, filing fees including charges or commissions that may be assessed to us by any collection agency retained to pursue this matter, which may be as much as 50% of the principle balance owing.  
I understand and agree to all condition and authorizations as a patient of this practice.

Date:

\_\_\_\_\_  
Patient's Signature or legal guardian  
Authorization for lifetime billing

\_\_\_\_\_  
Staff Witness

kr Rev 7/29/10