

PATIENT REGISTRATION FORM (please print)

Date: _____

Patient Name: _____ **Date of Birth:** ___/___/___

Sex: M F Home Phone: () _____ - _____ Cell Phone: () _____ - _____

Social Security Number: _____ Status: M S W D Sep. Partnered

Address: _____

Occupation: _____ Work Phone: () _____ - _____

Email address: _____

Would you like to subscribe to our monthly newsletter or special offers? ___ Yes ___ No

Employer Name & Address: _____

Name of person to notify in case of emergency: _____

Home Phone: () _____ - _____ Work Phone: () _____ - _____

Primary Insurance: _____ Subscriber: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Subscriber: _____

Policy #: _____ Group #: _____

Person insured or responsible for payment: _____

Insured's address (if different from patient): _____

Relationship of insured to patient: _____

Spouse name: _____ Work Phone: () _____ - _____

Employer Name & Address: _____

Patient Name: _____ **Date of Birth:** ____/____/____

How did you find out about Dr. Ormsby? _____

Reason for Appointment: _____

Your present state of health: _____

Family doctor: _____ Phone: _____

Are you taking any medications? If so, please list on medications sheet (see attached):

Any Allergies? (if so, reactions):

Have you ever smoked? _____ If so, when did you quit? _____

How much do you smoke? _____

Are you pregnant? _____ How many pregnancies have you had? _____

How much alcohol (beer, wine, spirits) do you drink in a week? _____

Are you currently undergoing treatment for any medical or psychological conditions? _____

List previous surgeries: _____

Do you have an Advance Directive? Yes ____ No ____

Thank you – please give these completed pages to the Front Desk Manager

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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Patient Name: _____ **Date of Birth:** ____/____/____

I, the undersigned consent and authorize Dr. Marcia Ormsby to obtain pre-operative, operative, and post-operative photographs of me or parts of my body as deemed necessary for the complete documentation and illustration of my surgical treatment.

I understand that such photographs may appear in medical publications or conferences, presentations and teaching courses and internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Marcia Ormsby.

____ You may publish my photos using the guidelines as stated above.
____ Chart Only; I do not wish to have my photos published.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1998 ("HIPAA").

I release and discharge Dr. Marcia Ormsby from all rights that I may have in the photographs, from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Signature _____ Date _____

Witness/Physician: _____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent or Guardian _____ Date _____

MARCIA V. ORMSBY, M.D.

ANNAPOLIS AESTHETIC SURGERY

An Artist's Eye. A Woman's Touch

Welcome to our surgical suite of Cosmetic Plastic Surgery. We look forward to our relationship with you, and to providing you with our very best care. We trust you will be completely satisfied with all of our services and that you will share with us your suggestions on how to better serve your needs.

So that you will understand your medical and financial responsibilities, take time now to read the following. We want you to be aware of what is expected prior to commencing any treatment. If you have questions or concerns, please let us know.

We offer a variety of procedures, surgical and non-surgical, including skin care. It is the goal of each staff member to work together with Dr. Ormsby in order to ensure that your experience at our office is a pleasant one.

Patient name: _____

Person responsible for payment: _____

In order for us to consistently provide you with the best medical care possible, we must adhere to the following financial policy. Please feel free to discuss any questions with the Business Manager.

- A consultation fee of \$75.00 is payable by you for today's appointment. If services in addition to a consultation are undertaken, they will also be payable by you today, along with the consultation fee.
- Payment in full is expected for all cosmetic surgery. Payment plans are available, and Business Manager can discuss terms with you. We do not render services on the assumption that your charges will be paid by insurance. Make sure you understand your own insurance coverage, as you are responsible for the entire bill. For those non-cosmetic procedures that are insurance reimbursable, we will give you the necessary information so that you can file your own claims.
- A late payment fee of \$25.00 per month is added if your account balance is still unpaid by you after 60 days for whatever reason.
- If you miss a scheduled appointment without informing us, you may be charged \$25.00.

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YOUR RESPONSIBILITIES ARE:

1. To provide us with accurate and complete information about your medical history, present condition, and any medications you are now taking, including vitamin and mineral supplements.
2. To inform us immediately of any medical instructions you receive with which you are unwilling or unable to comply, and to let us know of any unexpected changes or concerns that arise during the course of your treatment, and to assume responsibility for any consequences if you refuse treatment or do not follow our instructions.
3. To pay all charges prior to treatment, and to be responsible for your total bill. (We accept cash, check, MASTERCARD or VISA). The only exceptions are Medicare recipients; or any patient who arranges for a payment plan with Marilyn.
4. To take an active part in your recovery process, which includes follow-up office visits as recommended by Dr. Ormsby. (There is no charge for post-operative follow-up visits).

I have read and fully understand the above information concerning the financial policy, and my responsibilities, and I agree to adhere by them.

I authorize Marcia V. Ormsby, M.D. to provide information to my insurance carrier and /or attorney concerning medical services rendered by her if necessary.

I also authorize all records from other physicians who have treated me to be available to Dr. Ormsby if she requires them.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Date of Birth: ____/____/____

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (*Please provide specific details*)

Employee signature

Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.