



laura c. randolph, M.D.

Reason for visit: _____

Referring Physician: _____

How did you hear about our practice? _____

PATIENT REGISTRATION

Last Name _____ First Name, Middle Initial _____
 Street Address _____ City, State, Zip _____
 Home Ph. _____ Mobile Ph. _____ Email Address _____
 DOB _____ SSN _____ Sex M F Marital Status S M D W
 Employed Y N Employer _____ Work Phone _____
 Spouse's Name _____ Spouse's Employer _____
 Spouse's Work Phone _____ Spouse SSN _____ Spouse DOB _____

FOR MINORS ONLY

Guarantor Last Name _____ First Name, Middle Initial _____
 DOB _____ SSN _____ Sex M F Marital Status S M D W
 Relationship to Patient _____

EMERGENCY CONTACT PERSON

Last Name _____ First Name, Middle Initial _____
 Street Address _____ City, State, Zip _____
 Home Phone _____ Mobile Phone _____ Relationship to Patient _____

ACKNOWLEDGEMENT OF PRIVACY NOTICE

Do you give us permission to discuss your health care issues with a spouse or anyone else? N Y

Name (Last, First, MI) _____ Home/Cell Ph. _____ Relationship _____
 Name (Last, First MI) _____ Home/Cell Ph. _____ Relationship _____

Do you give us permission to call and/or leave messages at your home? N Y at your place of employment? N Y

Do you give us permission to send mailings to your home? N Y

PRIMARY INSURANCE

SECONDARY INSURANCE

Co-Payment _____ Co-Payment _____
 Insurance Company _____ Insurance Company _____
 Insurance Phone _____ Insurance Phone _____
 Insured's Name _____ Insured's Birthdate _____ Insured's Name _____ Insured's Birthdate _____
 Policy No. _____ Group/Plan No. _____ Policy No. _____ Group/Plan No. _____

ASSIGNMENT/AUTHORIZATION

I authorize release of any information concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Laura C. Randolph, M.D.S.C. I understand that I am financially responsible for all services regardless of insurance coverage. I understand that if I fail to keep any financial agreement that I make with Dr. Laura C. Randolph, that my account will be sent to collections and I will be responsible for all monies incurred on my behalf for collection of my account.

 Patient/Guardian Signature
 Relationship (select one) Self Spouse Parent Legal Guardian

 Date



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PRIVACY POLICY

- Dr. Laura C. Randolph and staff work diligently every day to respect the privacy of your personal information. Please take a moment to familiarize yourself with what information we collect, how we protect it and how we use it. This is the privacy policy of Laura C. Randolph M.D.S.C.
- The Staff has been trained in the importance of maintaining your confidentiality and enforces the facility's privacy rules.
- We only collect that information which is pertinent to providing you with quality patient care.
- We will make every effort to describe in plain English all aspects of your care. Your informed consent will be obtained for specific procedures performed by Dr. Laura C. Randolph or a qualified member of the medical staff designated by her. In addition, you will be asked to consent to allow your personal records to be monitored by approved external reviewers. In certain specific instances, your case history will be included in scientific study after you have been allowed to give your informed consent. You may rest assured that your privacy will be preserved.
- We will maintain physical, electronic, and procedural safeguards to protect personal information we obtain about you.
- We will share only personal information with other caregivers on a need-to-know-basis.
- We will respect your expressed desire not to share certain information. You may so direct at any time.
- We will require other providers to whom we disclose your personal information to adhere to Laura C. Randolph's Privacy Policy
- If at any time you should feel that your privacy is being compromised, please let the office manager know immediately.
- Thank you for allowing Dr. Laura C. Randolph and staff the opportunity to assist you in achieving your plastic and reconstructive surgery goals.

PERSONAL MEDICAL HISTORY

Do you have a power of attorney? N Y

If yes please list name(s) and phone number(s) _____

Do you have a living will? N Y

If yes, is the living will on file in our office? N Y

Do you acknowledge receipt of our HIPAA Privacy Notice N Y

AUTHORIZATION FOR EXAMINATION

I, _____ represent to the physicians and staff that I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent to authorize examination and treatment by my doctor and such assistant or staff as may be assigned by her

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for the services provided to me. A copy of this authorization shall be as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration.

I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the discretion of my physician/surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for the documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

I consent to permit a sample of blood be given and tested should any person (surgeon, nursing staff, or other personnel) within Dr. Laura C. Randolph's office be accidentally contaminated by blood or other bodily fluids

I consent to allow review of my medical record as part of the ongoing Performance Improvement Program by designated individuals within the office.

Patient/Guardian Signature
Relationship (select one) Self Spouse Parent Legal Guardian

Date