Doctor Rand Rodgers

Name:_____
Address:_____
E-mail address:_____
Telephone: Home ( ) _____Work: ( )_____
Cell: ( )_____
Social Security#_____Birth date:_____
Your Occupation:_____
Business Address:_____
Insurance Information: Policy holder's name_____
Primary Policy:_____Number:_____
Address:_____ Phone: _____
Secondary Policy:_____Number:_____
Address:_____Phone: _____
Referring Physician:_____Phone:_____
Address:_____
Internist:_____Phone:_____
Address:_____
Emergency Contact:_____Phone:_____
What is the reason for today's visit?_____
_____
Physician's who have treated you for this problem:_____
Medical conditions: (for example diabetes, high blood pressure, cancer):_____
_____
Please list all medications:_____
_____
Allergies to medications:_____
All past surgeries:_____
If patient is a child: Father's birth date_____Mother's_____

PATIENT CONSENT FORM

The Department of health and Human Services has established a privacy rule to insure the privacy of personal health care information. The privacy rule was also created in order to provide a standard whereby health care providers obtain their patient's consent for uses and disclosures of personal health information in order to satisfactorily carry out treatment, payment, and other health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimal necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health-care operations.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relations with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information (PHI). If you choose to give consent in this document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. By signing below, you acknowledge receipt of our full privacy notice.

Patient Name_____
Signature _____ Date_____

I, furthermore, give permission to Dr. Rodgers to disclose my personal health information to the following:

NAME	RELATION	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

DOCTOR RAND RODGERS

I hereby assign my insurance benefits to be paid directly to Dr. Rand Rodgers. I authorize Dr. Rodgers to release any information required to my insurance carrier. I recognize that my signature will be kept on file.

I acknowledge that my health care carrier may consider surgical care of the eyelids and face as cosmetic. Removal of upper an/or lower eyelid skin and fat is cosmetic and elevation of the eyelids (ptosis repair) may be considered cosmetic. I am aware that I bear full responsibility for all costs involved in cosmetic surgery including surgical fees, anesthesia fees, and facility fees.

Signed_____
Date _____

I give permission for Doctor Rand Rodgers to use my photos for publications, clinical presentations, texts and journals on aesthetic and reconstructive facial surgery and on the world wide web.

Signed_____
Date_____

I give permission to the office of Doctor Rand Rodgers to leave messages on my home answering machine. Such messages may include date, time, and location of surgery, pre-operative clearance and results of biopsies, blood tests, and radiologic scans.

Signed_____
Date_____