Randy D. Proffitt, M.D.

Date: **Chart No.:**_____

Name:_____

First Name Mi ddle Name Last Name

Address:

Street City State Zip Code

Social Security No.: **Gender:** M or F **Birth date:** **Age:**

Marital Status: **Spouse Name:**

Parent's Name: (If patient is a minor):

Home Phone: **Work Phone:** **Mobile Phone:**

Email:

Emergency Contact: **Relation:** **Phone:**

Employer:

Address:

Referring Physician: ____(First Name) (Last Name)

Primary Care Physician: First Name) (Last Name)

Gynecologist: (First Name) (Last Name)

If Accident – Date of Injury:_____

Primary Insurance:_____ **Policy #:** **Group #:**

Copay Amount:

Mailing Address of Insurance Company:

Name of Insured:_____ **Birth date:**_____ M or F

Social Security No. of Insured: **Employer:**

Secondary Insurance: **Policy #:**

Group #:_____

Mailing Address of Insurance Company:_____

Name of Insured: **Birth date:** M or F

Social Security No. of Insured: **Employer:**_____

I hereby authorize **Dr. Randy D. Proffitt, M.D.** to release to my insurance company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I also authorize and request the insurance company to pay directly to the above name doctor the amount due me in my pending claim for basic medical, major medical and/or surgical treatment or service, by reason of such treatment or services rendered to me. In accordance with my insurance contract, I agree to be held responsible for any medical fees which my insurance company considers medically unnecessary or which they do not pay to failure on my part to meet my deductible.

In consideration for the services performed, for the undersigned or any person listed on this form, the undersigned agrees to pay the reasonable charges therefore and for the collection of said charges, undersigned hereby waives all claims or rights of exemption allowed by the constitution and laws of the State of Alabama or any other state and further agrees to pay all costs of collection of said charges including a reasonable attorney's fee. This authorization covers all hospital, outpatient, or clinic services rendered in the future whether as a result of initial or successive admissions or treatment until revoked in writing. Such written revocation shall not affect services already performed or to be performed after any admission to the hospital or clinic until patient is dismissed.

Signature:_____ **Date:**

INSURED PERSON / PATIENT
(PARENT IF PATIENT IS A MINOR)

MEDICAL INFORMATION

Please Print

NAME

BIRTHDATE: **SOCIAL SECURITY NO.**

TODAY'S DATE:

For your benefit it is necessary that you answer these questions as accurately as possible so that we can determine your physical condition before undergoing surgery.

1. DO YOU HAVE: **YES** **NO**

- Heart Disease
- High Blood Pressure
- Diabetes
- Epilepsy
- Thyroid Disease
- Asthma
- Shortness of Breath
- Dizzy Spells
- Swelling of Ankles
- Chest Pain
- Prolonged Bleeding
- Jaundice
- Bruise Easily
- Miscarriage

2. DO YOU TAKE: **YES** **NO**

- Herbal Medicines
- Blood Thinner Medication
- Heart Medication
- High Blood Pressure Med
- Diuretics (water pills)
- Aspirin
- Diet Pills
- Birth Control Pills

3. SMOKING **YES** **NO**

4. DO YOU TAKE, OR HAVE YOU EVER TAKEN STEROIDS (CORTISONE, ETC.)

YES **NO**

5. ARE YOU ALLERGIC TO: **YES** **NO**

- Penicillin
- Local Anesthetic
- **LATEX ALLERGY**
- Other Drugs (please list)

6. LIST OPERATIONS YOU HAVE HAD: AND ANY COMPLICATIONS

Date:

Date:

Date:

7. LIST MEDICATIONS YOU TAKE:

8. PLEASE LIST ANY UNUSUAL MEDICAL PROBLEMS:

9. ARE SECOND OPINIONS OR PRE-DETERMINATIONS REQUIRED BY YOUR INSURANCE?

YES **NO**

10. Have you ever had a Staph Infection? Or any requiring IV antibiotic Treatment?

Request for Release of Medical Information

This signed and dated form allows Dr. Proffitt to obtain medical information from other physicians and/or other health care providers participating in my care. This form also allows Dr. Proffitt to release medical information to such providers as he deems necessary. I hereby authorize **Randy D. Proffitt, M.D., F.A.C.S.** to release/disclose to the entity stated below all medical records for all dates of care, contained within the record. I understand that all medical information regarding my treatment may be released. The releaser, its agents and employees are hereby relieved of any responsibility or liability that may arise from the release, faxing or reproduction of such records and/or information.

I understand that this consent is revocable, except to the extent that action has already been taken. Request for revocation of this authorization must be in writing to the Medical Record Department. This authorization will expire in one year.

_____

_____

_____

This signed and dated form allows for the release of medical records and request they be sent to:

Randy D. Proffitt, M.D., F.A.C.S.
6317 Piccadilly Square Drive
Mobile, Alabama 36609
Phone (251) 344-0322
Fax (251) 344-0395

Date: _____

Patient's Name: _____ Date of Birth: _____

Signature of Patient: _____

Signature of Witness: _____

Authorization to Release Information

This signed and dated form allows **Dr. Randy Proffitt** and his staff to release medical information to the individuals named below involved in your medical care. Other than the named person, we will not discuss anything related to your care with anyone if they are not listed in this release. The only exception is the other medical professionals and their offices/facilities as necessary to provide you with medical care as well as your insurance company.

Person(s) with whom you *would like* your medical history, test results, appointments, etc. discussed (example: spouse, children, and friends):

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

or

☐ Please check if you would *not like* your care discussed with family members or friends.

Patient's Signature:_____ Date of Birth:_____

Randy D. Proffitt, M.D., LLC

Patient Consent for Use and Disclosure
of Protected Health In formation
Authorization of Benefits

I give permission to **Randy D. Proffitt, M.D., LLC** to submit full medical records, within discretion, to my insurance companies if they so request and to other physicians that I am consulting if they so request.

I give permission to **Randy D. Proffitt, M.D., LLC** to disclose information concerning medical findings and treatment, from the initial visit until the date of conclusion of such treatment to those individuals who, by the sole determination of **Randy D. Proffitt, M.D., LLC** are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

I hereby authorize any payment due on my claim to be paid directly to **Randy D. Proffitt, M.D., LLC.** In addition, I agree to pay for the services I received which are not covered by my medical insurance. (These services may include elective cosmetic procedures)

With my consent, **Randy D. Proffitt, M.D., LLC** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Randy D. Proffitt, M.D., LLC** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Randy D. Proffitt, M.D., LLC** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Randy D. Proffitt, M.D., LLC** Privacy Officer at 6317 Piccadilly Square Drive, Mobile, AL 36609**.**

With my consent, **Randy D. Proffitt, M.D., LLC** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With my consent, **Randy D. Proffitt, M.D., LLC** may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to **Randy D. Proffitt, M.D., LLC's** use and disclosure of my PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Randy D. Proffitt, M.D., LLC** may decline to provide treatment to me

_____ _____

Signature of Patient Date

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS / SLIDES / AND/OR VIDEO FOOTAGE

AUTHORIZATION FOR RELEASE OF PATIENT IMAGE

Name _____

Address _____ _____, _____ _____
street address city state zip code

I consent to the taking of photos, slides or video footage by **Dr. Randy Proffitt** or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by **Dr. Randy Proffitt.** I further authorize **Dr. Randy Proffitt** or one of his/her associates to release to the American Society of Plastic Surgeons ("ASPS") such images.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of ASPS and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, websites, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

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

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from **Dr. Randy Proffitt**

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire one year from the date written below.

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 1996 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge **Dr. Randy Proffitt**, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and 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 the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature Date

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

_____ _____
Signature Date