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 (Cigarettes/Vaping)

	YES	NO
Past History of smoking?	❑	❑
Are you currently smoking?	❑	❑

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	❑	❑
DAIRY PRODUCTS	❑	❑
Other Drugs (please list)	❑	❑

_____

6. LIST OPERATIONS YOU HAVE HAD: AND ANY COMPLICATIONS

_____Date:_____

_____Date:_____

_____Date:_____

7. LIST ALL MEDICATIONS YOU TAKE:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

Randy D. Proffitt, M.D.

Date:_____ **Chart No.:**_____

Name:_____

First Name Middle Name Last Name

Address:_____ _____ _____ _____

Street City State Zip Code

Social Security No.:_____**Gender: M or F Birthdate:**_____ **Age:**_____

Preferred Language: _____**Marital Status:**____ **Spouse Name:**_____

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

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

Patient's Employer:_____

Employer Address:_____

Email:_____

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

Referring Physician:_____

Gynecologist: _____

Primary Care Physician:_____

If Accident – Date of Injury:_____

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

Copay Amount:_____

Mailing Address of Insurance Company:_____

_____

Name of Insured:_____ **Birthdate:**_____ **M or F**

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

Secondary Insurance:_____ **Policy #:**_____

Group #:_____

Mailing Address of Insurance Company:_____

_____

Name of Insured:_____ **Birthdate:**_____ **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)

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., LLC.** 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., LLC
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).

(Please intial below)
_____ I understand that if my insurance company deems my surgeries, procedures or office visits as medically unnecessary or as a non-covered charge I am then responsible for any balance due to Dr. Proffitt.

With my consent, **Randy D. Proffitt, M.D., LLC** may use and disclose protected health information (PHI) about me to carry out treatment, healthcare operations (TPO) and payment. Release of PHI for payment may include medical insurance companies, banking, finance companies and credit card companies as applicable. 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,** and/or his agents may contact me by telephone, text message or email at any telephone number or email address associated with my account, including wireless telephone numbers. You may also contact me by sending text messages or emails. You may also 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, collections 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.

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.

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

Randy D. Proffitt, M.D., F.A.C.S.

6317 Piccadilly Square Drive
Mobile, AL 36609

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If **Medicare** doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Randy Proffitt, M.D., F.A.C.S.
6317 Piccadilly Square Drive
Mobile, Alabama 36609
(251) 344-0322
Fax: (251) 344-0395
Website: www.drproffitt.com
Email: info@drproffitt.com

Cosmetic Surgery | Plastic and Reconstructive Surgery | Free Tissue Transfer

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

In our continuing efforts to improve patient satisfaction and quality of care, we ask that you to take a few extra moments and tell us how you heard about Dr. Proffitt.

Please check all that apply and please feel free to add any comments.

- ❑ *REALSELF.COM*
- ❑ *JUSTBREASTIMPLANTS.COM*
- ❑ *LOVEYOURLOOK.COM*
- ❑ *DRPROFFITT.COM*
- ❑ *WORD OF MOUTH*
- ❑ *OTHER WEBSITE:*_____
- ❑ *ANOTHER PATIENT:*_____
- ❑ *ANOTHER PHYSICIAN:*_____

COMMENTS:

Member of the American Society for Aesthetic Plastic Surgery

Diplomat: American Board of Plastic Surgery
Diplomat: American Board of Surgery
Fellow: American College of Surgeons

Member
American Society of Plastic Surgeons