PATIENT INFORMATION

PREFIX	LAST	FIRST	MIDDLE	SUFFIX

MAIDEN NAME	GENDER ❑ M ❑ F	SOCIAL SECURITY # - -	MARITAL STATUS	DOB

RACE	ETHNIC GROUP	LANGUAGE

ADDRESS

CITY	STATE	ZIP	EMPLOYER

PHONE (H)	PHONE (CELL)	PHONE (WORK)	EXT

EMAIL	PREFERRED CONTACT NUMBER ❑ HOME ❑ CELL ❑ WORK

WHO REFERRED YOU TO DR. MCKEOWN?	PHONE

FAMILY PHYSICIAN (FULL NAME)	PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INSURANCE CO.	SUBSCRIBER NAME
SUBSCRIBER SSN	SUBSCRIBER D.O.B.
POLICY NO./ID #	GROUP NO.

PATIENT RELATIONSHIP TO SUBSCRIBER ❑ SPOUSE ❑ CHILD
❑ MOTHER ❑ FATHER ❑ OTHER: (PLEASE SPECIFY)

SECONDARY INSURANCE

NAME OF INSURANCE CO.	SUBSCRIBER NAME
SUBSCRIBER SSN	SUBSCRIBER D.O.B.
POLICY NO./ID #	GROUP NO.

PATIENT RELATIONSHIP TO SUBSCRIBER ❑ SPOUSE ❑ CHILD
❑ MOTHER ❑ FATHER ❑ OTHER: (PLEASE SPECIFY)

FINANCIAL RESPONSIBILITY (OTHER THAN PATIENT)

RESPONSIBLE PARTY NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	
WORK PHONE	PREFERRED CONTACT NUMBER ❑ HOME ❑ CELL ❑ WORK	
EMPLOYER		

YOU MAY RELEASE MEDICAL INFORMATION TO

NAME	
RELATION	PHONE

FINAL AUTHORIZATION AND ACKNOWLEDGEMENT:
The following authorization and acknowledgement must be signed by the patient if over 18 years of age. It must be signed by the responsible person if the patient is a minor or not responsible for their care.

THIS AUTHORIZATION/ACKNOWLEDGEMENT MUST BE SIGNED PRIOR TO TREATMENT BEING RENDERED:
I hereby authorize the release of any information relating to my insurance claims. I hereby authorize payment to the doctor of benefits otherwise payable to me but not to exceed the charges shown. I agree to pay for the services rendered and acknowledge that I am legally liable for the services. I understand that insurance is being filed as a courtesy to me and that I am responsible for the full bill 60 days from the date the insurance is filed. I agree to pay a 25% collection agency fee/attorney fee and any filing fees, court costs or other expenses incurred if my account is referred to a collection agency or attorney for collections. I understand there is a $25.00 fee for any check returned by the bank. I understand that my insurance will not cover cosmetic services.

SIGNATURE OF PATIENT OR INSURED DATE

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regardng my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment of health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Direct inquiries to our HIPAA officer at:
Dr. Joseph McKeown
ATTN: Joan Moore
420 N. Ridge Rd., Suite 100
Richmond, VA 23229

DECLINE TO SIGN

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE