

NEW PATIENT/UPDATE INFORMATION

LINDA M. WATERS, MD., F.R.C.S.(C), FACS

Plastic and Reconstructive Surgery

723 Emerson St.

Palo Alto, CA 94301

(650) 328-9646 Fax (650) 328-9528

www.lindawatersmd.com

Date: _____

Patient: _____
(Last) (First) (M)

Address: _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Age: _____ Sex: _____ E-mail: _____

Telephone Number: Home (____) _____ Cell# (____) _____ Work# (____) _____

Referred By: _____

Reason for Referral: _____

Name of Primary Care Physician (PCP): _____ Phone # of (PCP) (____) _____

Address: _____
(Street) (City) (State) (Zip)

Stanford Medical Record # _____

Employed By: _____ Phone: _____

Work Address _____ City: _____ Zip: _____

Spouse/Partner/Parent Name (circle one): _____ Home: (____) _____

Employed By: _____ Work : (____) _____ Cell : (____) _____

Work Address: _____ City: _____ Zip: _____

Emergency Contact: _____ Relation: _____ Home (____) _____ Cell: (____) _____

Address, if different: _____

Responsible party for payment, if different: _____

Name: _____ Phone: (____) _____

Address: _____ City: _____ Zip: _____

INSURANCE INFORMATION

We require a copy of your medical insurance info/card for our files.

PRIMARY Insurance Company: _____

Group # _____ ID or Policy# _____

PHOTOGRAPH CONSENT

1. I consent to the photographing of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

RELEASE OF INSURANCE AND MEDICAL INFORMATION AND PATIENT RESPONSIBILITY

2. Patients are responsible for payment of all services rendered. You are responsible for selecting providers within your insurance network and obtaining appropriate authorizations for your visit from your primary care physician.
3. I hereby authorize Linda M. Waters to furnish the above insurance company(s) all requested medical information.
4. I hereby authorize payment of medical benefits directly to Linda M. Waters for services.

Date: _____

Patient's Signature

Acknowledgement of receipt of "Notice of Privacy Practices"

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In this Notice "you(r)" means you, and/or, your minor dependent that is being treated.

As required via the federal HIPPA regulations (Health Insurance Portability and Accountability Act) the providers at our medical practice, along with its nursing and administrative staff, under the guidance of the Physician(s), may share you(r) health information for the purposes of treatment, payment, and health care operations.

I understand that my health information may be used for the purposes of treatment, payment, and health care operations such as (but not limited to):

- A. Sharing my health information among providers (within and outside our medical practice), on a need to know basis, in order to medically treat me.
- B. Using my health information for medical billing purposes, including providing referrals to medical specialists, when necessary and appropriate.
- C. Sharing my health information with health insurance firms, government agencies, or other claims payers that request information related to benefits determinations, medical claims filed for visits, treatments, admissions, and other billing matters.
- D. Using my health care information for health care operations, including monitoring the quality of care, audits, surveys, and carrying out other medical practice business and administrative activities.
- E. My permission is given today for any medical treatment including, but not limited to, examination, injections, diagnostic testing or medical procedures as may be deemed advisable by members of this Medical Center.

I understand that all reasonable efforts will be made to protect the privacy of my health information whether maintained as a paper file or electronic file, and regardless of how it is communicated (verbally, or via fax, paper, or electronically).

I have been given the opportunity to read the "Notice of Privacy Practices" which outlines in more detail how my health care information is used and shared with others. The "Notice of Privacy Practices" explains when I need to give further approval for the providers to use my health information or share it outside of the medical practice, and when my permission is not needed for the providers to use my health information or share it outside of the medical practice (such as: required by law, public health activities, and so forth).

I understand that this medical practice has reserved the right to change the "Notice of Privacy Practices" at any time. I may obtain a current copy of the "Notice of Privacy Practices: by contacting the Privacy Officer of this medical practice.

My signature below constitutes my acknowledgement that I have been provided the opportunity to read and obtain a copy of the "Notice of Privacy Practices".

Signature of adult patient or a minor patient's parent or legal guardian

Print the signer's full name

Date