DELRAY BEACH PLASTIC SURGERY

JOHN G. WESTINE, MD | THE ART & SCIENCE OF BEAUTY

PATIENT NAME _____ **Sex □ M □ F**
First Last MI
PATIENT DATE OF BIRTH_____ **SSN#**_____

ADDRESS_____
_____
_____

HOME_____**CELL**_____
EMAIL_____
Any restrictions for contacting you? no □ yes□ _____

MARITAL STATUS □Single □ Married □ Divorced □Other_____
PATIENT'S EMPLOYER_____
ADDRESS _____
PHONE _____ **is it okay to call you at work? □yes □no**

HOW DID YOU HEAR OF DR? (mark all that apply)
□ phone book □ magazine_____ **□ website/blog/Facebook □ salon/spa**_____
□ friend/relative_____ **□doctor**_____**□other**_____

If you were referred by a specific person, may we thank them? □ yes □ no

EMERGENCY CONTACT _____
RELATIONSHIP_____
HOME# _____
CELL#_____

OFFICE POLICY

To avoid misunderstanding regarding health insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and the patients are personally responsible for payment of fees. There are no refunds for services rendered. All cosmetic surgery deposits are non-refundable upon cancellation.

_____ _____
Signature **Date**

PHOTOGRAPH AUTHORIZATION

In connection with the services which I am receiving, I consent that photographs may be taken of me. The photos shall be used for medical records only.

_____ _____
Signature **Date**

Notice of Privacy Practices
Patient acknowledgement form

As of April 14, 2003 the Federal Government has implemented privacy laws. The following is the privacy policy of my office.
TREATMENT We may disclose your health information to a physician or other healthcare provider providing treatment to you. We may disclose your records only if subpoenaed. We may send your records to another physician with your written permission.
X-RAYS We will send your x-rays (not your health information) to another physician with your written permission. We may send your x-rays if subpoenaed.

YOUR HEALTH INFORMATION We will not disclose your health information to anyone unless we have your written permission.

MAILING OR DISCLOSING YOUR HEALTH INFORMATION At no time will we disclose your health information for marketing purposes or for any other reason than your health treatment or at your request with your written permission.

ACCESS You have the right to get copies of your records with written request. We may charge you a reasonable fee for duplicating your records and/or X-rays.

NATIONAL SECURITY We may disclose to the armed forces your records as required by law.

APPOINTMENT REMINDERS We may remind you by telephone or post card of your appointments.

ABUSE OR NEGLECT We may disclose your health information to the authorities if you are a possible victim of abuse, neglect or domestic violence.

COMPLAINTS You as a patient have a right to complain about our privacy policy. Notify our privacy officer in writing.

ELECTRONIC FILING We may file electronically

PAYMENT We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company or a third party.

THE PRIVACY POLICY OF THIS OFFICE WILL REMAIN IN EFFECT FROM December 1, 2006 UNTIL IT IS REPLACED.

BY SIGNING THIS FORM, I AM ACKNOWLEDGING THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

_____ _____
Signature of Patient or/Legal Representative Date

By <u>INITIALING</u> the space below, I specifically authorize Dr John G. Westine to use and disclose my health reports to:

___ Primary Care Physician
___ Dentists
___ Hospitals
___ Family Members picking up information on my behalf.
___ Imaging Companies you are being referred to (i.e: MRI's Cat scans, Etc)
___ Medical Specialists
___ Outside Laboratories – for referral