CONSENT AUTHORIZATIONS

Consent to Treatment and Other Authorizations

I hereby consent to medical treatment rendered by Dr. Edmond and/or Samer W. Cabbabe also acknowledge my receipt of the physician's current Privacy Notice. If my treatment requires billing to my insurance carrier, I hereby authorize release of any medical information necessary to bill my insurer, and authorize payment of medical/surgical benefits to be made to Plastic Surgery Consultants or Dr. Edmond and/or Samer Cabbabe.

DATE: ____________________ SIGNATURE: ____

Photography Release

I understand that pre-treatment and post-treatment photographs are necessary to follow my medical care. My pre-treatment and post-treatment photos may be viewed for educational purposes by my physician or patients; or to be sent to my insurance company for pre-approval of reconstructive procedures. Educational purposes may include: use in physician consults with individual patients, use in physician seminars presented to potential patients or medical associations and use in social media including the practice website for prospective patients.

Plastic Surgery Consultants/Advanced Plastic Surgery has my permission to use the photographs for these purposes. This consent will be in effect until physician discontinues use of these photographs. I understand that my photographs will be handled with the highest possible level of confidentiality.

Signature____ Date __________________

Printed Name____

PATIENT REGISTRATION SHEET

PATIENT INFORMATION:

LAST NAME: ______________________ FIRST: ______________ MIDDLE INIT: ______ SEX: M F

ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP: ______

DATE OF BIRTH: ______________ MARITAL STATUS: M S D W SEP SS#: ______________

HOME PH#: ______________ WORK PH#: ______________ CELL PH#: ______________

EMPLOYER: ______________________

EMPLOYER ADDRESS: ______________________ CITY: ______________ STATE: ____ ZIP: ______

SPOUSE NAME: ______________________ EMAIL ADDRESS ______________________

WORK RELATED INJURY: Y N DATE OR ONSET OF INJURY: ______________________

IF PATIENT IS 18 OR UNDER:
FATHER'S FULL NAME: ______________________ HOME PH#: ______________ WORK PH#: ______________

MOTHER'S FULL NAME: ______________________ HOME PH#: ______________ WORK PH#: ______________

CONSENT FOR E-MAIL CONTACT:
SIGNATURE______________________

WHO IS FINANCIALLY RESPONSIBLE FOR PAYMENT?
(If patient is a minor, under age 18, both parents are responsible for payment of services rendered to their child according to state law.)

If patient is the responsible party, do not complete this section – CHECK HERE ❑

LAST NAME: ______________________ FIRST: ______________ MIDDLE INIT: ______________

ADDRESS: ______________________ CITY/STATE/ZIP ______________________

HOME PH#: ______________________ WORK PH#: ______________________

EMPLOYER: ______________________ SS#: ______________________

INSURANCE INFORMATION: (In addition to listing all insurance plans, please present your insurance cards to that we may obtain a copy.)

PRIMARY INSURANCE: ______________________

CLAIMS MAILING ADDRESS: ______________________

CITY/STATE ______________________ ZIP: ______________ PHONE #: ______________

INSURED'S NAME: ______________________ DATE OF BIRTH: ____________ RELATIONSHIP TO PT: ______________ SEX: M F

INSURED'S ADDRESS: ______________________ INSURED'S SS #: ______________________

EMPLOYER: ______________________ GROUP #: ______________________ I.D. # ______________

SECONDARY INSURANCE:
CLAIMS MAILING ADDRESS: ______________________

CITY/STATE: ______________________ ZIP: ______________ PHONE#: ______________

INSURED'S NAME: ______________________ DATE OF BIRTH: ______________ RELATIONSHIP TO PT: _____ SEX: M F

INSURED'S ADDRESS: ______________________ INSURED'S SS #: ______________________

EMPLOYER: ______________________ GROUP #: ______________________ I.D. # ______________

NEAREST RELATIVE OR FRIEND, NOT LIVING WITH YOU, THAT WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU OR IN CASE OF AN EMERGENCY:
NAME: ______________________ PHONE#: ______________________

WHOM MAY WE THANK FOR REFERRING YOU TO DR. CABBABE?
REFERRED BY DOCTOR: ______________ (NAME) REFERRED BY FRIEND/PATIENT: ______________ (NAME)
(CIRCLE ONE)
YELLOW PAGES ___ , TV ___, NEWSPAPER/MAGAZINE ___, RADIO ___, INTERNET ___, OTHER ______________________

PLEASE COMPLETE THE BACK OF THIS FORM