NEW ENGLAND
PLASTIC SURGERY CENTER
LOREEN ALI MD

Patient Name: ____ I prefer to be called : ________________________

Date of Birth: _________________SS# ________________ Marital Status: ***Circle one*** S M D Widow/ed

Address: ____City: ____________________State: _______ Zip:_______

Preferred Contact number check box ☐ Home ______________________________ ☐ Cell _______________________________

Email Address: ___________________ (email address to be used to communicate health information, practice news, cosmetic specials and events only generated by the practice. Email addresses are kept securely within our practice management system only)

Primary Care Physician: ______________________ Town: ________________Phone: _________________

Specialist who referred you ____________________ Town: _______________Phone:_________________

Your Cardiologist (if seeing one) _____________________________ Town: ______________Phone: _________________

Language Spoken ______________Race ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ Declined to state

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student Occupation ___________________________

MEDICAL EMERGENCY CONTACT INFORMATION

Contact Name: ____ Relationship:___________________________________

Home Phone: ____ Cell Phone: _____________________________________

AUTHORIZATION TO BILL INSURANCE

I hereby authorize and request my insurance company to pay New England Plastic Surgery Center directly the amount due on my claim for services provided to my dependent or me. I also agree that should the amount be insufficient to cover the entire medial and/or surgical expense, I will be responsible for the payment of the difference and if the service provided is considered a non-covered service; I will be responsible for payment of that service.

I authorize any holder of my medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid services or its intermediaries any information needed for this or related claim. I permit a copy of the authorization to be used in place of the original and request payment or medical services to be made to the party who accepts assignment. I certify that this information is true and correct to the best of my knowledge.

Responsible for the balance – Although you may have health coverage through another person, all billing/payment information will always be sent directly to you and will be your responsibility. ☐ I have reviewed a copy of the financial policy which is available at www.neplasticsurgerymd.com

Patient Signature ___________________________________ Print Name: __________________________Date: ____________

Guardian Signature _________________________________Print Name: ___________________________Date:____________

HIPAA PRIVACY INFORMATION – **Acknowledgement of Receipt of Notice of Privacy Practices Privacy notice of the privacy practices at New England Plastic Surgery available at www.neplasticsurgerymd.com**

I ___ (patient initial) understand that if I email photos or protected health information to this office, New England Plastic Surgery is only responsible for the content once received in this office and it will become part or your permanent electronic medical records. I also understand that when I leave the practice with my own personal health information such as my visit summary, pre/post op instructions etc. it is my responsibility to keep this information private and in safe keeping.

We will leave appointment reminders on the preferred contact phone number that you provided at the time of the appointment.

May we leave other medical information on/with?

Home Voicemail: ☐ YES ☐ NO Cell Phone Voicemail ☐ YES ☐ NO Automated Reminder calls ☐ YES ☐ NO

Authorization to discuss my appointments or health information with: ☐ I decline to give anyone permission to access

Name: ____________________________ Name: _________________________________Name: ________________________________

Relationship: _______________________ Relationship: ___________________________ Relationship:____________________________

Patient Signature ____________________________ Print Name:____Date: ____________

Guardian Signature: __________________________ Print Name: ____Date:_____________

Relationship to patient ________________________

Form Date 11/25/19