Welcome to Plastic Surgery of Southern Connecticut, L.L.C.

Joseph B. O'Connell, M.D., F.A.C.S.

Patient's Last Name | **First Name, Middle** | **Date**

Date of Birth | **Age** | **Marital Status** | **E-Mail Address**

Address – Street | **City** | **State** | **Zip**

Home Telephone | **Daytime Telephone** | **Cell Phone No.**

Referred By (please indicate physician's name, name of other source or how you heard about us) | **Business Phone**

Employed By | **Employer's Address** | **Occupation**

Name of Spouse | **Employed By** | **Employer's Address** | **Occupation**

In Case of Emergency Notify | **Relationship to Patient** | **Telephone**

Known Allergies including medication allergies, allergies to anesthetics and latex allergy

MEDICAL INSURANCE INFORMATION

Policyholder's Name | **Address** | **City** | **State** | **Zip**

Policyholder's Home Telephone Number | **Relationship to Patient** | **Occupation**

Plastic Surgery of Southern Connecticut, L.L.C. is committed to protecting the confidentiality of all personally identifiable information including social security numbers, driver's license numbers, credit or debit card numbers, bank account numbers, identification card numbers and health insurance numbers collected in the course of business. Access to this information is limited to those employees and others whose duties require such knowledge. Employees of this Company are prohibited from disclosing, directly or indirectly, such personally identifiable information to anyone unless there is a lawful business justification for the disclosure. Note: This Company does not collect social security numbers.

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION

I hereby authorize Plastic Surgery of Southern Connecticut, L.L.C. to release any medical information, including medical photographs and confidential health information to my insurance carriers and to allow a photocopy of my signature to be used to file insurance claims. I hereby authorize and direct payment of insurance benefits due for the services provided by Plastic Surgery of Southern Connecticut, L.L.C. directly to Plastic Surgery of Southern Connecticut, L.L.C. I understand that, regardless of insurance benefits, I am financially responsible for fees for all services rendered and agree to reimburse Plastic Surgery of Southern Connecticut, L.L.C. for any attorney and court costs necessary to collect outstanding fees. I understand that balances over 30 days due will accrue interest at 1.5% per month.. *I also understand that unless specifically informed otherwise, the physicians of Plastic Surgery of Southern Connecticut, L.L.C. do not participate contractually with <u>any</u> managed care entity, HMO or insurance company.*

Signature_____Date _____