ADVANCED
BREAST SURGERY

New Patient Registration Form

- **Name:**_____**Date of Birth:**_____
- **Sex:** ☐ Male ☐ Female
- Phone Number:_____
- Email Address:_____
- Home Address:_____

City:_____State**:**_____ ZIP:_____

- **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact

- Full Name: _____
- Relationship to Patient: _____
- Phone Number: _____

Primary Care Provider (PCP):_____

Referring Doctor (if different from **PCP**)**:**_____

Insurance Information

- Primary Insurance Name:_____
- Secondary Insurance Name:_____

Preferred Pharmacy

- Pharmacy Name:_____
- Pharmacy Phone:_____ City:_____ State:_____ ZIP:_____

Patient Consent & Signature

I certify that the information provided above is true and accurate to the best of my knowledge. I authorize the release of any medical or other information necessary to process insurance claims.

Patient Signature: _____**Date**:_____

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GENERAL TREATMENT CONSENT

Patient Name:_____**DOB:**_____

NOTICE OF NONDISCRIMINATION:

Advanced Breast Surgery PLLC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Advanced Breast Surgery does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or any other basis prohibited by law.

I UNDERSTAND THAT:

- I will ask questions regarding my care and treatment.
- I acknowledge that the practice of medicine and surgery is not an exact science, and no one has made promises or guarantees to me regarding the outcome of my treatment, care, or examination at Advanced Breast Surgery.
- Students and staff may see me and access my medical record for teaching or research purposes.
- The staff will confirm my identity and the procedure being done to ensure my safety.

STORAGE AND ELECTRONIC SHARING OF MEDICAL INFORMATION:

I understand that Advanced Breast Surgery will keep my or my child's medical information according to state law, federal law, and policy. I also understand that my medical information may be stored electronically and sent to or received from other healthcare providers and/or payers electronically. This includes my diagnosis, treatments, medications, and prescription information, as well as any details about my mental health, infectious diseases (e.g., HIV), or other sensitive health issues (e.g., drug or alcohol use disorder).

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI):

I understand that my PHI may include very personal information such as HIV/AIDS status, physical/mental illness, or alcohol/drug abuse. If I give someone access to my MyChart portal or request my PHI be shared with a third party, they will have access to this personal information. I acknowledge that Advanced Breast Surgery may be required by law to report certain medical information to agencies like the health department (e.g., for HIV, TB, etc.). If I am transferred to another facility, Advanced Breast Surgery's providers may access my medical records to follow up on my care and/or use the information for medical research.

PRIVACY NOTICE:

I have had the opportunity to receive a copy of the Notice of Privacy Practices and ask questions about the information provided. I may express concerns to the Patient and Family Experience Representative at the location where I receive care.

CONSENT TO CONTACT:

I consent to receive autodialed and/or pre-recorded telephone calls, text messages, and/or emails from Advanced Breast Surgery or its agents. These communications may include billing information, appointment reminders, and limited health information. I understand I am responsible for any communication charges from my phone provider(s).

BILLING CONSENT AND AUTHORIZATION TO RECEIVE PAYMENT:

- I request that payment of authorized Medicare benefits be made to Advanced Breast Surgery for any services provided.
- I understand that I am responsible for any charges not covered by insurance.
- If my account is not paid when due, Advanced Breast Surgery may retain a lawyer and/or collection agency for collection, and I will be responsible for any associated costs, including legal fees.

OUTPATIENT MEDICARE PATIENTS:

I understand that Medicare rules make me responsible for self-administered medicines furnished to me while I am an outpatient. I may seek reimbursement from Medicare Part D for these medicines, as outlined in Medicare Drug plan enrollment materials.

ASSIGNMENT:

I assign to Advanced Breast Surgery all benefits, claims, and rights regarding my charges, including the right to take action to seek payment, appeal the denial of payment, and pursue claims under ERISA. I authorize Advanced Breast Surgery to act on my behalf to collect payments and assist in any appeals or claims as needed.

TRANSLATION:

I understand that I can access this document in other languages upon request.

PATIENT SIGNATURE(S):

I have read this form and I understand it. All my questions have been answered.

Patient Signature:_____**Date:**_____

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Patient Name:_____Date:_____

MEDICATION ALLERGIES:

Do you have any allergies or reactions to medications? (Check one)

☐ Yes ☐ No

If yes, please list below

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

CURRENT MEDICATION LIST:

Please list all medications you are currently taking, including prescription, over-the-counter, vitamins, and supplements.

_____

_____

_____

_____

_____

_____

Patient Initials:_____