CIRILLO CENTER
PLASTIC SURGERY

Laura A. Gowen, MD

Welcome Form

Patient Information

Last Name _____ First _____ Middle _____
Marital Status: Single___ Married___ LTP___ Divorced___ Widowed___ Separated___

DOB _____ /_____ /_____

Gender: Female___ Male___

ETHNICITY: Hispanic____ Non-Hispanic ____ (required by insurance company in compliance with health reform)

RACE: American Indian or Alaskan Native___ Asian___ Black___ Caucasian___ Pacific Islander___ Other___

Preferred Language_____

eMail*_____

Address _____

City _____ State _____ Zip _____

Home (_____) _____ Cell* (_____) _____ Other (_____) _____

Best Contact Method (Please Circle): Home Cell Other Can we leave a detailed message? Yes___ No___

Emergency Contact _____Phone (_____) _____Relationship to Patient _____

Employer_____ Occupation _____

Primary Care Physician: _____ **Phone:** _____

How did you hear about us? (Check all that apply)

Physician Referral (name) ___ Website___ Print Advertisement ___
Friend/Family Referral (name) ___ Social Media ___ Other _____

Authorization to Disclose Protected Health Information (PHI)

Name _____ Relationship to Patient _____
Phone Number Cell (_____) _____ Home (_____) _____

Primary Insurance

Health Insurance Provider Name _____
Policy Holder Name_____ Relationship to Patient _____

Policy Holder DOB _____ /_____ /_____ Phone Number Cell (____) _____ Home (____) _____

Policy Holder eMail* _____

Policy Holder Address _____

Policy Holder City _____ State _____ Zip _____

Responsible Party employed by _____

Policy Holder Occupation: _____

*By providing my email address and mobile phone number, I give CCPS permission to send me appointment reminders, practice newsletters, and online review requests. I understand that I may opt-out at any time, and that CCPS will never sell or share my email/mobile with any external entity. Appointment reminder eMails and all texts are encrypted and HIPAA compliant to protect your privacy. Normal carrier SMS charges apply.
Check to opt-out of appointment reminder/newsletter eMail. [ ] *Check to opt-out of appointment reminder/online review text.* [ ]

CIRILLO CENTER
PLASTIC SURGERY

Laura A. Gowen, MD

HIPAA Consent Form

Patient Name: _____

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Patient or Representative

Relationship to Patient (if other than patient):_____ Date: ___/___/___

In front of _____
Printed Name – Practice Representative