Patient Demographic Information

Patient Name: _____

Preferred Name / Nickname: _____

Street Address: _____

City: _____State:_____ Zip: _____

Social Security #: _____ Birth Date: _____ / _____ / _____

Marital Status (circle) Gender:

May we include your address in mailings we periodically use to keep our patients informed of current happenings in the practice? Yes No

Contact Information

May we leave messages regarding appointments and patient care instructions at this contact? (Please Circle)

Home: (_____) _____-_____	Yes
Work: (_____) _____-_____	Yes
Mobile: (_____) _____-_____	Yes
Pager: (_____) _____-_____	Yes
Other: (_____) _____-_____	Yes
Fax: (_____) _____-_____	Yes
e-mail: _____	Yes

Please circle your preferred contact number (please circle): Other

Emergency Contact

Name: (First) _____ (Middle) _____ (Last) _____

Relationship to patient: _____

Home: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

Primary Care Provider (Physician): _____

Pharmacy:_____ Address:_____ Phone: _____

Where did you hear about us (Please circle one):

D Magazine Living Magazine Brochure New Beauty Physician Referral

Google Ad Internet Search Health Grades Television AAFPRS Website

Friend or physician – if so, please let us know their name: _____

Other: _____

Employment Information

Employment (circle one): Full time Part time Full time student Part time student Retired Other

Occupation: _____ Company or School: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

Insurance Company Name: _____

Insurance Phone Number for Providers to Call:: _____

Patient's Insurance ID Number _____Policy Group or FECA Number_____

Please fill out this section if primary insured is other than patient.

Name of Primary Insured: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Birth Date: _____/_____/_____

Employer: _____

Phone: (_____) _____-_____

Insured's relationship to Patient: _____ Insured's Gender: Male Female

D.J. Verret, MD, PA files claims for any of the Managed Care Plans with which we participate. **Any applicable co-payment, co-insurance or deductible is expected to be paid at the time of service and the undersigned agrees to be responsible for any charges not covered by a third party payer.** Our office is willing to assist in claim filing for insurance carriers with which we are not contracted. We require that these arrangements be made with our office staff prior to your visit. D.J. Verret, MD, PA does not participate in the Medicaid system and undersigned acknowledges that he/she is responsible for payment for any services that may otherwise be covered by Medicaid. _____initial

I hereby authorize D.J. Verret, MD, PA to release my medical or incidental information that may be necessary for medical care or to process medical insurance claims for which payment is assigned to the provider. I assign D.J. Verret, MD, PA all payments for medical services rendered to me or my dependents for services filed to insurance on my behalf.

_____initial

I hereby give my consent for medical treatment by the physician or under the direction of the physician of D.J. Verret, MD, PA to myself or my dependent. _____initial

_____ _____

Patient/Parent/Guardian Signature Date

Privacy Practices

A complete copy of the HIPAA related privacy practices for D.J. Verret, MD, PA is available online at http://innovationsfps.com/PDF/Notice%20of%20Privacy%20Practices.pdf or can be obtained by asking the office staff for a copy or in writing by mailing: Office Manager; D.J. Verret, MD, PA; 6545 Preston Road, Suite 200; Plano, TX 75024.

Dr. D.J. Verret and D.J. Verret, MD, PA (collectively labeled "*Physician*") agree to provide treatment to and maintain Privacy of *Patient* as outlined in the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

_____ _____

Patient/Parent/Guardian Signature Date

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean the undersigned or the undersigned's power of attorney. "Physician" shall be understood to mean D.J. Verret, MD of D.J. Verret, MD, PA.

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Facial Plastic and Reconstructive Surgery board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the American Academy of Facial Plastic & Reconstructive Surgery.

In further consideration for this, I, (the Physician), agree to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

_____ _____

Patient/Guardian Date Physician Date