Earl Gage, MD – Plastic and Reconstructive Surgery

Today's Date: ____________________

PATIENT DEMOGRAPHICS

Name: Last: __________________________ First: __________________________ M.I.__________

Sex: ☐ Male ☐ Female Birth date: ____________________ Social Security # __________________

Address: ____ Home Phone: ______________________

____ Work Phone: ______________________

City: ____ Mobile Phone: ______________________

State: ______________ Zip: __________________ E-mail: __________________________

Employer __________________________________ Part-Time / Full-Time

Student __________________________________ Part-Time / Full-Time

Marital Status______________

PRIMARY CARE PROVIDER INFORMATION

Primary Doctor (PCP): ____

Address____Phone________________

Referring Doctor: ____

Address____Phone________________

<table>
<tr><th colspan="4">Primary Insurance</th></tr>
<tr><td>Insurance Company Name</td><td>Subscriber's Name</td><td colspan="2">Subscriber's Social Security Number</td></tr>
<tr><td colspan="2">Subscriber's Relationship to Patient
☐Self ☐Spouse ☐Parent ☐Guardian ☐Other</td><td>Subscriber's DOB
/ /</td><td>Subscriber's Sex
☐Male ☐Female</td></tr>
<tr><td>Subscriber's Employer</td><td>Patient's ID #</td><td>Group #</td><td>Copay Amount</td></tr>
<tr><td colspan="2">Employer Address</td><td>City</td><td>State Zip</td></tr>
<tr><td colspan="2">Insurance Company Address</td><td>City</td><td>State Zip</td></tr>
</table>

Secondary Insurance			
Insurance Company Name	Subscriber's Name		Social Security Number
Subscriber's Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Guardian ☐Other	Subscriber's DOB / /		Subscriber's Sex ☐Male ☐Female
Subscriber's Employer	Patient's ID #	Group #	Copay Amount
Employer Address	City	State	Zip
Insurance Company Address	City	State	Zip

Emergency Contact Information		
Contact Name	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Guardian ☐Other	Contact Phone ( )

Yes, I give permission for Dr. Gage's staff to give detailed information regarding my treatment via:

☐ **Answering machine @**__________________ ☐ **Mail** ☐ **Email** ______________________________

Earl Gage, MD – Plastic and Reconstructive Surgery

Medical History

Why are you seeing Dr. Gage? ______________________________
____

When did this problem begin? ______________________________

How has it changed over time? ______________________________

What treatment have you had for this problem? ______________________________

Current medications: ☐ **None**
List both prescription and non-prescription medications and how long each has been taken.
____
____
____

Allergies: ☐ **None**
List all allergies to medications or other food/ environmental substances and the reaction(s).
____
____

Past Medical History	**Previous Illnesses & Hospitalizations**

Past General State of Health: ☐Excellent ☐Good ☐Fair ☐Poor

☐Arthritis	☐Bronchitis	☐Stomach Cancer	☐Varicose Veins	☐Paralysis	☐Prostate Problem
☐Anemia	☐Skin Problems	☐Pneumonia	☐Gallstones	☐Colon Cancer	☐Phlebitis
☐Blood Diseases	☐Muscle Problem	☐Pleurisy	☐Jaundice	☐Bowel Obstruction	☐Clotted Veins
☐Leukemia	☐Headaches	☐Tuberculosis	☐Liver Trouble	☐Kidney Infection	☐Nervousness
☐Cancer________	☐Sinusitis	☐Lung Cancer	☐Hepatitis	☐Kidney Stones	☐Mental Illness
☐Diabetes	☐Hay Fever	☐Emphysema	☐Pancreatitis	☐Bladder Trouble	☐Drug Problem
☐Hypertension	☐Blurred Vision	☐Heart Disease	☐Syphilis	☐Clotting Problem	
☐Stroke	☐Heart Attack	☐Gout	☐Asthma	☐Stomach trouble	
☐Gonorrhea	☐Epilepsy	☐Thyroid Trouble	☐Angina		

Please list any Surgeries (type and date):

____

____

____

____

Please list any Hospitalizations (reason and date):

____

____

____

____

Family History

Relationship	Age If Living	Age At Death	State of Health	Illnesses	Cause of Death
Father					
Mother					
Sibling's					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					

Social History

Current Weight:_______ **Usual Weight:**_______ **Maximum Weight:**_______ **Min Weight:**_________

Nutrition: ☐Good ☐Fair ☐Poor
Alcohol Use: ☐None ☐Social Drinker ☐Heavy Drinker
Tobacco Use ☐None ☐Former Smoker _____ packs/day stopped ____years ago
☐Current Smoker_____ packs/day
Recreational Drug Use:
☐None ☐Yes Provide Details_______________________________

Type of Employment: ______________________
Mental Work: ☐Light ☐Moderate ☐Heavy
Physical Work: ☐Light ☐Moderate ☐Heavy
Exercise: ☐Light ☐Moderate ☐Heavy

Review of Systems

(Check those which have occurred recently)

General
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Weakness
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fainting
- ☐ ________

Skin
- ☐ Color Changes
- ☐ Nail Changes
- ☐ Hair Changes
- ☐ Mole Changes
- ☐ Rashes
- ☐ Itching
- ☐ Sores
- ☐ Dryness
- ☐ ________

Head
- ☐ Headaches
- ☐ Injuries
- ☐ Bumps
- ☐ Glasses
- ☐ Contacts
- ☐ ________
- ☐ ________
- ☐ ________
- ☐ ________

Eyes
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Redness/Itching
- ☐ Burning
- ☐ Swelling
- ☐ Pain
- ☐ Dryness
- ☐ Tearing

Ears
- ☐ Hard of Hearing
- ☐ Deafness
- ☐ Ringing
- ☐ Discharge
- ☐ Earache
- ☐ Itching
- ☐ Loss of Balance
- ☐ Dizziness
- ☐ Room Spins

Nose
- ☐ Decreased Smell
- ☐ Bleeding
- ☐ Pain
- ☐ Discharge
- ☐ Obstruction
- ☐ Post Nasal Drip
- ☐ Deviated Septum
- ☐ Runny Nose
- ☐ Sinus Congestion

Mouth
- ☐ Bleeding Gums
- ☐ Sores
- ☐ Dental Problem
- ☐ Pain
- ☐ Bad Breath
- ☐ Loss of Taste
- ☐ Dry Mouth
- ☐ Ulcers
- ☐ Blisters

Neck
- ☐ Enlargement
- ☐ Stiffness
- ☐ Soreness
- ☐ Lumps
- ☐ Masses
- ☐ ________
- ☐ ________
- ☐ ________
- ☐ ________

Breasts
- ☐ Discharge
- ☐ Lumps
- ☐ Pain
- ☐ Bleeding
- ☐ Nipple Changes
- ☐ Skin Changes
- ☐ Fullness
- ☐ ________
- ☐ ________

Lungs
- ☐ Cough
- ☐ Phlegm
- ☐ Blood in Sputum
- ☐ Short in Breath
- ☐ Wheezing
- ☐ Pain
- ☐ Congestion
- ☐ Inhalant Exposu
- ☐ ________

Heart
- ☐ Murmur
- ☐ Palpitations
- ☐ Rapid Beat
- ☐ Swollen Legs
- ☐ Cold Extremities
- ☐ Chest Pain
- ☐ Chest Pressure
- ☐ Varicose Veins
- ☐ Blood Clots

Blood
- ☐ Anemia
- ☐ Low Blood Iron
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Swollen Nodes
- ☐ Painful Nodes
- ☐ Sugar in Blood
- ☐ Red Spots
- ☐ ________

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Belching
- ☐ Heartburn
- ☐ Indigestion
- ☐ Irregularity
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Poor Appetite
- ☐ Food Intolerance
- ☐ Bloody Stools
- ☐ Black Stools
- ☐ ________
- ☐ ________

Genitourinary
- ☐ Urgency
- ☐ Incontinence
- ☐ Straining
- ☐ Void Frequently
- ☐ Stones
- ☐ Burning
- ☐ Bed Wetting
- ☐ ________
- ☐ ________
- ☐ Small Stream
- ☐ Discharge
- ☐ Sores
- ☐ Impotence
- ☐ Dribbling
- ☐ Cloudy Urine
- ☐ Bloody Urine
- ☐ ________
- ☐ ________

Gynecological
- ☐ Spotting
- ☐ Cramps
- ☐ Discharge
- ☐ Itching
- ☐ Painful Intercourse
- ☐ Irreg. Periods
- ☐ Hot Flashes
- ☐ Contraception
- ☐ Age/1st Period __
- ☐ Age/Menopause
- ☐ Duration of Cycle
- ☐ Duration of Flow
- ☐ #/Pregnancies__
- ☐ #/Births__
- ☐ #/Miscarriage__
- ☐ #/Abortions
- ☐ Flow: Hv-Md-Lt
- ☐ ________

Muscle/Neurologic
- ☐ Pain-Weak-Cramp
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Numbness
- ☐ Paralysis
- ☐ Memory Loss
- ☐ Dizziness
- ☐ Seizures
- ☐ ________

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Hallucinations
- ☐ Drug Dependency
- ☐ Suicidal Tendency
- ☐ ________
- ☐ ________
- ☐ ________

Endocrine
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Voice Changes
- ☐ Extreme Thirst
- ☐ Breast Changes
- ☐ ________
- ☐ ________
- ☐ ________
- ☐ ________

Please add any health information Dr. Gage should know:

____

____

____

Earl Gage, MD – Plastic and Reconstructive Surgery

Informed Consent for Photographic Release

Patient Name ______________________ DOB ________
Address ______________________
____
(street address, city, state and zip code)
Email Address ______________________
Phone Number ______________________

I consent to the taking of photographs by Dr. Earl Gage or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Gage.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of Dr. Earl Gage and may be retained by Dr. Gage or released by Dr. Gage for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, brochures or web sites for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable. I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Earl Gage.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge Dr. Earl Gage and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

If I wish to limit the use of my photos, I understand that I may do so by **initialing below which uses I wish to exclude:**

___ Informational brochures
___ Websites
___ Medical journals, textbooks
___ Printed advertisements
___ Electronically distributed advertisements

I certify that I have read the above Authorization and Release and fully understand its term.

______________________ ______________________
Patient Print Name Date Witness Print Name Date

______________________ ______________________
Patient Signature Witness Signature

Name: ______________________

DOB: ____________ MR#: __________ CSN#: __________

Physician and Hospital Services Agreement

1. **Annual Consent for Services:** I agree to the services that may be performed by a Mercy physician or non-physician provider ("provider") or facility. I understand I can withdraw this agreement at any time. This agreement applies to any provider services I may obtain from Mercy providers at a clinic or physician's office and also to any hospital services I may obtain at a Mercy hospital or from a hospital-based clinic location. I understand that except in an emergency, no major procedure or treatment will be performed without providing me an opportunity to give informed consent, meaning the provider will first provide me with information including the nature of the procedure or treatment, risks, benefits, and alternatives.
2. **Telehealth Services:** I give my permission for consult-based services that may be provided to me from another location by live video technology ("telehealth"). I understand that I can withdraw this permission at any time by telling my provider when telehealth services are recommended to me and that if I choose to withdraw this permission, there may be certain services that I am not able to receive at a Mercy facility. I also understand and agree that: (i) I may refuse telehealth services at any time without affecting my right to future care or treatment and without risking any third party payor benefits to which I am entitled; (ii) I will be informed of the alternatives, if any, to the telehealth services that are available to me; (iii) I will have the right to access the medical record of the telehealth services as provided by law; (iv) I give my permission for the sharing, storage, and retention of identifiable images or other information from the telehealth service, with the understanding that like in-person care, any identifiable images or other information will not be shared except as required or permitted by law; (v) I have the right to know who will be present during the telehealth services and may exclude anyone from either location; and (vi) there will be no videotaping or recording of telehealth services.
3. **Financial Agreement:** I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed in Mercy's Charge Description Master as of the date of treatment, or a different amount as may be determined under my (or the patient's) insurance plan(s) or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. Mercy will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.
4. **Assignment of Insurance Benefits:** I assign to Mercy, my physician or other non-Mercy health care professionals involved in my (or the patient's) care my (or the patient's) rights under all insurance and benefit plan documents, and authorize direct payment to each health care provider of all insurance and plan benefits payments for services provided to me (or the patient) by these providers. By paying my providers directly, my insurance company or employer is fulfilling its obligations to me (or the patient) under the insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.
5. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Mercy to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

Name: ______________________________

DOB: ______________ MR#: __________ CSN#: __________

6. **Notice of Privacy Practices:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP), which describes when Mercy may use or disclose information for treatment, payment and health care operations. The NOPP is considered part of this Agreement by this reference. I understand that the NOPP is only provided the first time I receive services from the hospital and is otherwise available upon request and on Mercy's website.
7. **Images and Monitoring:** I understand that Mercy may make and use recordings, films, or other images for identification, diagnosis, treatment, performance improvement, or educational purposes. I understand that Mercy may provide or make available monitoring services through mobile application, medical device, or other technology. I understand that Mercy facilities may use video monitoring in patient care areas when there is clinical need and in common areas for security purposes. I consent to such images, technology and video monitoring, with the understanding that any images, audio, or data are not readily available to visitors or the public and will not be disclosed except as required or permitted by law.
8. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.
9. **Clinic and Hospital Rules:** I understand that my visitors and I must obey all Mercy clinic and hospital rules. I understand that if I or my visitors do not follow the rules, Mercy may pursue corrective action.
10. **Personal Valuables:** I understand that as a patient, I am encouraged to leave valuable personal items at home. While Mercy may maintain a safe for small personal items of usual value, Mercy is not responsible for the loss or damage to these items.
11. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Mercy of any changes as soon as possible.
12. **Independent Contractor/Provider:** I understand that separate bills may be sent for professional services from non-Mercy providers such as radiologists, pathologists, and anesthesiologists, in addition to the Mercy bill.
13. **Phone Calls, Text Messages:** I authorize Mercy and its collection agencies to contact me, or a representative I appoint, about my account or my experience, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Mercy from third parties. I authorize contact with me by telephone, voice message, and text message and authorize the use of automated dialing and texting technology and artificial or pre-recorded voice, even if I am charged for the call or text under my phone plan. I agree such contact will not be "unsolicited" for purposes of local, state or federal law. I agree that Mercy and its collection agencies may monitor and/or record any communication.

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Signature: ______________________________ Date: ____________ Time: ____________

If signed by other than patient, indicate relationship: ______________________________

Nondiscrimination Notice

Mercy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Mercy does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Mercy provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. Mercy also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, you or your representative can contact your local Mercy facility. If you believe that Mercy has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Mercy by mail or phone at: 14528 S. Outer 40, Suite 100, Chesterfield, MO 63017, Attention: Chief Compliance Officer, 1-844-764-0100. If you need help filing a grievance, the Chief Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Available

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-364-0425.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-802-3924.

繁體中文 (Chinese)
注意：如果您講中文，可免費為您提供語言援助服務。普通話服務請致電 1-844-802-3927；粵語服務請致電1-844-372-8337。

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-802-3930.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-802-3925번으로 전화해 주십시오.

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-802-3928.

Tagalog (Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-820-7170.

Français (French)
ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-802-3931.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, вы можете воспользоваться бесплатными услугами перевода. Звоните 1-844-802-3926.

اُردُو (Urdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-844-372-8338.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-802-3929.

ગુજરાતી (Gujarati)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-372-8340.

हिंदी (Hindi)
ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं मुफ्त में उपलब्ध हैं। 1-844-372-8344 पर कॉल करें।

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-372-8347 تماس بگیرید.

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-477-7622.

Italiano (Italian)
ATTENZIONE: Se parlate italiano, potete usufruire di servizi di assistenza linguistica totalmente gratuiti. Chiamate il numero 1-844-802-4021.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-477-7617まで、お電話にてご連絡ください。

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε στον αριθμό 1-844-477-7620.

Srpsko-hrvatski (Serbian/Croatian/Bosnian)
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-477-7623.

Kajin Ṃajōḷ (Marshallese)
LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaaḷọk 1-844-865-1243.

Português (Portuguese)
ATENÇÃO: se você fala português, tem à sua disposição serviços linguísticos gratuitos. Ligue para 1-844-477-7618.

Hmoob (Hmong)
LUS CEEV: Yog hais tias koj hais lus Hmoob peb muaj cov kev pab cuam hais ua koj hom lus pub rau koj yam tsis xam tus nqi hlo li. Hu rau 1-844-477-7621.

မြန်မာနှ (Burmese)
သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-844-477-7624 သို့ ခေါ်ဆိုပါ။

Deitsch (Pennsylvania Dutch)
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-372-8349.

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-372-8350.

Oroomiffa (Oromo)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-372-8351.

አማርኛ (Amharic)
አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነጻ ይቀርብልዎታል። ወደ ሚከተለው ቁጥር ይደውሉ 1-844-372-8355.

tsalagi gawonihisdi (Cherokee)
Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-844-372-8357.

Kiswahili (Swahili)
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-844-701-0309.

Authorization for Release of Protected Health Information

Patient Identification

Printed Name: ______________________________ Date of Birth: ____________________

Address: ______________________________ SSN: ____________________

______________________________ Telephone: ____________________

Information is to be released by:

____
(Physician or Facility)

____
(Street Address)

____
(City, State and Zip Code)

____
(Telephone Number)

Information is to be sent to:

Mercy Clinic Plastic Surgery / Dr. Earl Gage
(Individual/ Agency/ Facility)
621 S. New Ballas Rd., Ste. 281A
(Street Address)
St. Louis, MO 63141
(City, State and Zip Code)
314-251-4530 (Telephone Number)
314-251-5772 (fax number)

Information To Be Released – Covering the Periods of Health Care

From (date) ____________________ to (date) ____________________

Please check type of information to be released:

☐ Complete health record	☐ Pathology Report	☐ Radiology Report
☐ Laboratory test results	☐ Complete billing record	☐ EKG Report
☐ Other (specify)		

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment
☐ Other (specify)		

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. *Check One:* ☐ Yes ☐ No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. *Check One:* ☐ Yes ☐ No

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the St. John's Mercy Medical Center practice to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event ____________________, or 90 days from date of signature, unless otherwise specified.

Re-release

I understand the information released pursuant to this Authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The practice, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. **By signing below, you authorize your provider, identified above, to release your protected health information specified above.**

Signature: ______________________________ Date: ____________________

Authority to Sign - if not patient: ______________________________ Witness: ____________________

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specify ____________________

ID Verified by: ______________________________

Patient's Request to Access Protected Health Information ("PHI")

I request my PHI from the following Mercy Facility: ______________________

Patient's Name: ______________________ Patient's Date of Birth: ______________

Patient's Address: ______________________

Patient's Phone Number: ______________________

I request a copy of the following PHI: *(please check the boxes below)*

☐ Physician Office Notes	☐ X-ray Reports	☐ Mammogram Report
☐ Discharge Summary	☐ Laboratory Reports	☐ Physician Orders
☐ History/Physical	☐ EKG	☐ Emergency Department Record
☐ Consultation Reports	☐ Pathology Reports	☐ Billing Statements
☐ Operative Reports	☐ Progress Notes	☐ Abstract of Health Information
☐ X-Ray Images	☐ Radiology Images	☐ Other *(specify)*

Date(s) of Service of PHI Requested: From Date: ______________ To Date: ______________

(if dates are not specified, records will be provided for all dates of service)

IMPORTANT: If my record contains information regarding drug/alcohol abuse, mental health treatment, HIV/AIDS testing or treatment, genetic information, communicable diseases or other sensitive information I request that such information be included with my records: ☐ **Yes** *(include with my records)* ☐ **No** *(do not include with my records)*

I request that PHI specified above be provided:

☐ To me

☐ To the following person/entity: ______________________

(Specify name and address of person/entity to whom you would like your PHI to be sent)

I request that PHI be provided in the following format (if readily reproducible in this format):

☐ Paper Copy

☐ Electronic Copy via *(check below)*

☐ PDF Attachment to E-Mail ☐ CD ☐ Flash Drive

☐ Uploaded to MyMercy Web Portal ☐ Other: ______________

I request that access to PHI be provided by the following method:

☐ Personal pick-up at above specified Mercy facility

☐ Inspection at above specified Mercy facility: *Requested Appointment Date/Time:* ______________

(You will receive a call at above phone number to confirm this requested appointment)

☐ Mailed to the following address: ______________________

☐ Emailed by **Secure Mail** to the following e-mail address: ______________________

☐ Emailed by **Unsecure Mail** to the following e-mail address: ______________________

☐ Faxed to the following fax number: ______________________

☐ Available to me via MyMercy Web Portal

☐ Other: *(specify)* ______________________

ACKNOWLEDGMENT: I understand that the CD/Flash Drive is not secure and that I am responsible for protecting information on the CD/Flash Drive. I also understand that unsecure/unencrypted e-mail is not secure and while in transit it can be intercepted and seen by others. **By requesting to receive my PHI electronically on a CD/Flash Drive or by unsecure e-mail I acknowledge that I understand and accept these risks.**

I understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law.

Printed Name: ____________________

Signature: ____________________

Date: ____________________

Access Requested By: *(Check One)*

☐ Patient ☐ Parent (for minors) ☐ Personal Representative

If this request is signed by the patient's personal representative:
Please specify your authority to act on behalf of the patient and attach supporting documentation:

____

****

INTERNAL USE ONLY

Verification Via:

Photo ID: ☐ Yes ☐ No

Matching Signature: ☐ Yes ☐ No

Other: *(specify)* ____________________

Personal representative documentation provided and checked: ☐ Yes ☐ No

Request: ☐ Approved ☐ Denied (reason: ____________________)

Processed by: ____________________ Date: __________

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR OR GENETIC COUNSELOR. WE WILL REQUEST TO COPY YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR YOUR FILE.

- **APPOINTMENTS –** 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $25 may then be added to your account. Cancellations for Ancillary Services will have a higher fee.
- **REFERRALS –** If your plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's service.
- **CO-PAYMENTS –** By law we must collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit
- **FMLA AND/OR WORKMAN COMP –** There is a $20.00 charge for completion of Workman Comp or FMLA forms.
- **OUT OF NETWORK PLANS –** You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.
- **SELF-PAY PATIENTS –** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS –** The parent who brings the child to the appointment is responsible for payment of services rendered, MERCY KIDS GENETICS will not be involved with separation or divorce disputes.