Keelee J. MacPhee, MD - Plastic & Reconstructive Surgery

New Patient Information Sheet

Legal Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security#: \_\_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by Friend/Physician/Primary MD, name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer’s contact info:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary MD contact info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party (please complete if patient is a minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_ Phone(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE READ AND SIGN BELOW:

I hereby assign payment directly to Keelee J. MacPhee, MD for any medical care or surgical procedures performed. I authorize release of information acquired in the course of my examination or treatment as outlined in the Privacy Policy of this practice. I agree to be responsible for payment of service determined by my insurance carrier as not medically necessary or non-covered service(s). I agree to pay and be responsible for any coinsurance, copayments or deductibles deemed patient responsibility by my insurance company. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I also acknowledge that I have read and understand the practice’s “Notice of Privacy Practices.” I hereby grant permission for the use of any record, illustration, photograph, or other imaging record created in my case, for use in the examination, testing, credentialing, and or certifying purposes by The American Board of Plastic Surgery, Inc.

**STARTING on December 15, 2014** Dr. MacPhee will be opting out of insurance networks, and will not participate with any insurance plans after those contracts have terminated.  Patients are responsible for payment of all fees.  As a courtesy to our patients seeking insurance reimbursement, we will require a non-refundable administrative fee for preauthorization, predetermination, and post-operative courtesy claim filing.  In some cases, your insurance may reimburse you for a portion of the fees you have paid.  We encourage you to contact your insurance company for further details about your benefits and their payment processes.

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Patient signature (Parent/Guardian if patient is a minor) Date signed