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 I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.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.

The only insurance that Dr. MacPhee accepts is Medicare. 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 submissions to help determine if your insurance will cover your surgery. We will provide the postop information needed to file a patient claim form to request a patient refund. 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.

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