Med Art Pros South, LLC 1508 W. Louisiana St., McKinney, TX 75069 (214) 363-2055 WWW.MEDICALARTPROSTHETICS.COM

PATIENT REGISTRATION FORM

EMAIL ADDRESS:

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH	MARITAL STATUS

ADDRESS	CITY	STATE	ZIP CODE	HOME or MOBILE PHONE with area code

SOCIAL SECURITY NUMBER	SPOUSE'S NAME	SPOUSES SOCIAL SECURITY NUMBER	SPOUSE'S DATE OF BIRTH

REFERRED BY include phone number	EMERGENCY CONTACT include phone number

REASON FOR VISIT	DIAGNOSIS

EMPLOYER	ADDRESS	PHONE NUMBER	HOW LONG

SPOUSE'S EMPLOYER	ADDRESS	PHONE NUMBER	HOW LONG

PRIMARY INSURANCE COMPANY	ADDRESS	PHONE NUMBER

POLICY NUMBER	GROUP NUMBER	PRIMARY INSURED NAME	PRIMARY INSURED DATE OF BIRTH

SECONDARY INSURANCE COMPANY	ADDRESS	PHONE NUMBER

POLICY NUMBER	GROUP NUMBER	PRIMARY INSURED NAME	PRIMARY INSURED DATE OF BIRTH

Appointments are considered a contract. A 24 hour notice of inability to be present should be given to the office. We will gladly fill out insurance forms but due to delays by insurance companies and their varied procedures of payment, all fees are the responsibility of the patients. Quotations for fees will be honored for 60 days.

DATE: _____ SIGNATURE: _____

MEDICAL ART PROSTHETICS, LLC

INITIAL PATIENT INTERVIEW FORM

Date: _____ Patient Name: _____

If out of town, local number to be used: _____

Cell phone number: _____

Emergency Contact: _____

Phone Number: _____

Introduction

Age: _____ Race: _____ Sex: _____

Accompanied by: _____

Language Spoken: _____

Referral Source: _____

Purpose of Referral: _____

_____

Diagnosis: _____

History of Illness or Injury: _____

_____

If Injury, was it due to an Auto accident? _____ Place (State) _____

Other accident? _____ Was it work related? _____

Date of accident: _____ Date of onset of symptoms: _____

Initial Occurrence: _____

Course of Treatment (past prosthesis): _____

Surgical History: _____

_____

MEDICAL ART PROSTHETICS, LLC

PAST MEDICAL HISTORY

Today's Date: _____

MD: _____ MD Phone: ( )_____

Please indicate any medical problems:

- ❑ Skin (irritation and rashes)
- ❑ Eye (Glaucoma, Cataracts)
- ❑ Ear
- ❑ Sinus and Respiratory Systems
- ❑ Throat
- ❑ Heart/Circulatory (RH, Fever, murmur, HTN)
- ❑ Liver (hepatitis, mono)
- ❑ Kidney (urinary tract)
- ❑ Bone/joint (arthritis, ortho surg, breaks)
- ❑ Neuromuscular
- ❑ Psychiatric
- ❑ Hematology (anemia, transfusion, clotting)
- ❑ Diabetes
- ❑ Digestive System
- ❑ Tumor (benign/malignant)
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Tobacco use
- ❑ ETOH use (alcohol)
- ❑ Endocrine System (Thyroid)
- ❑ Currently pregnant?
- ❑ Other hosp/Surg/Trauma
- ❑ STD's (herpes/HIV)
- ❑ Medical Allergies

Please explain any of the above (dates, details);

_____
_____
_____
_____

Please list all medications you are currently taking, including any vitamins and herbals. Please include dosage if known.

_____
_____
_____
_____

MedArtPros South, LLC
Tax ID: 30-0598374
NPI: 1215268297

General Consent for Care and Treatment Consent

At this point in your case, no specific treatment plan may have been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure.

This consent provides us with your permission to perform reasonable and necessary examinations and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific treatment is recommended; and (2) you consent to treatment at this office. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan, and we encourage you to ask questions. Since MedArtPros South, LLC does not perform invasive procedures, you will not be asked to sign additional consent forms prior to the fabrication, delivery, or repair of a specific prosthesis.

I hereby give Med Art Pros South, LLC permission to give me medical treatment.

Legal Signature: _____ Date _____

(Please Print Below)

Name: _____

Address: _____

_____

Parent or Legal Guardian (As Applicable)

Name: _____

Address: _____

_____

MedArtPros South, LLC
Tax ID: 30-0598374
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Payment Policy

During your consultation and evaluation today, you will be given specific information regarding your prosthetic treatment plan. **There is a $100 consultation fee.** After the consultation, you will be provided a quotation for the total cost of your custom-made prosthesis. In some cases, we can begin the process at the time of your consultation, or you may elect to return at a later date to begin the process.

We require a 50% down payment of the quoted fee to begin the fabrication process. The balance will be due on the day your prosthesis is completed and delivered. For your convenience, Medical Art Prosthetics, LLC accepts cash payments, checks, Visa, MasterCard and Discover.

It is your responsibility to know the details of your insurance policy, we will assist with filing a claim on your behalf so that you may be reimbursed from your insurance company. However, due to the many different policies, limitations and networks, our office requests that the client make payment as noted above in bold print. We will seek prior authorization if your plan requires it. However, the insurance carrier's allowed amount is often less than what we collect.

We reserve the right to charge for missed or cancelled appointments. Excessive abuse of missing scheduled appointments may result in discharge from our practice.

I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for the cost of the collection.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Printed Name Date

MEDIA CONSENT

I hereby give Med Art Pros South, LLC , and its legal representatives and assigns, those for whom Allison Vest is acting, and those acting with her authority or permission, the absolute right and permission to copyright and/or use, re-use and/or publish, or republish, photographs/videos or photographs/videos of me, or photographs/videos in which I may be included in whole or in part, or composite photographs/videos in color or otherwise, made through any media at the clinic or elsewhere for art, advertising, website, education, medical/legal records, or any other lawful purpose. I consent to the use of any printed matter or digital in conjunction therewith.

I give my permission for photographs/videos, which may be taken on subsequent visits.

I hereby release, discharge and agree to save harmless Med Art Pros South, LLC, its legal representatives or assigns, and all persons acting under her permission or authority or those for whom he is acting, from any liability with regard to being photographed/videotaped.

I hereby warrant that I am of full age and have every right to contract in my own name in the above regard. I hereby state further that I have read the above authorization, release and agreement, prior to its execution, and that I am fully familiar with the contents thereof.

Legal Signature: _____Date _____

(Please Print)

Name: _____

Address: _____

_____

Parent or Legal Guardian
Name: _____

Address: _____

_____

Med Art Pros South, LLC

1508 W. Louisiana St.

McKinney, TX 75069

Acknowledgement of Receipt of Privacy Notice

Med Art Pros South, LLC provides maxillofacial and somato prosthetics. It is necessary that office maintain healthcare information on all our patients. At times this information may be shared for the purposes of treatment, billing and healthcare operations.

Federal law requires that all patients be given a copy of this privacy notice. It describes how patient health information is used and shared.

This is our current privacy notice. If you have any questions pertaining to this notice, please inform the office personnel so that all questions may be answered to your satisfaction.

Efforts will be made to protect the privacy of your health information, whether it is maintained on paper or electronically and regardless of how it is communicated.

I have been given a copy of Med Art Pros South, LLC privacy notice.

Name(Print) _____ Date _____

Signature _____

When the patient is a minor, or unable to give consent, the signature of a patient, guardian or other representative is required.

Name(Print) _____ Date _____

Signature_____

Relationship to Patient _____