Tierney Plastic Surgery, PLC.

Name: _____

Height: _____ Weight: _____

Date of Last Physical Examination: ____/____/____
By Dr. _____

Date of Last Mammogram: ____/____/____

Personal History of: (Please Check)

___ Diabetes	___ Hypertension	___ Heart Disease
___ Kidney Failure	___ Asthma	___ Pneumonia
___ Emphysema	___ Lung Disease	___ Thyroid Disorder
___ Heart Attack	___ Irreg. Heartbeat	___ Stomach Ulcers
___ Hepatitis	___ Seizures	___ Stroke
___ Depression	___ Vision Problems	___ Blood Transfusion
___ Drug Abuse	___ Alcohol Abuse	___ Unexplained Wt Loss
___ MRSA	___ Eating Disorder	___ Other: _____

___ Cancer (Please Specify Type): _____

___ Chemotherapy (Date Started and Finished): _____

___ Radiation (Date Started and Finished): _____

Family History (Please specify): _____

Tobacco History: (Please Circle) Cigarettes Cigars Smokeless Tobacco
Do you smoke presently? Yes No How many pack per day? _____
If not presently, when did you quit? _____

Surgical History: (Please List) _____

Exercise History:
How often do you exercise? _____
What type of exercise? _____
Is your weight stable? _____

TIERNEY PLASTIC SURGERY, PLC.

DATE:_____

PATIENT'S FULL NAME:_____
PATIENT'S ADDRESS:_____
CITY:_____STATE_____ZIP CODE_____

HOME PHONE: (____)_____ CELL PHONE: (____)_____
MAY WE LEAVE A MESSAGE? YES/NO EMAIL:_____

SEX: M F BIRTHDAY____/____/____ AGE_____ SSN:____/____/____

MARITAL STATUS:_____ SPOUSES FULL NAME:_____

ETHNICITY:
CAUCASIAN
HISPANIC/LATINO
UNKNOWN

RACE:
AMERICAN INDIAN/ALASKAN NATIVE
ASIAN
BLACK/AFRICAN AMERICAN
NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER
WHITE
OTHER

PATIENT'S EMPLOYER:_____
EMPLOYER'S ADDRESS:_____
WORK PHONE: (____)_____ FAX:(____)_____

INSURANCE INFORMATION (IF WE ARE FILLING INSURANCE, PLEASE COMPLETE)
PRIMARY INSURANCE:_____
POLICYHOLDER NAME:_____ SUBSCRIBER SSN:____/____/____
RELATIONSHIP TO PATIENT:_____ SUBSCRIBER DOB:____/____/____

SECONDARY INSURANCE:_____
POLICYHOLDER NAME:_____ SUBSCRIBER SSN:____/____/____
RELATIONSHIP TO PATIENT:_____ SUBSCRIBER DOB:____/____/____

RESPONSIBLE PARTY INFORMATION (IF APPLICABLE)
NAME:_____
RESPONSIBLE PARTY'S ADDRESS:_____
RESPONSIBLE PARTY'S PHONE NUMBER:_____
RELATIONSHIP TO PATIENT:_____ SUBSCRIBER DOB:____/____/____

EMERGENCY CONTACT:_____ PHONE NUMBER:_____

REASON FOR CONSULTATION:_____
HOW DID YOU LEARN ABOUT TIERNEY PLASTIC SURGERY?
REFERRED BY DOCTOR:_____
REFERRED BY:_____FRIEND FAMILY CO-WORKER
YELLOW PAGES INTERNET TV RADIO NEWSPAPER OTHER

Tierney Plastic Surgery, PLC.

Name: ______________________________ DOB: ____/____/____

Pharmacy: ____________________________ Phone: (____) __________

Address: ____

City: ____________________ State: _____ Zip Code: __________

Drug Allergies: (Please Specify Reactions) ____

____

____

Date	Drug Name	Dose	Frequency	Notes

Tierney Plastic Surgery, PLC

2011 Church Street
Suite 805
Nashville, TN. 37203
615-320-8585

Patient Name_____

Date of Birth_____

Social Security Number_____

I authorize the following:

_____ I may be called at my home telephone number
_____ I may be called at my work telephone number
_____ I may be called on my cell phone number
_____ A voice message may be left on (Mark each allowable telephone)
___Home Telephone___Work Telephone___Cell Phone
_____ I may be faxed information

I understand that Tierney Plastic Surgery, PLC will not be permitted to contact me except as I have indicated.

I authorize Tierney Plastic Surgery, PLC to fax and receive by fax my personal health information as needed for treatment, payment and health operations.

I authorize Tierney Plastic Surgery, PLC to submit prescriptions to my pharmacy by telephone and/or fax machine.

I authorize the following people to discuss my health information, insurance and billing information:

Name_____ Relationship_____
Name_____Relationship_____

Signature_____Date_____

TIERNEY PLASTIC SURGERY, PLC
2011 CHURCH STREET, SUITE 805
NASHVILLE, TN. 37203
(615)-320-8585

ASSIGNMENT OF BENEFITS

I hereby give authorization for payment of insurance benefits to be made directly to **Tierney Plastic Surgery, PLC** and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

In the event my account should become delinquent, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature _____ Date _____

Relationship to Patient _____

We request payment of co-pays and deductibles at the time service is rendered.

Tierney Plastic Surgery, PLC.
2011 Church Street, Suite 805
Nashville, TN 37203

Patient Agreement

Limitation of Practice: Patient understands that Dr. Tierney's practice is limited to Plastic and Reconstructive Surgery.

Patient Consent: Patient hereby gives consent, if needed, for drawing blood samples for diagnosis or in case of accidental puncture or exposure to medical personnel during my course of treatment either in the offices or in the hospital. These tests may include AIDS testing.

Privacy Policy

All patients have a right to review our Notice of Privacy Practices. Any employee of the practice can provide you a copy of the Notice of Privacy Practices. If you would like to restrict access or request modifications be made to your Personal Health Information, please request the required form from a member of our staff.

Collection Policy

Insurance Claims Filing

In all cases, the patient is responsible for payment of their account. As a courtesy, Tierney Plastic Surgery, P.L.C. will file a claim to the patient's insurance company.

Assignment and Release: Patient hereby authorizes and assigns applicable insurance benefits to be paid directly to the physician; Patient is financially responsible for non-covered services. Patient authorizes release of information necessary to process insurance claims. Patient authorizes photographs to be restricted for medical, education or insurance purposes and information released to other practitioners in good faith effort for my medical care.

Medicare: Patient requests that payment of authorized Medicare benefits be made either to the patient or on the patient's behalf to Tierney Plastic Surgery, P.L.C. and their associates for any services furnished the patient by that physician. Patient authorizes any holder of medical information about the patient to release to the Health Care Financing Administration (Medicare) or its agents any information needed to determine these benefits payable for related services. This form is not to be used by the patient for Medicare reimbursement.

Managed Care Plans and Referrals

Managed care plans (e.g. HMO's) require specialist and sub-specialists to obtain a referral number before the physician can see a patient. The patient is responsible for obtaining a referral number, not this office. Failure to have a referral number prior to service will result in reduced benefits by the managed care plan. Therefore, the patient is responsible for any balance not paid by the coverage plan.

Co-Payments

In all cases, the patient is responsible for making co-payments at the time of the patient visit in the form of cash or check. If a co-payment is not made at the time of the patients visit, Tierney Plastic Surgery, PLC., reserves the right to require co-payment to be made prior to all future patient visits.

Maximum 30-Day Period for Unpaid Balances

Patient Balances are due 30 days after insurance coverage payment has been made. In the alternative, the patient must make acceptable payment arrangements by contacting the Billing Department at Tierney Plastic Surgery, PLC., Balances may be paid via cash, check, Visa, or MasterCard.

Unpaid Balances

If for any reason the patient cannot make scheduled payments, the patient must immediately contact the Office Manager at Tierney Plastic Surgery, PLC., to make acceptable arrangements. Tierney Plastic Surgery, PLC., reserves the right to refer all unpaid accounts to collection agencies. Any fees associated with collection, including collection agency contingency fees and court costs, will be added to the patient's account balance. After accounts are placed with collection agencies, all patient visits and procedures will be on a cash only basis.

Service Charge

Tierney Plastic Surgery, PLC., reserves the right to assess a service charge, not to exceed $20 per month, to a patient account for any unpaid balance over 30 days after the insurance coverage has been paid. No service charges will be assessed to a patient's account where the patient has made payment arrangements with the Billing Department and payments are being made as agreed.

Provider Signature _____ Date _____

Patient Signature _____ Date _____

ALL QUESTIONS CONCERNING THESE POLICIES SHOULD BE DIRECTED TO THE ADMINISTRATOR

Tierney Plastic Surgery, PLC.
2011 Church Street, Suite 805 Nashville, TN 37205