# THE LUCAS CENTER

(865) 218-6210

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In All Fields)

**Patient's Name** _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ☐ No ☐ Yes E-mail _____

Contact Restrictions: _____ **Pharmacy Name & Phone Number** _____

Age _____ Birthdate ___/___/___ SS# ___-___-___ Sex ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married Spouse's Name: _____ Phone# _____

**Primary Care Physician** _____ **Referring Physician** _____

Phone # _____ Phone # _____

**Patient's Employer** _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address _____
Street & Suite # City State Zip

**Emergency Contact**

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

**Primary Health Insurance Company** _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ _____

**Insured**: Name _____ DOB _____ Employer _____

**Secondary Health Insurance Company** _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ _____

**Insured**: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Lucas to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Lucas and myself.

**Signature** _____ **Date** _____

# The Lucas Center for Plastic Surgery
# Health Information Questionnaire

Patient's Name:_____ Today's Date:_____

DOB: _____ Sex: M F Married: Y N
Are you currently Pregnant OR Nursing: Y N
Responsible Adult Available to Assist During Recovery Period: Y N
Relationship:_____

Smoke: Y N Amount: _____ Caffeine: Y N Amount:_____
Alcohol: Y N Amount:_____ How often?_____

List All Prescription and Non-Prescription Drugs (attach list if necessary)

| Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Drug Allergies: Y N List Drug and Type of Reaction:_____
_____
Latex Allergy: Y N Tape Allergy: Y N

**Have you ever had**:

| | | | | | |
|---|---|---|---|---|---|
| Abnormal Bleeding | Y N | Asthma | Y N | Cancer | Y N type: _____ |
| Anemia | Y N | Diabetes | Y N | High Blood Pressure | Y N |
| Heart Attack | Y N | Hepatitis | Y N | Blood Clots | Y N |
| Mitral Valve Prolapse | Y N | Stroke | Y N | Kidney Disease | Y N |
| Weight Changes | Y N | Gastric Bypass | Y N | type?_____ | |
| Memory Loss | Y N | | | | |

Have you ever been under psychiatric care? Y N When?_____
Have you ever received a blood transfusion? Y N If yes, what year?_____
Have you ever been tested for HIV? Y N If yes, what year?_____

PREVIOUS HOSPITALIZATIONS OR SURGERIES:

| Date | Type of Surgery | Reason |
|---|---|---|
| | | |
| | | |
| | | |

How do you do with Anesthesia?_____
Primary Care Physician _____ Date last seen
Preferred Pharmacy and Number _____
Date last Chest X-Ray _____ Last EKG _____Last Mammogram_____

THE LUCAS CENTER
280 Ft. Sanders West Blvd.
Bldg. 4, Suite 112
KNOXVILLE, TN 37922

PATIENT NAME:_____ DATE OF BIRTH:_____

Please check the appropriate answer and sign below:

Do you smoke? Yes____ No____

_____ _____
Patient Signature Date

If you answered "yes" to this question, please read the following. This information will be discussed with you during your office visit.

## INFORMED CONSENT FOR PATIENTS WHO SMOKE

As a smoker, I, _____, have been informed and understand that smoking and its subsequent physiological effects pose serious consequences for smokers undergoing medical treatment and undergoing or recovering from surgery.

Smoking decreases the supply of oxygen to tissues and a decreased oxygen supply delays wound healing. Nicotine is a vasoconstrictor that will reduce oxygen to tissues. Smoking interferes with healing of surgical wounds and may also lead to skin actually dying and requiring further treatment or surgery.

I understand that I should refrain from smoking three to four weeks prior to surgery and refrain from smoking after surgery and that risks are still increased to some extent.

I have read this informed consent document and understand the dangers of smoking prior to, during, and after my surgery and treatment.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

# The Lucas Center

Physician Practice Patient Registration Agreement

IN CONSIDERATION OF THIS PHYSICIAN PRACTICE (THE "PRACTICE") FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:

I. CONSENT TO MEDICAL TREATMENT AND SERVICES: The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes consent to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds medically necessary. There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees the Practice, and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

II. CONSENT TO COMMUNICABLE DISEASE TESTING: The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to the patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

III. CALCULATION AND PAYMENT OF CHARGES: The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following: (1) The Practice's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the chargemaster. Charges on the patient's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued. (2) The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient. (3) The Practice has both an uninsured patient discount policy and an indigent care policy. If the patient is uninsured, the patient is automatically entitled to a discount on chargemaster rates in accordance with the Practice's uninsured patient discount policy. In addition, if the patient is uninsured and meets certain criteria set forth in the Practice's indigent care policy (including, without limitation, income criteria), the patient may be entitled to further discounts to chargemaster rates. Please contact the Practice's financial counselors in our office for more information. (4) The amount of the patient's Practice charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under the Practice's policies. (5) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS: The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice's billing such payers for items and services furnished by the Practice to patient. The undersigned herby irrevocably assigns to The Lucas Center all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation or government entity having notice of this assignment is authorized and directed to pay directly to The Lucas Center all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section III or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are the patient's obligation. **The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services.** If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

**The Lucas Center**
Physician Practice Patient Registration Agreement

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to this Agreement are not effective or enforceable unless accepted in writing.

IX. CONTACTING PATIENT: Patient may be contacted at the following number: _____.
In addition, *please check one of the following:*

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name: _____ Relation to patient: _____ Phone: _____

Name: _____ Relation to patient: _____ Phone: _____

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than patient.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED: _____ PRINTED NAME: _____

PATIENT NAME: _____ RELATIONSHIP TO PATIENT: _____

DATE: _____ TIME: _____ AM / PM

*A copy of this agreement will be provided on request.*

THE LUCAS CENTER
280 FORT SANDERS WEST BLVD.
BLDG. 4, SUITE 112
KNOXVILLE, TN 37922

# CONSENT FOR PHOTOGRAPHY

**PATIENT NAME:** _____ **RECORD #**_____

I understand that photographing and/or videotaping may be deemed appropriate as part of my/my child's evaluation and treatment by the physicians and staff of The Lucas Center. I understand and accept that I/my child may be recognized from my/my child's likeness or case history.

I authorize the physician of The Lucas Center, to use my/my child's photographs, videotapes and case information in educational and scientific settings, including lectures and multi-media presentations for an audience of healthcare professionals, at which members of the press may be present, and medical, surgical and scientific journal articles.

I authorize the use of my/my child's photographs and case information in the following educational/marketing settings: the practice's patient education materials; the file of pre- and post-operative patient photographs available to prospective patients for viewing; newspaper and magazine articles in which the practice's physician participates; the practice's web site; other web sites approved by the practice for education and marketing; and lectures and multi-media presentations given by the practice's physician to the general public.

In any case, it is specifically understood that I / my child shall not be identified by name.

I understand that this consent remains in effect until revoked by me in writing.

Therefore, I (initial one):

_____ give my permission for photographs, videotapes or case history to be used as described above.

_____do not give my permission for photographs, videotapes or case history to be used as described above.

_____ _____

**Signature (patient or legal guardian if minor)** **Date**

_____ _____

**Witness signature** **Date**