William M. Portnoy, MD, FACS 160 West 18th Street New York, NY 10011

PATIENT REGISTRATION (Please Write Legibly!!)

Today's Date: ___________________________

Patient Name: ____ Sex: □ Male □ Female Age: ______

Address: ____City: ________________________

State: _____________ Zip Code: ___________ E-mail: ____________________________________

Tel:(Home) ____________________ (Work) _____________________ (Cell)______________________

Date of Birth: ___ ___ _____ (If under the age of 18 must be accompanied by parent) S.S.# ___________________

Marital Status: _______________ Significant Other: ____

Emergency Contact: ______________________________ Relationship: ___________________________

Phone: (H) __________________________________ (W) ______________________________________

Are you employed? □ Yes □ No What is your occupation? ___________________________________

Name of employer: ____

Work Address: ____

Who referred you to Dr. Portnoy? ____

Address / Phone:____

Why are you seeing Dr. Portnoy?____

____

***** A fee of $200 will be charged to be paid either before or at the time this service is rendered for all cosmetic surgical consultations. This fee will be put towards the cost of your procedure provided it is performed within 2 months of the consultation. A grace period of 24 hours is afforded for cancellation of your cosmetic consultation. Should you fail to cancel your appointment within this 24-hour grace period; a $100 fee will be charged to your credit card. We kindly asked that you provide your contact and demographic information, the signed HIPPA privacy notice along with your credit card information (this information is secured and protected under the HIPPA Privacy Act). If you do not possess a credit card, a $200 money order or cash must be presented to the office to secure your appointment. If you fail to provide this information, we regrettably cannot hold an appointment for this service.***

Credit Card Type: __________ ***Exp. Date:*** ___________

Credit Card #: __________________________________

Billing Zip Code: ___________

I understand that all medical costs incurred by me are my responsibility. I also understand that I am responsible for any collection and/or legal efforts that may be necessary on my account.

Signature of Patient: ____ Date: ___________________

Office of William M. Portnoy, M.D.

Introduction to Privacy Notice

Dear Patient,

In 1996, The US Department of Health and Human Services issued the Health Insurance Portability and Accountability Act (HIPPA). This act essentially regulates how health related information (what has come to be known as "covered transactions") are electronically transmitted. Furthermore, a series of other provisions with respect to patient privacy and security standards have been issued, and were instituted April 14, 2003. This is a summary of the ways in which medical information about you may be used and disclosed, and how you can get access to this information. Dr. Portnoy, his associates, and his entire staff will use your medical information as part of rendering patient care. Your medical information may be used for treatment, payment, or health care operations. For example, your medical information may be used by the health care professional treating you, by the office insurance coordinator to process your payment for the services rendered, and by administrative personnel reviewing the quality and appropriateness of the care you receive. Your information may also be disclosed pursuant to applicable federal and state law.

The complete Notice of Privacy Practices is prepared for your review. **We encourage you to read the entire Notice. You are required to acknowledge in writing that you have read a copy of the Notice.** A copy of this document will be maintained in your medical record. The attached Notice is effective as of April 14, 2003.

IN SIGNING, PATIENT ACKNOWLEDGES RECEIPT OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION:

____ Dated:________________________

Signature of Patient or Representative New York, New York

Patient's Name (Printed):____________________________________

Name of Personal Representative: ______________________________
(Printed) (If Applicable)

Relationship to Patient:_____________________________________
(If Applicable)