James T. Robison IV, M.D.
Andrew P. Trussler, M.D.
Plastic and Reconstructive Surgery and Surgery of the Hand
5656 Bee Cave Rd., Suite J200 Austin, TX 78746
www.drjimrobison.com *Tel (512)450-1077* *Fax (512)450-1817* *www.drtrussler.com*

New Patient Information Sheet

Patient Name_____ Date of Birth___/___/___ Male___ Female___
First MI Last Month Day Year

Address_____ City_____ State_____ Zip_____

Email_____ Cell Phone#_____ Home or Work Phone#_____

Emergency Contact/Person with whom we may discuss your health care: _____
Name Phone

About Your Visit Today

Reason for Your Visit_____ Date of Injury/Onset _____

Name of E.R. _____ Date of E.R. Visit _____ E.R. Doctor's Name _____

Have you seen any other ER, PCP, or Urgent Care Facility for this injury?_____

About Your Health

What are your health issues? _____

Do you smoke? Y/N If yes, packs per day ___ Do you drink alcohol? Y/N If yes, amount___ drinks per *day/week/month*

Do you have any drug allergies? Y/N If yes, list_____

Insurance Coverage Information

Primary Insurance_____ ID#_____ Group#_____ Phone#_____

Subscriber Name_____ Subscriber Date of Birth_____ Relationship to Patient_____

Secondary Insurance_____ ID#_____ Group#_____ Phone#_____

Subscriber Name_____ Subscriber Date of Birth_____ Relationship to Patient_____

Is this a Worker's Comp Injury? Y/N Employer Name_____ Employer Phone#_____

W/C Carrier Name_____ W/C Carrier Phone#_____ Claim #_____

****Please turn over, read and sign ****

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Release of Information

I hereby authorize James T. Robison IV, M.D., or Andrew P. Trussler, M.D. to release any information necessary to process my insurance/Medicare claim acquired in the course of my examination or treatment and to allow a photocopy of my signature to be used to process my insurance/Medicare claim for the period of LIFETIME. In addition, I hereby authorize any and all past medical history to be released to James T. Robison IV, M.D., or Andrew P. Trussler, M.D.

Benefit Assignment, Payment Authorization and Agreement to Pay for Professional Services

I claim any insurance benefits due to me for services rendered by James T. Robison IV, M.D., or Andrew P. Trussler, M.D. and authorize and direct my carrier to issue payment checks directly to James T. Robison IV, M.D., or Andrew P. Trussler, M.D. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by any carrier. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full.

Full Disclosure Statement

I understand that James T. Robison IV, M.D. has an ownership interest in the Hospital at Westlake Medical Center and Surgicare of South Austin.

Email Use and Privacy Statement

I agree to the use of email as a means of communication with James T. Robison IV, M.D., or Andrew P. Trussler, M.D. and their office staff, although it will not be the primary means of communication. I agree to contact James T. Robison IV, M.D., or Andrew P. Trussler, M.D. by telephone or in person about critical or time-sensitive issues as there will be times when he does not have access to email. I understand and accept the risks that the use of email poses to the confidentiality of my health information.

To the best of my knowledge all statements and answers made on this form are true, complete, and correct.

X_____ _____ _____

PRINTED NAME of Patient/Responsible Party **SIGNATURE** **Date**

Consent for Use and Disclosure of Protected Health Information

By signing this consent below, you are consenting to the use and disclosure of your protected health information for treatment, payment and health care operations.

James T. Robison IV, M.D., and Andrew P. Trussler, M.D. are concerned about the privacy of your protected health information. We have adopted a Notice of Privacy Practices ("Notice") for protected health information. You are referred to our Notice for a more complete description of uses and disclosures of protected health information. You have the right to review the Notice prior to signing this consent. We reserve the right to change our office's privacy practices that are described in our Notice. To obtain a revised Notice, please ask at our reception desk.

You have the right to request that our office restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Our office is not required to agree to requested restrictions. If our office agrees to a requested restriction, such restriction is binding on us. (To avoid any miscommunications, we ask that any such requests for restrictions from you be in writing.) You have the right to revoke this consent in writing, except to the extent that our office has taken action in reliance on your consent.

I have read, been offered a copy of, and understand the Notice of Privacy Practices posted in the office of James T. Robison IV, M.D., and Andrew P. Trussler, M.D.

X_____ _____ _____

PRINTED NAME of Patient/Responsible Party **SIGNATURE**