The PLASTIC SURGERY Center

www.sacplasticsurgery.com

REGISTRATION

Date: _____ Account # _____ ☐ New ☐ Update

Patient information - Please Print

Patient Legal Name_____ DOB _____ Age _____ SSN _____ / _____ /_____

Address _____ City_____ State _____ Zip Code_____

Home Phone (_____) _____ Previous or Maiden Name _____

Work Phone (_____) _____ Occupation _____

Cell Phone (_____) _____ Primary Language _____

Email Address: _____

How did you hear about us? _____

Are you interested in Financing options? _____

Please mark what procedures you are possibly interested in

BODY

☐ Mommy Maker Over ☐ Tummy Tuck ☐ Brazilian Butt Lift ☐ Liposuction

☐ Breast Augmentation ☐ Breast Lift ☐ Breast Reduction ☐ Spider Veins

☐ Thigh Lift ☐ Arm Lift ☐ Laser Hair Removal ☐ Laser Tattoo Removal

FACE

☐ Face Lift ☐ Brow Lift ☐ Upper Bleph

☐ Lower Bleph ☐ Rhinoplasty

☐ Derma Fillers ☐ Co2 Laser ☐ Botox

☐ Skin Rejuvenation

Any previous plastic surgery consultations? _____

Any previous plastic surgery? _____ Were you satisfied? _____

IN CASE OF EMERGENCY NOTIFY

Name of nearest relative or friend not living with you _____

Home Phone (_____) _____ Work Phone (_____)_____

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PATIENT RIGHTS AND RESPONSIBILITIES

I . The patient has the right to receive considerate and respectful care.

2. The patient has the right to know the name of the physician responsible for coordinating his or her care.

3. The patient has the right to obtain information from his or her physician in terms that can be reasonably understood. Information may include but is not limited to his or her diagnosis, treatment, prognosis and medically significant alternatives for care or treatment that may be available. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person on his or her behalf. When medical alternatives are to be incorporated into the plan of care, the patient has the right to know the name of the person(s) responsible for the procedures and treatments.

4. The patient has the right to obtain the necessary information from his or her physician to give informed consent before the start of any procedure and treatment. Necessary information includes but is not limited to the specific procedure and treatment, the probable duration of incapacitation, the medically significant risks involved and provisions for emergency care.

5. The patient has the right to expect American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) accredited facilities to provide evaluation, services and referrals as indicated for urgent situations. When medically permissible, the patient or designated support person(s) will receive complete information and explanation about the need for and alternatives to transferring to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer.

6. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his or her action.

7. The patient has the right to obtain information about any financial and professional relationship that exists between this facility and other health care and educational institutions insofar as his or her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedure or treatment.

8. The patient has a right to be advised if AAAASF accredited facilities propose to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in research projects.

9. The patient has the right to every consideration for privacy throughout his or her medical care experience, including but not limited to the following:

   - Confidentiality and discreet conduct during case discussions
   - Consultations
   - Examinations
   - Treatments

   Those not directly involved in his or her care must have the permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential.

10. The patient has the right to expect reasonable continuity of care, including but not limited to the following:

    - The right to know in advance what appointment times and physicians are available and where
    - The right to access information from his or her physician, regarding continuing health care requirements following discharge
    - The number to call for questions or emergency care

11. The patient has the right to access and examine an explanation of his or her bill regardless of the source of payment.

12. The patient and designated support person(s) have the right to know what facility rules and regulations apply to their conduct as a patient and guest during all phases of treatment.

Patient Responsibilities

It is the patient's responsibility to participate fully in decisions involving his or her own health care and to accept the consequences of these decisions if complications occur.

It is the patient's responsibility to follow up on his or her physician's instructions, take medications when prescribed and ask questions concerning his or her own health care that he or she feels is necessary.

Signature _____ Date _____

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MEDICAL HISTORY

(Please Print)

Patient_____ Date_____

Account #_____ Date Of Birth_____ Age _____

Please fill out the following information completely. If you are unsure of any information requested, please be sure to ask your physician at the time of your appointment. Please respond to each statement and answer "n/a" if appropriate. Thank you.

- Height _____ Weight _____
- Gender: ☐ Female ☐ Male ☐ Transgender
- Vision: Do you wear glasses? ☐ YES ☐ NO Contacts? ☐ YES ☐ NO
- Are you legally blind? ☐ YES ☐ NO ☐ Right eye ☐ Left eye ☐ Both eyes
- Are you **ALLERGIC** to any **MEDICATION** and/or **FOODS?** ☐ YES ☐ NO **If YES, please list and explain:**

  _____

  _____
- Are you currently taking any medications? ☐ YES ☐ NO **If YES, please list below:**

  _____

  _____
- Are you **ALLERGIC** to **LATEX?** ☐ YES ☐ NO **If YES, have you been tested?** ☐ YES ☐ NO
- Are you currently taking any medication that contains aspirin? ☐ YES ☐ NO **If so, please circle any in the following list:** ASPIRIN** BAYER** EXCEDRIN** BUFFERIN** IBUPROFEN** ADVIL** NUPRIN** MOTRIN** OR ANY MEDICATION FOR ARTHRITIS ****OR OTHER:**_____
- Prior surgeries? ☐ YES ☐ NO **If YES, please list:**_____

  _____
- Any complications with the surgery? ☐ YES ☐ NO **If YES, please explain below:**

  _____
- Any complications with anesthesia?

  _____
- Any medical conditions as a child? ☐ YES ☐ NO
- Any medical conditions as an adult? ☐ YES ☐ NO

  If YES, please explain: _____
- Any significant illness in your family? ☐ YES ☐ NO **If Yes, please explain:**

  _____

  _____
- Do you smoke? ☐ YES ☐ NO ☐ TOBACCO ☐ MARIJUANA **If YES, how much per day?**_____
- Do you drink alcohol? ☐ YES ☐ NO **If YES, how much per week?** _____

Please turn this page over and complete the medical information.

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MEDICAL HISTORY

AIRWAY

Capped, chipped, broken teeth.	☐ Yes	☐ No	☐ Unsure
Difficulty opening your mouth fully?	☐ Yes	☐ No	☐ Unsure

RESPIRATORY

Used tobacco within the year.	☐ Yes	☐ No	☐ Unsure
Persistent cough.	☐ Yes	☐ No	☐ Unsure
Sputum, phlegm, mucus production.	☐ Yes	☐ No	☐ Unsure
Asthma, wheezing.	☐ Yes	☐ No	☐ Unsure
Bronchitis, Emphysema, COPD Tuberculosis.	☐ Yes	☐ No	☐ Unsure
Shortness of breath after walking two flights of stairs?	☐ Yes	☐ No	☐ Unsure
Recent cold?	☐ Yes	☐ No	☐ Unsure
Do you have a history of sleep apnea?	☐ Yes	☐ No	☐ Unsure
Do you use a breathing device? If yes bring it with you the day of surgery.	☐ Yes	☐ No	☐ Unsure

HEART

Chest pain, angina, MI, heart attack.	☐ Yes	☐ No	☐ Unsure
Leg swelling, edema, CHF.	☐ Yes	☐ No	☐ Unsure
Paralysis.	☐ Yes	☐ No	☐ Unsure
High blood pressure.	☐ Yes	☐ No	☐ Unsure
Heart murmur, prolapsed mitral valve, rheumatic fever.	☐ Yes	☐ No	☐ Unsure
Legs cramp when walking.	☐ Yes	☐ No	☐ Unsure

SKIN

Problems with wounds healing.	☐ Yes	☐ No	☐ Unsure
Scar badly.	☐ Yes	☐ No	☐ Unsure
Bruise easily, excessive bleeding.	☐ Yes	☐ No	☐ Unsure
Allergic reaction to adhesive tape.	☐ Yes	☐ No	☐ Unsure

ENDOCRINE

Diabetes, If yes you will need an insulin order from your Doctor.	☐ Yes	☐ No	☐ Unsure
Thyroid problems, heat or cold intolerance.	☐ Yes	☐ No	☐ Unsure
Low blood sugar.	☐ Yes	☐ No	☐ Unsure

ABDOMEN

Hiatal hernia, frequent regurgitation, heartburn.	☐ Yes	☐ No	☐ Unsure
Ulcers, vomiting blood.	☐ Yes	☐ No	☐ Unsure
Hepatitis, jaundice.	☐ Yes	☐ No	☐ Unsure
Liver disease, cirrhosis.	☐ Yes	☐ No	☐ Unsure
Kidney disease.	☐ Yes	☐ No	☐ Unsure

GENITOURINARY

Could you be pregnant?	☐ Yes	☐ No	☐ Unsure
Difficulty passing urine.	☐ Yes	☐ No	☐ Unsure
At risk for AIDS or venereal disease.	☐ Yes	☐ No	☐ Unsure

MUSCULOSKELETAL

Physical limitations, appliances, or prostheses	☐ Yes	☐ No	☐ Unsure
Arthritis (jaw, neck, back)	☐ Yes	☐ No	☐ Unsure
Phlebitis	☐ Yes	☐ No	☐ Unsure

NEUROLOGICAL/PSYCHIATRIC

Seizures, convulsions, fainting, epilepsy.	☐ Yes	☐ No	☐ Unsure
Stroke, fleeting blindness, or weakness.	☐ Yes	☐ No	☐ Unsure
Psychiatric treatment.	☐ Yes	☐ No	☐ Unsure
Anxious about possible surgery.	☐ Yes	☐ No	☐ Unsure

GENERAL

Headaches, unexplained weight loss.	☐ Yes	☐ No	☐ Unsure
Steroid use within 1 year.	☐ Yes	☐ No	☐ Unsure
Blood transfusions.	☐ Yes	☐ No	☐ Unsure
Have used recreation drugs.	☐ Yes	☐ No	☐ Unsure
Anemia or bleeding disorder.	☐ Yes	☐ No	☐ Unsure
Glaucoma	☐ Yes	☐ No	☐ Unsure
Chemotherapy (within 6 months.)	☐ Yes	☐ No	☐ Unsure
Personal or family history of blood clots.	☐ Yes	☐ No	☐ Unsure

If you answered YES to Any of the above, please explain:

_____

_____

_____

HIPAA ACKNOWLEDGEMENT

_____ PATIENT PRIVACY PRACTICES:

Initials

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent, or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our Notice of Privacy Practices policy, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

_____ CONSENT TO TREATMENT AND RECORD RELEASE AUTHORIZATION:

Initials

I authorize The Plastic Surgery Center to evaluate and treat me or my family member. I have read and understand the above clinic policies and I further acknowledge that I accept the terms outlined in each of the above policies. I hereby authorize The Plastic Surgery Center to release to my referring physician, insurance company, or legal guardian, any information, including diagnosis and records of treatment, concerning my medical history and plastic surgery care.

ACKNOWLEDGMENT:

- I acknowledge that I have received access to the “Notice of Privacy Practices” for The Plastic Surgery Center. I have read and understand the “HIPAA & Release of Medical Information Policy”.
- I hereby authorize The Plastic Surgery Center to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I further acknowledge and understand that I accept the terms outlined in each of the policies.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.

X _____ _____

Patient or Guardian Signature Date

_____ TELEPHONE CONSUMER PROTECTION ACT (TCPA):

Initials

I agree that the facility, The Plastic Surgery Center or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as “collectors”) to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

_____ FINANCIAL RESPONSIBILITY:

Initials

Payment Authorization and Release of Information

I (refers to the undersigned throughout this document) understand that all fees incurred are the responsibility of the patient, patient’s parent, patient’s legal guardian, and/or authorized agent, and I acknowledge responsibility for any and all charges billed to me for medical and surgical services rendered to myself and my family. I further acknowledge that insurance companies are billed as a courtesy to the patient.

I authorize The Plastic Surgery Center to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination tendered to me during the period of such medical care.

I hereby authorize any health insurance company(ies) insuring me and my family members to pay The Plastic Surgery Center for medical and surgical services rendered to the above named patient.

I understand that The Plastic Surgery Center will NOT bill any insurance company for procedures considered cosmetic unless there is prior authorization. If I wish to bill for my surgery I MUST wait to have the surgery until after authorization from my insurance company has been obtained by The Plastic Surgery Center. Should I choose to have my surgery before authorization, The Plastic Surgery Center will not assist in any way billing for insurance purposes.

X _____ _____

Signature Date

Periodically we distribute the latest cosmetic and skin care news as well as special savings offers. By providing this information I give permission to the office of The Plastic Surgery Center and The Skin Care & Laser Center and its affiliate’s permission to contact me via email address provided above.

Patient Signature _____

Spouse/Parent _____

Phone (_____) _____

Responsible Party if other than patient: _____

Phone (_____) _____

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ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **The Plastic Surgery Center.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

INSURANCE INFORMATION

Please have your insurance cards ready to be copied when you return this information to the front desk.

Primary Care Physician (PCP) _____ PCP Phone _____

PCP Address _____ City _____ State _____ Zip Code _____

Primary Insurance _____ **IPA/Medical Group** _____

Policy ID # _____ Group # _____

Phone (____)_____ Policy Holder _____ DOB _____ Employer _____

Secondary Insurance _____ **IPA/Medical Group** _____

Policy ID # _____ Group # _____

Phone (____)_____ Policy Holder _____ DOB _____ Employer _____

PREFERRED PHARMACY INFORMATION

Primary Pharmacy

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Phone (____) _____

Secondary Pharmacy

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Phone (____) _____

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AUTHORIZATION FOR THE RELEASE OF MEDICAL IMAGES

Name_____

The Plastic Surgery Center (TPSC) incorporates photographs into the patient's medical records. Photos are kept confidential and are subject to the same safeguards as other patient information. We may provide photos to insurers if needed to obtain prior authorization for treatment.

With patient approval, photos are used in articles published in professional journals and textbooks, research and teaching, presentations at physician meetings, and marketing - including publication on our web site, patient seminars, "before and after" photo albums, and other media advertising.

I hereby authorize TPSC to use my photographic images in articles published in professional journals and textbooks, for research and teaching, in presentations at physician meetings, and in marketing - including publication on our web site, patient seminars, "before and after" photo albums, and other media advertising.

I understand that I may revoke this authorization in writing at any time.

I understand that all attempts to block my identity will be made, but that in some cases my image may be identifiable.

I have read and understand the above authorization.

Signature: _____ Witness: _____ Date: _____

RELEASE OF MEDICAL

_____ Initials **DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE:**

I agree that the practice may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, The Plastic Surgery Center will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Phone #: _____

Print Name: _____ Phone #: _____

Print Name: _____ Phone #: _____