Patient Copy

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. **"HIPPA"** provides penalties for covered entities that misuses personal health information.

As required by **"HIPPA"**, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

PLASTIC SURGERY SPECIALISTS Robert A. Hardesty, M.D., F.A.C.S. Della C. Bennett, M.D. Leah R. Zalsman, PA-C	Patient Name: DOB: MR# Date of Service:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatments, payments, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

I attempted to obtain the patient's signature in acknowledge on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

Plastic Surgery Specialists and Services ❑ Robert A. Hardesty, M.D., F.A.C.S. ❑ Della C. Bennett, M.D. ❑ Leah R. Zalsman, PA-C	PT Name: DOB: MR# Date of Service:

PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Primary Care Physician: _____
Address: _____
_____
Phone: (_____) _____

Personal History

Birthplace:	Date of Birth:
Nationality:	Religion:
Marital Status:	Health of Spouse:
Education:	
Occupation(s):	
Residence past 5 years:	
Sleep (hours):	Aids to sleep:
Recreation:	
Exercise:	
Average per day (circle):	
Y N Alcohol - Amount & Type:	
Y N Tobacco - Amount & Type:	
Y N Tea/Coffee - Amount & Type:	

Medicines Taken Regularly	Reason	Dose/Frequency

Personal Past History (Circle YES or NO)

Have you ever had:		Year	Anesthesia Problems		Year
Whooping Cough	Y N	_____	Malignant Hyperthermia	Y N	_____
Polio	Y N	_____	Troubles w/ tube placement	Y N	_____
Scarlet Fever	Y N	_____	Other (list) _____		
Diphtheria	Y N	_____	_____		
Meningitis	Y N	_____	**Operations**		
Infectious Mono	Y N	_____	Facial	Y N	_____
Valley Fever	Y N	_____	Appendix	Y N	_____
Tuberculosis	Y N	_____	Gallbladder	Y N	_____
Exposure to TB	Y N	_____	Stomach	Y N	_____
Diabetes	Y N	_____	Breast	Y N	_____
Hives	Y N	_____	Uterus	Y N	_____
Cancer	Y N	_____	Prostate	Y N	_____
Venereal Disease	Y N	_____	Hernia	Y N	_____
Arthritis	Y N	_____	Thyroid	Y N	_____
Back/Neck Trouble	Y N	_____	Varicose Veins	Y N	_____
Bronchitis	Y N	_____	Hemorrhoids	Y N	_____
Pneumonia	Y N	_____	Heart	Y N	_____
Pleurisy	Y N	_____	Liposuction	Y N	_____
Asthma	Y N	_____	Other (list)_____		
Emphysema	Y N	_____	_____		
Rheumatic Fever	Y N	_____	_____		
High Blood Pressure	Y N	_____	_____		
Heart Disease	Y N	_____	_____		
Blood Clots/DVT	Y N	_____			
Pulmonary Embolism	Y N	_____			
Anemia	Y N	_____			
Bleeding/Transfusion	Y N	_____	**Injuries**		
Hepatitis (yellow jaundice)	Y N	_____	Head	Y N	_____
Ulcer	Y N	_____	Chest	Y N	_____
Bladder Infections	Y N	_____	Abdomen	Y N	_____
Kidney Disease	Y N	_____	Broken Bones	Y N	_____
Hay Fever/Sinusitis	Y N	_____	Back	Y N	_____
Glaucoma	Y N	_____	Other (list) _____		
Nose Bleeds	Y N	_____	_____		
			_____		

Family History

Has any blood relative had any of the following (circle Yes or No. If Yes, what relationship?):

Anemia	Y N	_____
Bleeding Tendency	Y N	_____
Leukemia	Y N	_____
Blood Clots/DVT	Y N	_____
Pulmonary Embolism	Y N	_____
Repeated Infections	Y N	_____
Crippling Infections	Y N	_____
Heart Disease	Y N	_____
Chronic Lung Disease	Y N	_____
Tuberculosis	Y N	_____
High Blood Pressure	Y N	_____
Kidney Disease	Y N	_____
Asthma	Y N	_____
Severe Allergies	Y N	_____
Mental Illness	Y N	_____
Convulsions or fits	Y N	_____
Migraine Headaches	Y N	_____
Diabetes	Y N	_____
Obesity	Y N	_____
Thyroid Trouble	Y N	_____
Peptic Ulcer	Y N	_____
Cancer	Y N	_____
Malignant Hyperthermia	Y N	_____

	Present Age or Age at Death	If living, Health (Good, Fair, Poor). If deceased, cause of death.
Father		
Mother		
Brothers/Sisters		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Children		
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Allergies

Are you allergic to:

Tetanus Antitoxin	Y N	
Penicillin	Y N	
Sulfa	Y N	
Latex	Y N	
Other drugs (list)	Y N	
_____		
_____		
_____		
_____		
Foods	Y N	
Cosmetics	Y N	
Other	Y N	

Immunizations

Small Pox	Y N	
Tetanus	Y N	
Polio Shots	Y N	
Polio Oral	Y N	
Hepatitis	Y N	
Other (list)	Y N	
_____		
_____		
_____		

PLEASE TURN OVER THIS PAGE. FILL OUT BOTH SIDES OF THIS FORM.

PLASTIC SURGERY SPECIALISTS ❑ Robert A. Hardesty, M.D., F.A.C.S. ❑ Della C. Bennett, M.D. ❑ Leah R. Zalsman, PA-C	Patient Name: DOB: MR# Date of Service:

Past Medical History Updated 4/23/2009

HAVE YOU RECENTLY HAD THE FOLLOWING: CIRCLE YES OR NO. IF IN DOUBT, LEAVE BLANK.

General

Tires easily, weakness	Y	N
Marked weight change	Y	N
Night sweats	Y	N
Persistent fever	Y	N
Sensitivity to heat	Y	N
Sensitivity to cold	Y	N

Skin

Eruptions (rash)	Y	N
Change in color	Y	N
Change in hair	Y	N
Change in nails	Y	N

Eyes

Trouble seeing	Y	N
Eye pain	Y	N
Inflamed eyes	Y	N
Double vision	Y	N
Worn glasses	Y	N

Ears

Loss of hearing	Y	N
Ringing in ears	Y	N
Discharge	Y	N

Nose

Loss of smell	Y	N
Frequent colds	Y	N
Obstruction	Y	N
Excess discharge	Y	N
Nosebleeds	Y	N

Mouth

Sore gums	Y	N
Soreness of tongue	Y	N
Dental problems	Y	N

Throat

Postnasal drainage	Y	N
Soreness	Y	N
Hoarseness	Y	N

Breasts

Lumps	Y	N
Discharge	Y	N

Cardio-Respiratory System

Cough, persisting	Y	N
Sputum (Phlegm)	Y	N
Bloody Sputum	Y	N
Wheezing	Y	N
Chest pain or discomfort	Y	N
Pain on breathing	Y	N
Shortness of breath	Y	N
Difficulty breathing while lying down	Y	N
Swelling of ankles	Y	N
Bluish fingertips or lips	Y	N
High blood pressure	Y	N
Palpitations	Y	N
Vein trouble	Y	N

Digestive System

Change in appetite	Y	N
Difficulty swallowing	Y	N
Heartburn	Y	N
Abdominal distress	Y	N
Bleeding or excess gas	Y	N
Abdominal enlargement	Y	N
Nausea	Y	N
Vomiting	Y	N
Rectal bleeding	Y	N
Tarry stools	Y	N
Dark urine	Y	N
Jaundice	Y	N
Constipation	Y	N
Diarrhea	Y	N
Hemorrhoids	Y	N

Genitourinary System

Increase in frequency of urination (day)	Y	N
Increase in frequency of urination (nights)	Y	N
Feel need to urinate without much urine	Y	N
Unable to hold urine	Y	N
Albuminuria	Y	N
Impotence	Y	N
Lack of sex drive	Y	N
Pain with intercourse	Y	N

Endocrine

Thyroid trouble	Y	N
Adrenal trouble	Y	N
Cortisone treatment	Y	N
Diabetes	Y	N

Locomotor

Muscle cramps	Y	N
Muscle weakness	Y	N
Pain in joints	Y	N
Swollen joints	Y	N
Stiffness	Y	N
Deformity of joints	Y	N

Nervous System

Headaches	Y	N
Dizziness	Y	N
Fainting	Y	N
Convulsions or fits	Y	N
Nervousness	Y	N
Depression	Y	N
Change in sensation	Y	N
Memory loss	Y	N
Poor coordination	Y	N
Weakness or paralysis	Y	N

Sleep Disorder

Snoring	Y	N
Excessive sleepiness	Y	N
Pauses in breathing while sleeping	Y	N
Insomnia	Y	N
Sleeplessness	Y	N

GYN-OB ❑ Male or Child – Not applicable

Started menstruating at age ____ Date of last pap test _____
Interval between periods ____ days Duration: _____ days
Flow: Light Normal Heavy Date of last period: _____
Pain with periods: Yes No Duration _____
Number of pregnancies _____ Number of miscarriages _____
Number of births _____ Weight of babies at birth ____

(To be completed by patient)
What is the major reason for today's visit?
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Patient's Signature Date

_____ _____
Physician's Signature Date

PLASTIC SURGERY SPECIALISTS	Patient Name:
❑ Robert A. Hardesty, M.D., F.A.C.S.	DOB:
❑ Della C. Bennett, M.D.	MR#
❑ Leah R. Zalsman, PA-C	Date of Service:

PATIENT CONTACT INFORMATION

Your confidentiality is paramount to us

How would you like us to contact you for messages?

- ☐ Home phone number: (_____) _____
  - ☐ OK to leave message on answering machine.
  - ☐ **DO NOT** leave message on answering machine.
  - ☐ **NO**, do not call my home, use alternate number.

  Alternate number: (_____)_____

- ☐ Work phone number: (_____)_____
  - ☐ **OK** to state why we are calling.
  - ☐ **DO NOT** state why we are calling

- ☐ Cell phone number: (_____)_____
  - ☐ **OK** to call and/or leave a message on my cell phone.
  - ☐ **OK** to send a text message to my cell phone. List carrier: _____

- ☐ E-mail address:_____
  - ☐ **OK** to contact me via e-mail

- ☐ For written material to be mailed to me, please send to this address:

_____ ☐ OK TO SEND MAIL INFO.

_____ ☐ PLEASE **DO NOT** SEND INFO.

I AM INTERESTED IN:

FACIAL REJUVENATION
☐Brow Lift
☐Eyelid Surgery
☐Nasal Surgery
☐Face Lift
☐Chin

BODY CONTOURING
☐Tummy Tuck
☐Liposuction
☐Arm Reduction

AESTHETICIAN SERVICES
☐Skin Care
☐Peels

BREAST
☐Augmentation
☐Reduction
☐Lift

NON-SURGICAL
☐Laser (Hair removal, Vein)
☐Botox
☐Fillers (Collagen)

NUTRITION
☐Weight Reduction
☐Antiaging

HOW DID YOU HEAR ABOUT THIS OFFICE?

☐Patient ☐Print Ad ☐Friend ☐Physician
☐Market Night ☐ Internet ☐Yellow Pages ☐Seminar
☐American Society of Plastic Surgeons ☐Other_____

PRINT YOUR NAME: _____DOB:_____

Patient Signature:_____ Date:_____

PLASTIC SURGERY SPECIALISTS AND SERVICES, INC.
☐ Robert A. Hardesty, M.D., F.A.C.S.
☐ Della C. Bennett, M.D.
☐ Leah R. Zalsman, PA-C

Patient Contact Info Created 1/31/06 NB
Updated 6/1/2009

Patient Name:

DOB:

MR#:

Date of Service: