PATIENT CONTACT INFORMATION

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 test message to my cell phone. List carrier:_____

- Email address: _____
  - OK to contact me via e-mail
  - OK to send monthly specials
  - Facebook: if you "friend us" receive additional discounts
- Home 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)
□Skin Tightening
□Fat

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:_____

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 ("HIPAA") 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. **"HIPAA"** provides penalties for covered entities that misuses personal health information.

As required by **"HIPAA"**, 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

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California.
1-800-633-2322
www.mbc.ca.gov

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: _____

Imagine Plastic Surgery	Patient Name DOB: MR# Date of Service:

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS QUESTIONNAIRE	
(CIRCLE ALL THAT APPLY)	
PAST MEDICAL HISTORY	**COMMENTS**
Respiratory: ☐**NONE** Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease, Difficulty Breathing, Pneumonia, Chronic Cough, Shortness of Breath, Recent Upper Respiratory Infection, Tuberculosis, History of Deep Vein Thrombosis, Pulmonary Embolism in family or self, Sleep Apnea	
Liver/Gastrointestinal: ☐ **- NONE** Bowel Obstruction, Cirrhosis, Jaundice/Hepatitis, Hiatal Hernia/Reflux, Chronic Nausea/Vomiting, Ulcers, Urinary Tract Infection, Ulcers	
Renal/Endocrine: ☐ **- NONE** Diabetes, Renal failure, Thyroid disease, Urinary retention, Significant Weight Loss/Gain.	
Cardiovascular: ☐ **- NONE** Abnormal EKG, Irregular Heart Beat, Angina, Heart Attack, Arteriosclerosis Heart Disease, Congestive Heart Failure, Exercise Intolerance, Hypertension, Murmur, Pacemaker, Valvular Disease, Rheumatic Fever.	
Neuro/Musculoskeletal: ☐ **- NONE** Difficulty Opening Mouth for Dentist, Arthritis, Back problems, Cerebrovascular Accident/Stroke/Transient Ischemic Attack, Headaches, Muscle Weakness, Syncope, Seizures, Epilepsy, Paralysis, Paresthesia, Depression, Anxiety	
Other: ☐ **- NONE** Anemia, Sickle Cell Anemia, Bleeding tendencies, Cancer, Chemotherapy, Immunosuppressed, Pregnancy, Recent steroid use, Blood Transfusion, HIV, Loose/Damaged Teeth, Caps, Crowns, Bridges, Dentures, Piercings, Metal Implants	
Do you smoke? How many packs per day? ☐ **- NO or Describe in comments**	
Do you drink alcohol? How frequent? ☐ **- NO or Describe in comments**	
Do you use recreation drugs? What and how frequent? ☐ **- NO or Describe in comments**	
Is there any family history of:	
Do you, or is there a family history of anesthesia problems following General Anesthesia but not limited to the following; High fever after receiving General Anesthesia, A family or personal history of Malignant Hyperthermia, a muscle or neuromuscular disorder, high temperature following exercise; a personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or serious exercise. ☐ **- NO or Describe in comments**	
High Blood pressure? ☐ **- NO or Describe in comments**	
Heart Disease ☐ **- NO or Describe in comments**	
Stroke ☐ **- NO or Describe in comments**	
Lung Disease ☐ **- NO or Describe in comments**	
Diabetes ☐ **- NO or Describe in comments**	
Bleeding Disorder ☐ **- NO or Describe in comments**	
Cancer ☐ **- NO or Describe in comments**	
Previous Surgery and date(s): ☐ **- None or Please describe:**	
Any complications? ☐ **- None or Please describe:**	
Is there anything we should be aware of that is not listed here? ☐ **- None or Please describe:**	
Allergies/Medication Sensitivities with Reaction: ☐ **NONE**	
Do you take any Prescription, Over the counter, or Herbal Medications? ☐ - None or Please list Name, Dose, and Frequency.	

_____

Patients Signature and Date

_____ _____

Anesthesiologist Signature and Date Physician Signature and Date

Imagine Plastic Surgery	Patient Name DOB: MR# Date of Service: