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**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

**RELEASE OF MEDICAL/EMERGENCY CONTACT**

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

Initials

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.

Please print the below information:

Primary Representative \_\_\_\_\_ Phone # \_\_\_\_\_

Secondary Representative \_\_\_\_\_ Phone # \_\_\_\_\_

Tertiary Representative \_\_\_\_\_ Phone # \_\_\_\_\_



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## PATIENT RIGHTS AND RESPONSIBILITIES

1. 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
  - TreatmentsThose 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:
• What do you do for daily exercise?
• Are you able to go up stairs without becoming short of breath? [ ] YES [ ] NO
• 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?
• Have you ever been diagnosed with COVID-19? [ ] YES [ ] NO If YES, did you have respiratory symptoms related to COVID-19? [ ] YES [ ] NO Were you hospitalized? [ ] YES [ ] NO
• Have you been vaccinated for COVID-19? [ ] YES [ ] NO If YES, what dates?

Please turn this page over and complete the medical information.



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MEDICAL HISTORY

AIRWAY

- Capped, chipped, broken teeth.
Difficulty opening your mouth fully?

RESPIRATORY

- Used tobacco within the year.
Persistent cough.
Sputum, phlegm, mucus production.
Asthma, wheezing.
Bronchitis, Emphysema, COPD
Tuberculosis.
Shortness of breath after walking
two flights of stairs?
Recent cold?
Do you have a history of sleep apnea?
Do you use a breathing device? If yes
bring it with you the day of surgery.

HEART

- Chest pain, angina, MI, heart attack.
Leg swelling, edema, CHF.
Paralysis.
High blood pressure.
Heart murmur, prolapsed mitral
valve, rheumatic fever.
Legs cramp when walking.

SKIN

- Problems with wounds healing.
Scar badly.
Bruise easily, excessive bleeding.
Allergic reaction to adhesive tape.

ENDOCRINE

- Diabetes, If yes you will need an
insulin order from your Doctor.
Thyroid problems, heat or cold
intolerance.
Low blood sugar.

ABDOMEN

- Hiatal hernia, frequent
regurgitation, heartburn.
Ulcers, vomiting blood.
Hepatitis, jaundice.
Liver disease, cirrhosis.
Kidney disease.

GENITOURINARY

- Could you be pregnant?
Difficulty passing urine.
At risk for AIDS or
venereal disease.

MUSCULOSKELETAL

- Physical limitations,
appliances, or prostheses
Arthritis (jaw, neck, back)
Phlebitis

NEUROLOGICAL/PSYCHIATRIC

- Seizures, convulsions,
fainting, epilepsy.
Stroke, fleeting blindness,
or weakness.
Psychiatric treatment.
Anxious about possible
surgery.

GENERAL

- Headaches, unexplained
weight loss.
Steroid use within 1 year.
Blood transfusions.
Have used recreation drugs.
Anemia or bleeding disorder.
Glaucoma
Chemotherapy
(within 6 months.)
Personal or family history
of blood clots.

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

Horizontal lines for handwritten explanation.



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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 (\_\_\_\_) \_\_\_\_\_

# 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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## 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, and "before and after" photo albums.

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, and "before and after" photo albums.

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: \_\_\_\_\_