



AESTHETIC SURGERY ASSOCIATES

Registration Information

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Birth Date: ____/____/____ Age: ____ SSN#: ____ - ____ - ____ Driver's Licence: State: ____ #: ____

Patient Phone: Home: (____) _____ Cell: (____) _____

Business: (____) _____ Other: (____) _____

E-mail: _____ Occupation: _____

Patient / Spouse (circle one) Employer: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Emergency Contact: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Alternate Phone: (____) _____

Referral Source: _____

Insurance Information

(Please list ALL insurances, including supplementary plans)

Insurance Company: _____

Insured Name: _____

Insured's Birth Date: ____/____/____ Insured's SSN#: ____ - ____ - ____

Group #: _____ ID #: _____

Assignment of Benefits

I hereby authorize direct payment of medical and/or surgical benefits to Aesthetic Surgery Associates for services rendered by its physicians in person or under their supervision. I understand that I am financially responsible for any balance not covered by any insurance.

I hereby authorize Aesthetic Surgery Associates to release any medical information that may be necessary for either medical care and/or in processing applications for financial benefits.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

Signature: _____ Date: ____/____/____

Printed Name: _____

Responsible Person: _____ Date: ____/____/____

Relationship to Patient: _____

Social History

Although some of the following questions may be highly personal in nature, they are intended to insure your safety during surgery and in the recovery period. Many supplements, drugs and medications can have serious interactions with anesthesia. In addition, living situations and the degree of support during recovery can have significant impact on how smoothly your post-operative course can be. We apologize for any feelings that the questions may raise regarding your privacy. Our only interest is in the safety and quality of your care. Rest assured, your answers to the questions will remain private unless you specifically agree to release the information in writing.

Are you: married single divorced widowed separated

Do you live with: alone family friend

Do you smoke? (including vaping) yes no If so, how many packs a day? _____
For how long? _____

Do you take any recreational drugs? yes no If so, what? _____
How often? _____

Do you drink alcohol? yes no How many drinks in a week? _____

Do you exercise? yes no How many times a week? 1 2 3 4 5 6 every day

Do you have significant fears or phobias related to medical care? yes no

If you have fears, what are they? _____

Do you have hobbies? yes no What are they? _____

Women Only

Are you pregnant now?	yes no	Are you planning additional pregnancies?	yes no
Age period began	_____	Number of pregnancies:	1 2 3 4 5 6 more
Did You Breast Feed?	yes no	Number of Children:	1 2 3 4 5 6 more

Medical History

To assist our doctor's and staff in delivering the highest quality of care possible, we need information that will help us assess your overall health status and conditions that may affect your care

Height: _____ ft. _____ inches Weight: _____ lbs.

Primary Care Doctor: _____ Phone: (____) _____

Exactly why are you here to see our Doctor (Chief Complaint)? _____

Do you have any allergies to drugs or medications? yes no If yes, please list them: _____

Do you use any Aspirin, Motrin, Naprosyn, or other Anti-inflammatory medicines: yes no

Have you ever had surgery? yes no If yes, please list them: _____

Have you ever had trouble with any anesthetic? yes no If so, please explain: _____

Do you have any illnesses? Please list them: _____

Do you take any medications? yes no If yes, please list them: _____

Do you take any dietary supplements, vitamins, or herbal preparations? yes no

What are they? _____



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Family History:

Has any blood relative ever had the following?

Breast Cancer	yes	no	High Blood Pressure	yes	no	Kidney Disease	yes	no
Other Cancers	yes	no	Heart Disease	yes	no	Liver Disease	yes	no
Melanoma	yes	no	Stroke	yes	no	Bleeding disorder	yes	no
Depression	yes	no	Congenital Deformity	yes	no	Diabetes	yes	no

Past Medical History

Have you ever had the following?

Breast Cancer	yes	no	High Blood Pressure	yes	no	Kidney Disease	yes	no
Other Cancers	yes	no	Heart Disease	yes	no	Liver Disease	yes	no
Melanoma	yes	no	Stroke	yes	no	Bleeding disorder	yes	no
Depression	yes	no	Congenital Deformity	yes	no	Mitral Valve prolapse	yes	no
Stomach Ulcer	yes	no	Thyroid Disease	yes	no	Diabetes	yes	no
AIDS or HIV+	yes	no	Hepatitis	yes	no	Anemia	yes	no
Tuberculosis	yes	no	Asthma	yes	no	Glaucoma	yes	no
Arthritis	yes	no	Rheumatic Fever	yes	no	Contact lenses	yes	no
Eating Disorders	yes	no	Migraine Headaches	yes	no			

Any other medical problem not previously listed? _____

Review of Systems

Do you have now or have you had within the past year?

Weight Change	yes	no	Swollen feet or ankles	yes	no	Seizures	yes	no
Dry Eyes	yes	no	Skin Rash	yes	no	Joint or Muscle Pain	yes	no
Chronic Cough	yes	no	Chest Pain	yes	no	Swollen lymph nodes	yes	no
Rapid Heart Beat	yes	no	Irregular Heart Beat	yes	no	Easy Bruising	yes	no
Depression	yes	no	Chronic Diarrhea	yes	no	Easy Bleeding	yes	no
Severe Infections	yes	no	Jaundice	yes	no	Numbness in hands/feet	yes	no
Visual changes	yes	no	Shortness of Breath	yes	no	Breast masses or lumps	yes	no
Urinary Burning	yes	no	Urinary incontinence	yes	no	Heat or cold intolerance	yes	no
Blood Clots/DVT	yes	no						

Women Only

Date of last mammogram _____ Where was it done? _____

Do you do regular breast self-examinations yes no How Often? _____

Are you currently taking any birth control medication (including IUDs, etc)? yes no

If so, please list: _____

I VERIFY THAT THE PRECEEDING INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

X _____

Date: ____/____/____



AESTHETIC SURGERY ASSOCIATES

Patient Privacy Notice

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

Your privacy and safeguarding your medical information are critical concerns to us here at Aesthetic Surgery Associates. The Federal Government's Health Information Portability and Accountability Act (HIPAA) require that every patient receives notification about how the details of your current or past health condition (Protected Health Information or PHI) are disclosed to those outside our practice. We agree with this policy, and will do our utmost to protect personal information about you that our practice may have in your record. Although our policy is to disclose information only after receiving a written release from you, or from someone legally responsible for you, we will disclose information to persons and organizations outside the practice under certain conditions. These conditions involve filing insurance claims, communicating with other doctors or organizations (hospitals, labs, health care agencies and governmental agencies), or performing those tasks necessary to conduct your medical care.

Given the complexity of modern medicine, and the insurance industry, there are a number of appropriate circumstances in which we will need to disclose or use your Protected Medical Information without your specific written consent. These uses are best described in terms of the following categories:

For Treatment: In order to undertake, coordinate, or complete a patient's treatment we may need to disclose Protected Health Information to nurses, pharmacists, doctors, lab technicians, X-ray technicians and other individuals involved in your care.

For Health Care Operations: We may use or disclose your Protected Health Information to others in connection with reviews of our practice carried out as part of a quality assurance program or records review conducted by outside insurance agencies or governmental agencies responsible for regulation medical practices or insuring compliance with existing regulations. If these reviews are conducted, we will make every attempt to protect your identity and comply with the review while protecting the anonymity of our patients. However, sufficient material may need to be disclosed that could possibly reveal your Protected Medical Information.

Appointment Reminders or Verification: We may need to disclose Protected Health Information about you in connection with appointment reminders by phone or by mail. Simply by identifying ourselves as a caller, other persons may learn that you are under treatment by us. We will make every effort to be discreet, but your information may need to be used to remind you or an appointment, or verify to others that you have an appointment.

Individuals Involved in Care of Payment of Care: Our practice may disclose Protected Health Information to friends or family members who are involved in our patient's care. Information will be disclosed with the intent of insuring the accurate conduct of care, or to answer questions about appropriate delivery of care.

Research / Medical Literature: Our doctors participate in research which may involve collection and use of your Protected Medical Information in connection with a study, journal article, or educational program. Before using your information, a valid authorization to do so will be specifically requested from you. You are under no obligation to participate in any research being conducted.

As Required by Law or to Avert a Serious Threat to Health or Safety: Protected Health Information may be disclosed or used when required by public law. An example of this is the requirement to release specific patient information when certain kind of communicable disease is involved in your treatment.

For Payment: Our practice may use or disclose Protected Health Information to third-party payers (insurance companies or Government Agencies) so that we may receive payment for treating you.



Patient Privacy Consent

The following is a consent that gives Aesthetic Surgery Associates, its staff, and Physicians permission to use or disclose Protected Health Information for treatment purposes, payment for medical services, or health care operations. These uses are described in the patient privacy statement, a copy of which has been supplied to you with this consent.

Although Protected Medical Information can be released to third-parties under current federal and state law without a specific consent being signed, we at Aesthetic Surgery Associates feel that it is important for every patient to understand the concept and use of their personal information as applies to our practice.

Protected Health Information is specific information that our practice has compiled as part of your medical record. It includes information such as: past medical history, history of present illness, review of systems, physical exam, diagnosis, procedure or operative reports, laboratory results, clinical photographs, x-ray results, pathology results, and information regarding medically implanted devices. Personal information such as your name, address, insurance information, social security number, and other items are included in the definition.

Under certain conditions or circumstances, treatment may be conditional upon signing this consent. These circumstances involve concerns we may have that restrictions will compromise the quality or appropriateness of your care.

Your Rights

You have the right to review our Privacy Policy Statement before signing this consent, and we encourage you to do so. If you have any questions about this consent, or our Privacy policy, please bring it to the attention of our staff and we will be more than happy to clarify them for you.

You have the right to submit a request in writing at any time in the future to restrict this consent, or revoke it. Your request to revoke or restrict Protected Health Information will not affect information that has already been disclosed prior to your request.

Consent

I hereby give permission for Aesthetic Surgery Associates to use or disclose my Protected Health Information for Treatment Purposes, Medical Services, or Health Care Operations. This authorization includes release of any medical information that may be necessary for either medical care or processing applications for financial benefits.

Signature: _____ Date: ____/____/____

Printed Name: _____

Authorized Representative: _____

Relationship: _____ Date: ____/____/____



Patient Rights

UNDER THE NEW HIPAA GUIDELINES, YOU HAVE SPECIFIC RIGHTS CONCERNING THE USE OF AND DISCLOSURE OF YOUR PROTECTED MEDICAL INFORMATION. PLEASE READ THE FOLLOWING CAREFULLY SO THAT YOU UNDERSTAND THOSE RIGHTS

Right to Request Restrictions: You have the right to request restrictions and limitations on how your Protected Medical Information is used or disclosed. This is done through a written request specifying the limitations that you wish to have placed. We will make every effort to agree to reasonable requests that do not complicate or compromise your care. If we agree to your requested restrictions, we will abide by them until such time as the patient removes them in writing. Aesthetic Surgery Associates may not be able to safely or thoroughly conduct your care with these restrictions, and is not required to agree to them.

Right to Inspect and Copy Your Information: You have the right to inspect and obtain a copy of Protected Medical Information that may be used to make treatment decisions in your care. Simply make the request in writing to our office for a copy of your information. A small fee may be charged for copies to defray the additional office expense.

Right to Amend: You have the right to make a written request to amend medical information that you believe is inaccurate or incomplete. We have every interest in maintaining highly accurate records about you and welcome the chance to further improve them. Please submit any changes to us in writing. However, Aesthetic Surgery Associates may deny the request if we feel that the original information is accurate or complete.

Right to Request Confidential Communications: You have the right to request that our practice, or its physicians, communicate with you in a certain manner (for example: e-mail, mail, cell phone etc.). This is to assure that you are able to select the method that most protects your privacy. Your request will need to be submitted in writing.

Right to an Accounting of Disclosures: You have the right to request an accounting of all disclosures our practice has made of your Protected Health Information over a reasonable period of time. You may be charged an administrative fee for each list requested.

Right to a copy of the Privacy Statement and Statement of Patient Rights: You will be furnished with a copy of this document when you first register with our practice. Additional copies will be provided on request. When and if the practice develops a web site, the document will be available as a download.

The Practice's Responsibilities

Aesthetic Surgery Associates and its Physicians are required by law to maintain the Patient Privacy Notice and abide by its terms from its effective date. If our privacy practices are modified in the future, and these modifications affect use and disclosure of previously obtained Protected Health Information, the modified policy can be obtained from our practice on demand. In the event that we change our policy, or if a change in the law affects the patient's rights or our responsibility, we will promptly amend our privacy policy and advise our patients of the change.

Point of Contact: If you have concerns about your Protected Medical Information, or need additional help in understanding how and under what circumstances it is used, please contact our office.

Effective Date of this Privacy Policy: September 6th, 2002

I have reviewed the Patient Privacy Notice and have received a copy when requested.

Patient Signature: _____ **Date:** ____/____/____

Printed Name: _____ **(initials)** _____