Desert Plastic Surgery

Cosmetic and Reconstructive Plastic Surgery

John M. Pierce, M.D.

Patient Name_____ Age_____ Date of Birth_____
Last First M.I.

How Would You Like To Be Addressed: _____

Street Address_____ City_____ State_____ Zip_____

Home Phone_(____)_____ Cell Phone_(____)_____ E-mail_____

How would you like to be contacted?: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐Widowed ☐ Divorced ☐ Separated

Occupation:_____ Employer:_____ Social Security #:_____

Employer Address:_____ Employer Phone:_(____)_____

Emergency Contact Person:_____ Relationship: _____ Phone:_(____)_____

Patient Referred by:_____ Primary Physician: _____

Reason For This Visit: _____

Are There Any Other Procedures/Services You Are Interested In?_____

Have You Seen Any Other Plastic Surgeons For This Problem: ☐ Yes ☐ No If yes, list names: _____

How Did You Hear About Our Practice: _____

Would You Like To Be Added To Our Newsletter Mailing List (need E-mail address): ☐ Yes ☐ No

Insurance Plan Name: _____ Address: _____

Policy or ID Number: _____ Group #: _____ Effective Date: _____

Insured Name (if different than patient): _____

Insured Social Security Number:_____ Insured Date of Birth:_____

Secondary Insurance: _____ Policy #: _____

Person Financially Responsible: ☐ Patient ☐ Spouse ☐ Parent ☐ Other _____

Authorization for Assignment & Release (All Patients/Guarantors must sign and date this section)

I authorize my insurance benefits to be paid the practice/doctor. I authorize my medical information to be released as required to justify medical necessity on billing documents. I understand and agree to be responsible for any elective or non-covered services that may be provided. I understand that I am financially liable for payment for services rendered and that I am responsible for providing all pertaining insurance information to expedite insurance reimbursement. I agree to pay my required co-pay at the time of service, and agree that if I do not possess current insurance coverage, that I will pay in full for services rendered at the time of service. I request that payment of authorized Medicare benefits be made on my behalf to Desert Plastic Surgery for any services provided to me if indicated.

Patient/Guarantor Signature _____ Date _____

INFORMATION FOR CASE HISTORY FILE

(Please complete all areas Please Print)

PAST MEDICAL HISTORY

General Health: Good_____ Fair_____ Poor_____

If not "Good" please explain: _____

_____

Height_____ Weight_____ Date of last recent physical check up? _____

Did it include an electrocardiogram? Yes____ No____ Chest X-Ray Yes____ No____

Serious Illness (Please List) _____

PREVIOUS SURGERY (Please List)

Operation	Year	Hospital City	Surgeon's Name	Anesthesia(Local /General)

Have you had any complications from any previous surgeries? Yes_____ No_____

If "Yes" please explain_____

PERTINENT PREOPERATIVE INFORMATION

Please list all medications you are now taking (including blood thinners, aspirin, bufferin, birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, etc._____

_____

Are you allergic to any medications? Yes____ No____ If yes, please explain:_____

_____

Please check any of the following that pertain to your health:

_____Heart Problems	_____Heart Murmur
_____Lungs	_____High Blood Pressure
_____Kidneys	_____Liver Disease
_____Herpes	_____HIV

Do you require large amounts of local anesthetic for medical procedures?	Yes___No___
Have you ever had a bad reaction to a local anesthetic (Novocain, etc.)?	Yes___No___
Do you smoke?	Yes___No___
Do you bruise unusually easily?	Yes___No___
Do you form large scars or keloids?	Yes___No___
Do you have, or have you had any significant emotional problems?	Yes___No___
Have you ever had psychiatric care or been advised to see a psychiatrist?	Yes___No___

Signature_____

Relationship to Patient (Self, Mother , etc.)_____

SIGNATURE AUTHORIZATION

ASSIGNMENT: I hereby assign my insurance benefits to be paid directly to DESERT PLASTIC SUGERY. I am financially responsible for the non-covered services.

Signature_____ Date_____

RELEASE: I authorize DESERT PLASTIC SURGERY to release to my insurance carrier(s) any information required to process this claim.

Signature_____

I request that payment of authorized Medicare benefits be made on my behalf to DESERT PLASTIC SURGERY to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____ Date_____

Notice of Privacy Practices

To our patients: This notice describes how health information about you as a patient of this practice, may be used and disclosed, and how you can gain access to your Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy:

- **Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.**
- **We realize that these laws are complicated, but we must provide you with the following information: Use and disclosure of your health information in certain circumstances.**

The following circumstances may require us to use or disclose your health information:

1. **To public health authorities and health oversight agencies that are authorized by law to collect information.**
2. **Lawsuits and similar proceedings in response to a court or administrative order.**
3. **If required to do so by a law enforcement official.**
4. **When necessary to reduce or prevent a serious threat to your health and safety of the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.**
5. **If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.**
6. **To federal officials for intelligence and national security activities authorized by law.**
7. **To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.**
8. **For Workers Compensation and similar programs.**

Your rights regarding your health information:

1. **Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.**
2. **You can request a restriction in our use or disclosure of your health information for the treatment, payment or health information to only certain individuals involved in your care or payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when information is necessary to treat you.**
3. **You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *Desert Plastic Surgery, 3300 N.* 75th Street, Scottsdale, AZ 85251.**
4. **You may ask to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, it must be done in writing and submitted to our office.**
5. **Right to a copy of this notice: You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.**
6. **Right to file a complaint: If you believe your privacy rights have been violated, you may file a Complaint with our practice or the Secretary of the Department of Health and Human Services. To File a complaint with our practice, contact the office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.**
7. **Right to an authorization for the use and disclosures: Our practice will obtain written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. "If a disclosure of your protected health information was made for a reason other treatment, payment or health care operations, you have a right to receive an accounting of the disclosure."**

- **If you have any questions regarding this notice or our health information privacy policies, please contact the office at 480-990-8808.**
- **I hereby acknowledge that I have been presented with a copy of *Desert Plastic Surgery* Notice of Privacy Practice.**

Signature _____ **Date** _____

Please Print Name _____

Source: Advocacy Resource Center of the American Medical Association, October 1999