PATIENT REGISTRATION FORM

Welcome to our office! Please PRINT and complete ALL sections below

PATIENT'S PERSONAL INFORMATION Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

S.S.#: ________________________________ Sex: ❑ Male ❑ Female EMAIL: ________________________________

Last Name: ______________________________ First Name: ___________________________ Middle:________________

Street Address: ____

City: ___________________________________ State: _________________________ Zip Code: _____________________

Home Phone : (_____) ___________________ Work Phone: (_____) ______________ Cell Phone: (___)_________________

best place to reach you during business office hours? ❑ Home ❑ Work ❑ Cell ❑ Email ❑ Other ____________________

Date of Birth: _____/_____/_________ Age: ________ Driver's License: _________________________ State: __________

Employer's Name: ____ Phone Number: (_____) ______________

Address: ____ City: _______________________ State: __________ Zip: ________

Your occupation: ____

If Minor, Name of school: ____ ❑ Full time ❑ Part time

Spouse's/ Parent's name: ____ Work Phone: (_____) ______________________

Spouse's Social Security #: _______-_____-__________

PATIENT'S RESPONSIBLE PARTY INFORMATION

Responsible party: ____ Date of Birth: _____/_____/_______

Relation to Patient: ❑ Self ❑ Spouse ❑ Other _______________________ Social Security #: _______-_____-__________

Responsible party's home phone: (_____) __________________ Responsible party's work phone: (_____) ___________________

Address: ____ City: _______________________ State: __________ Zip: ________

PATIENT'S INSURANCE INFORMATION

PRIMARY insurance company's name: ____

Insurance address: __________________________________ City: _______________________ State: _________ Zip: _________

Policy holder's name: ____ Date of Birth _____/_____/_______

Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other Insurance Phone (______)_____________________

Insurance ID Number: ____ Group Number: ___________________________

SECONDARY insurance company's name: ____

Insurance address: ___________________________________ City: _______________________ State: _________ Zip: ________

Policy holder's name: ____ Date of Birth _____/_____/_______

Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other Insurance Phone: (____) _____________________

Insurance ID Number: ____ Group Number: __________________________

PATIENT'S REFERRAL INFORMATION

Referred by:____ Phone: (_____) ______________________

EMERGENCY CONTACT

Name of person not living with you: ____ Relationship: ___________________

Address: ____ City: _______________________ State: __________ Zip: ________

Home Phone: (____) ______________________________ Work Phone: (_____) ____

RELEASE OF MEDICAL RECORDS

I hereby give authorization for PREMIERE PLASTIC SURGERY to obtain medical records including my medical history, mental or physical condition, evaluation, services rendered and treatment from: ____

Patient signature: ____Date: ___________________

PREMIERE PLASTIC SURGERY

PERSONAL HEALTH QUESTIONNAIRE

Patient Name: Today's Date:

MEDICAL EVALUATION

MEDICAL EVALUATION	
How is your general health?	
Are you presently being treated for any medical conditions?	☐ Yes ☐ No
If yes, please explain:	
When was your last physical examination?	
Primary Care Physician:	
Other physicians:	

EYES	
Visual Loss (one or both)	☐ Yes ☐ No
"Dry" eyes	☐ Yes ☐ No
Itching or Irritation	☐ Yes ☐ No
Blurred or Double Vision	☐ Yes ☐ No
Crossed or Lazy eyes	☐ Yes ☐ No
Cornea Problems	☐ Yes ☐ No
Thyroid Eye Disease	☐ Yes ☐ No
Wear Glasses/Contacts	☐ Yes ☐ No
Previous eye/eyelid surgery	☐ Yes ☐ No
If yes, explain:	

NOSE	
Difficulty Breathing	☐ Yes ☐ No
Previous Injury	☐ Yes ☐ No
Nasal Allergies	☐ Yes ☐ No
Nose Bleeds	☐ Yes ☐ No
Sinus Conditions	☐ Yes ☐ No
Previous Nasal/Sinus Surgery	☐ Yes ☐ No
If yes, what type:	

FACE	
Previous Aesthetic Surgery	☐ Yes ☐ No
If yes, what type:	
Irradiation to Face or Neck	☐ Yes ☐ No
Facial Paralysis / Weakness	☐ Yes ☐ No
Facial Skin Problems	☐ Yes ☐ No
Other Skin Problems	☐ Yes ☐ No
If yes, what type:	

CARDIOVASCULAR	
Coronary or Heart Attack	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Palpitations/Irregular Beat	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No
Stroke	☐ Yes ☐ No

CHEST	
Shortness of Breath	☐ Yes ☐ No
Chronic Lung Disease	☐ Yes ☐ No
Cough	☐ Yes ☐ No
Asthma	☐ Yes ☐ No

BREAST	
Pain or Discomfort	☐ Yes ☐ No
Cysts or Lumps	☐ Yes ☐ No
Have you had Biopsies	☐ Yes ☐ No
Breast Cancer in Family	☐ Yes ☐ No
If yes, who:	
Recent Mammogram- Ultrasound- MRI?	☐ Yes ☐ No
If yes, when:	

PSYCHIATRIC	
Have you received treatment	☐ Yes ☐ No
If yes, were you hospitalized	
Any recent crisis in your life	☐ Yes ☐ No

OTHER	
Liver Disorder	☐ Yes ☐ No
Hepatitis / Cirrhosis	☐ Yes ☐ No
Kidney / Bladder Disorders	☐ Yes ☐ No

PREMIERE PLASTIC SURGERY

HEALTH QUESTIONNAIRE – Page Two Patient Name:

ALLERGIES

Any Drug Allergies (including local Anesthetic & Codeine)	☐ Yes ☐ No

If yes, Drug	Reaction

MEDICATIONS

List any medications and dosage you are taking or have taken within the last month

Question	Answer
Do you take Aspirin or medication that contains Aspirin	☐ Yes ☐ No
Taken a Steroid over the past year	☐ Yes ☐ No
Taking Vitamin E	☐ Yes ☐ No

FAMILY HISTORY

History of Medical Problems or Illness

Mother:
Father:
Sister:
Brother:

OTHER (Continued)

Condition	Answer
Chronic Infections	☐ Yes ☐ No
Spinal or Back Disorders	☐ Yes ☐ No
Previous Blood Clots	☐ Yes ☐ No
Previous Thrombophlebitis	☐ Yes ☐ No
Autoimmune Disease	☐ Yes ☐ No
Lupus, Rheumatoid Arthritis	☐ Yes ☐ No
Stomach / Digestive Disorder	☐ Yes ☐ No
Bleeding Disorders- Self	☐ Yes ☐ No
Bleeding Disorders – Family	☐ Yes ☐ No
Blood Transfusions	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No
Keloids or Unusual Scaring	☐ Yes ☐ No
Are you Pregnant?	☐ Yes ☐ No

SOCIAL

Question	Answer
Do you Smoke?	☐ Yes ☐ No
If so, How many per day:	
Alcohol Consumption?	☐ Yes ☐ No
Drinks per day:	
Do you use any Drugs?	☐ Yes ☐ No

CHILDHOOD MEDICAL HISTORY

Item	Answer
Had All Known Baby Shots	☐ Yes ☐ No
Polio Immunization	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
CURRENT HEIGHT	
CURRENT WEIGHT	

SURGERY (operations)

Type/ Date /Complications or Difficulties
1.
2.
3.
4.

ADMISSIONS TO HOSPITALS

Reason/ Date /Complications or Difficulties
1.
2.
3.
4.

Do you have an advanced directive? ☐ Yes ☐ No	An advance directive tells your doctor what kind of care you would like if you become unable to make medical decisions (if you are in a coma for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives.

WHAT COSMETIC SURGERY & CONCERNS WOULD YOU LIKE TO DISCUSS?

Patient/ Legal guardian/Parent Signature

Date

PREMIERE PLASTIC SURGERY

ASSIGNMENT OF BENEFIT

I hereby agree to irrevocably assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medi-Cal, Champus, and all other government sponsored programs, private insurance and any other health plans to:

PREMIERE PLASTIC SURGERY
Howard K. Nam, MD, Inc. Tom A. Flashman, MD, Inc
Brian A. Cox, MD, Inc
Harold L. Rosenfeld, MD, Inc. Christopher K. Tiner, MD, Inc.
Lawton W. Tang, MD- Charles T. Resnick, MD
1044 S. Fair Oaks Avenue, Suite 101, Pasadena, CA 91105

I hereby instruct and direct the insurance company to pay by check made out and mailed to. if my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct the insurance company to make out the check to me and mail as follows:

c/o PREMIERE PLASTIC SURGERY
C/o Howard K. Nam, MD, Inc.- C/o Tom A. Flashman, MD, Inc.
C/o Brian A. Cox, MD, Inc.
C/o Harold L. Rosenfeld, MD, Inc.- C/o Christopher K. Tiner, MD, Inc.
c/o Lawton W. Tang, MD- c/o Charles T. Resnick, MD, Inc

Medicare will only pay for services that are determined to be "Reasonable and Necessary" under section 1882(a) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "Reasonable and Necessary" under Medicare program standards, Medicare will deny payment for that service.
I understand that, as a courtesy to me, the above named physician will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the medical office in the collection of the outstanding fees.

AUTHORIZATION OF DESIGNATED REPRESENTATIVE TO APPEAL A DETERMINATION

I hereby authorize Howard K. Nam, M.D., Tom A. Flashman, M.D., Brian A. Cox, M.D., Harold L. Rosenfeld, Christopher K. Tiner, MD, Lawton W. Tang. MD, Charles T. Resnick and Shankar Lakshman, MD and its representative to appeal a claim determination on my behalf.
As my Designated Representative, and, as part of the appeal, I hereby authorize them to:
A) submit claim on my behalf;
B) act on my behalf in pursuing and appealing the benefit determination under my insurance plan.
C) initiate formal complaints to any State and Federal agency that has jurisdiction over my benefits;
D) submit any and all requests for benefit information from my insurance plan; all medical and financial information contained in my insurance file include but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder or developmental disability, cancer and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed
I understand this information is privileged and confidential and will only be released as specified in this authorization.

This authorization is valid for a period of five years.
A photocopy of this authorization shall be considered as effective and valid as the original.

Very truly yours,

_______________________ _______________________

Date *Patient or Legal guardian's Signature*

____

Print Patient Name

PREMIERE PLASTIC SURGERY

PATIENT FINANCIAL POLICY

Thank you for choosing us. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist.

How May I Pay?

We accept payment by cash, money orders, cashier's checks, personal checks, MasterCard or VISA charge cards or debit cards. There will be a $20 charge for all checks returned for nonsufficient funds.

Do I Need a Referral?

If you have an HMO plan with which we are contracted, you will need an authorization number from your primary care physician. If we have not received the authorization number prior to your arrival at the office, we have a telephone available for you to call your primary care physician to attempt to obtain it. We are required by HMO's and certain POS plans to have this number prior to providing services to you.

If you are unable to obtain the referral, you will be re-scheduled for your visit.

What If My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors (patients less than 18 years of age) on all of the patient's visits. The accompanying adult is responsible for payment of the account, according to the policy outlined on these pages.

Patient Responsibility

All patients are responsible for knowing the requirements of their insurance plans, including which labs and radiology facilities they may use, what services are covered, etc. Our staff will assist our patients, but we cannot be responsible for knowing or interpreting the benefits of each individual policy. Our office staff will do all we can, but insurance companies have the last word on payment; therefore, ultimate responsibility lies with the patient.

Surgery

If our physician recommends surgery, we will obtain your insurance information at the time that you check out and you should contact our surgery scheduler within the next few days. She will be able to answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved and complete all precertifications and/or authorizations as required by your insurance.

The surgery scheduler may request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate that shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the surgery scheduler.

Whenever you undergo surgery, you will be billed by the surgeon, the anesthesiologist, the facility and the pathologist. We can only guarantee the surgeon and facility's affiliation to your insurance's network. Anesthesiologists and pathologists may not be contracted with your insurance.

I understand and agree that my health coverage involves an arrangement between my health plan and myself and that my physician is not a contracting provider with my health plan. Furthermore, I understand that this office will prepare any necessary reports and forms to bill my health plan. Any amount paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that any remaining balance after my health plan has made payment will be charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

________________________________ *Date*

________________________________ *Patient or Legal guardian's Signature*

________________________________ *Print Patient Name*

PREMIERE PLASTIC SURGERY

PATIENT PHOTOGRAPHIC AUTHORIZATION AND CONSENT

I consent to the taking of photographs of me, (or parts of my body), by or his designee in connection with the plastic surgery procedure(s) to be performed by :

(please initial in the box to left of the physician that applies)

☐ Brian A. Cox, MD ☐ Harold L. Rosenfeld, MD

☐ Christopher K. Tiner, MD ☐ Lawton W. Tang, MD

I further consent to the release by the above named physician to the American Society of Plastic Surgeons ("ASPS"), and/or the American Board of Plastic Surgery, Inc. of such photographs.

I understand that such photographs may be published by ASPS in any print, visual, or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication.

______________________________ ______________________________

Date *Patient or Legal guardian's Signature*

____

Print Patient Name

****

IF PATIENT IS A MINOR, LEGAL GUARDIAN NEEDS TO COMPLETE AND SIGN BELOW:

I, ________________________________ have read the Authorization and Release. I am the parent, guardian, or conservator of____________________________, a minor. I am authorized to sign this consent on his / her behalf and I grant this consent as a voluntary contribution in the interest of education, examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

______________________________ ______________________________

Date *Patient or Legal guardian's Signature*

____

Print Patient Name

PREMIERE PLASTIC SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF

PREMIERE
PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the above doctors Notice of Privacy Practices.

____

Patient Name (print)

____

Signature / Date

____

Received by:

PREMIERE PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

❖ Your protected healthcare information may be released to other healthcare professionals within Premiere Plastic Surgery, INC for the purpose of providing you with quality healthcare.

❖ Your protected healthcare information may be released to your insurance provider for the purpose of Premiere Plastic Surgery, INC receiving payment for providing you with needed healthcare services.

❖ Your protected healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

❖ Your protected healthcare information may be released to other healthcare providers in the event you need emergency care.

❖ Your protected healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).

❖ Your protected healthcare information may not be released for any other purpose than that which is identified in this notice.

❖ Your protected healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release protected healthcare information at any time.

❖ You may be contacted by Premiere Plastic Surgery, INC to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

❖ You may be contacted by Premiere Plastic Surgery, INC for the purposes of marketing to support Premiere Plastic Surgery, INC's operations.

❖ You have the right to restrict the use of your confidential healthcare information. However, Premiere Plastic Surgery, INC may chose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

❖ You have the right to receive confidential communication about your health status.

❖ You have the right to review and photocopy any/all portions of your healthcare information.

❖ You have the right to make changes to your healthcare information.

❖ You have the right to know who has accessed your protected healthcare information and for what purpose.

❖ You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

❖ Premiere Plastic Surgery, INC is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.

❖ Premiere Plastic Surgery, INC will abide by the terms of this notice. Premiere Plastic Surgery, INC reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.

PREMIERE PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES, continued

- ❖ You have the right to complain to Premiere Plastic Surgery, INC if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to Premiere Plastic Surgery, INC:

  ATTN: Ms. Valerie Kwan, Administrator
  Premiere Plastic Surgery, INC
  1044 S. Fair Oaks Avenue
  Suite 110
  Pasadena, CA 91105

  - All complaints will be investigated. No personal issue will be raised for filing a complaint with Premiere Plastic Surgery, INC.

- ❖ For further information about this Privacy Notice, please contact:

  - Valerie Kwan
  - Privacy Officer
  - (626) 449-4859

- ❖ This notice was published and becomes effective on **March 31, 2008**.

PREMIERE PLASTIC SURGERY