Cosmetic Surgery Associates
6430 Rockledge Drive, #100
Bethesda, MD 20817
(p) 301-493-4334
www.cosmeticplastics.com

Cosmetic Surgery
ASSOCIATES

Patient Information Form ~ 10/6/2015

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

DOB & Age: _____

Sex: _____ SSN: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about us?

- ☐ Doctor Referral _____
- ☐ Patient Referral _____
- ☐ Washingtonian
- ☐ Angies List
- ☐ Realself.com
- ☐ Facebook
- ☐ Google
- ☐ Healthgrades.com
- ☐ Vitals.com
- ☐ RateMDs.com
- ☐ Bethesda Magazine
- ☐ Northern VA Magazine
- ☐ New Beauty Magazine
- ☐ Other _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Assignment and Release

I, _____ _____, have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured / Guardian Date

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Consent to Communicate

Patient Name: _____ _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA Information and Consent Form

Patient Name: _____ _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

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Health History

Pt. _____ Date: _____ Dr. _____

Thank you for answering the following questions. Your answers provide important information that will affect your care. They will be held in the strictest confidence.

Height: _____ Weight: _____

Current Medications (Including herbals such as Ginseng, Ginkoba, etc.):

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, what medications(s)?. _____

_____

Is there a possibility you may be pregnant?: ☐ Yes ☐ No Due Date: _____

Have you or do you currently have:	YES	NO
Latex Allergy?	☐	☐
High Blood Pressure?	☐	☐
Heart attack(s)?	☐	☐
Heart Murmur?	☐	☐
Irregular heart beat?	☐	☐
Chest pain, angina?	☐	☐
Pacemaker?	☐	☐
Heart Surgery?	☐	☐
Asthma?	☐	☐
Emphysema?	☐	☐
Hepatitis or liver disease?	☐	☐
Bleeding disorder?	☐	☐
Epilepsy or convulsions?	☐	☐
Stroke?	☐	☐
Thyroid disease?	☐	☐
Diabetes?	☐	☐
Kidney disease?	☐	☐
AIDS or HIV infection?	☐	☐
Eye disease or glaucoma?	☐	☐
Radiation therapy?	☐	☐
Chemotherapy?	☐	☐
Malignant hyperthermia?	☐	☐
Sleep apnea?	☐	☐
Blood clots, you or any family history?	☐	☐

Please list all previous surgeries:

Do you smoke? ☐ Yes ☐ No Packs per day? _____
Have you ever smoked? ☐ Yes ☐ No When did you quit? _____

Are you under the care of a psychiatrist / psychologist? ☐ Yes ☐ No
If so, for what are you being treated:? _____

Signature: _____ Date: _____