THE WOMEN'S PLASTIC SURGERY CENTRE

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name	First	Middle	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If no what is your legal name?	(Maiden Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	SSN	Home Phone No. ( )

City	State	Zip Code	Cell Phone No. ( )

E-Mail Address

Occupation	Employer	Employer Phone No. ( )

Who referred you to our office today? (**REQUIRED**) ❑ Dr. _____ ❑ Insurance Plan ❑ Internet

❑ Family/Friend ❑ Phone Book ❑ Advertisement _____ ❑ Other _____

Primary Care Physician: _____ Referring Physician: _____

Phone Number: _____ Phone Number: _____

INSURANCE INFORMATION (PLEASE FILL OUT ALL

Primary Insurance Subscriber	Birth Date / /	Address (if different)	Home Phone No. ( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Please indicate primary insurance ❑ Aetna ❑ Anthem ❑ Cigna ❑ Health Alliance ❑ Humana

❑ Medicare ❑ Medical Mutual ❑ United Health Care ❑ Other _____

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Insurance ID#	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance	Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Insurance ID#

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Women's Plastic Surgery Centre or my insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

(OFFICE USE ONLY)

Name: _____ Surgical Dates: _____

DOB: _____

ACTIVE PROBLEM	DATE OF ONSET

PAST SURGICAL / MEDICAL HISTORY

MEDICATIONS – PRESCRIPTION & OVER-THE-COUNTER	
☐ VITAMIN / HERBAL SUPPLEMENTS	☐ ANTI-INFLAMMATORY

CARDIOVASCULAR ☐
ENDOCRINE ☐
E.N.T. ☐
G.I. / G.U. ☐
HEMATOLOGY / LYMPH ☐
MUSCULOSKELETAL ☐
NEUROLOGICAL ☐
PULMONARY ☐

FAMILY HISTORY

TOBACCO	NONE	PACKS PER DAY_____
		# OF YEARS _____
ALCOHOL	NONE	MODERATE
	LIGHT	HEAVY

ALLERGIES	
LATEX	☐ YES ☐ NO

Updated 3/9/2006 2:13 PM

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, _____, authorize Dr. Butterfield and/or The Women's Plastic Surgery Centre, and/or her representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please **initial** in the boxes marked Yes or No for each item)

Yes	No	Medium
		in the office **photo album** for prospective patients.
		in office **seminars** for prospective patients.
		on our **website** for prospective patients.

Additional Comments: The photos used will not include your face or other identifying marks on the body, unless specifically agreed to by yourself.

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Butterfield and/or The Women's Plastic Surgery Centre in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Butterfield , for which Dr. Butterfield may be receive direct or indirect remuneration.

2. I will not be identified by name in any of the media described above.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to 4750 E. Galbraith Road. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. This authorization will not expire except to the extent action has been taken thereon.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Butterfield and/or The Women's Plastic Surgery Centre.

5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

6. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Butterfield and/or The Women's Plastic Surgery Centre from all liability, including liability for negligence, that in any way arises out of:

any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact the office at (513) 891-5610.

Signature _____ Date _____

Witness _____

NOTICE OF PRIVACY PRACTICES

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

WHO WILL FOLLOW THIS NOTICE?

This Notice describes the practices of The Women's Plastic Surgery Centre and the practices that will be followed by all of The Women's Plastic Surgery Centre workforce members who handle your medical information.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

The Women's Plastic Surgery Centre understands that medical information about you and your health is personal. We are committed to protecting medical information about you. We maintain our records and conduct our treatment environment with a goal of providing the highest level of protection for your medical information, while still providing you with the highest level of medical care. This Notice applies to all of the records of your medical care which are received or created by The Women's Plastic Surgery Centre.

Your other medical treatment providers (e.g., doctors, hospitals, home health agencies, etc.) may have different policies or notices regarding the use and disclosure of your medical information.

This Notice will tell you about the ways in which The Women's Plastic Surgery Centre may use and disclose medical information about you. Your medical information, also referred to as "protected health information," is that information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health information and related health care services.

In this Notice, we also describe your rights and certain obligations «Practice_Name» has regarding the use and disclosure of your protected health information. We are required by law to make sure that medical and other information that identifies you (protected health information) is kept private; to give you this Notice of our legal duties and privacy practices with respect to protected health information about you; and to follow the terms of the Notice that is currently in effect.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

By becoming a patient of The Women's Plastic Surgery Centre, you are giving consent for The Women's Plastic Surgery Centre to use your protected health information for certain activities, including treatment, payment and other health care operations. Sometimes, you may hear these three activities referred to as "TPO."

First of all, we may use and disclose protected health information about you so that The Women's Plastic Surgery Centre and its medical professionals can treat you. For example, we may use your past medical information in order to diagnose your present condition or we may provide information regarding your medical condition to another doctor to whom we refer you for additional care. We may also use and disclose protected health information about you so that we may be paid for the medical treatment we provide you. For example, we will submit protected health information about you to your insurance company in order to receive payment for services we have provided to you. We may also use and disclose protected health information about you for The Women's Plastic Surgery Centre 's health care operations, in other words, those other tasks that we need to perform to make sure that you are provided the highest quality of medical care. For example, we may use your protected health information to evaluate how we can better meet your needs or we may provide protected health information about you to an auditor who reviews our books so that we can keep our license to provide medical services in **Ohio** .

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following uses of your protected health information may be made without any additional authorization from you. (Not every use or disclosure is listed, but be assured that all uses and disclosures made by «Practice_Name» are only those which are permitted under the law):

USES AND DISCLOSURES FOR APPOINTMENT REMINDERS

We may use and disclose your medical information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing at 4750 E. Galbraith Rd., Suite 215, Cincinnati, Ohio 45236. We will accommodate all reasonable requests.

USES AND DISCLOSURES TO OTHERS INVOLVED IN YOUR HEALTH CARE

We may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your medical care. If you are unable to agree or object to this disclosure, we may disclose such information as necessary if we determine that it is in your best interests based on our professional judgment. We may also use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

USES AND DISCLOSURES IN EMERGENCY SITUATIONS
We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician will attempt to obtain your acknowledgment of this Notice as soon as reasonably practicable after the delivery of treatment.

USES AND DISCLOSURES FOR HEALTH-RELATED BENEFITS OR SERVICES
From time to time, The Women's Plastic Surgery Centre may use and disclose protected health information to tell you about certain health-related benefits or services that may be of interest to you.

USES AND DISCLOSURES REQUIRED BY LAW
We will use or disclose protected health information about you when required to do so by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if the law requires us to do so, of any such uses or disclosures. We must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the law.

USES AND DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES
We may disclose your protected health information for public health activities and disclosure for such purposes will be to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for purposes such as controlling disease, injury or disability. Disclosures to public health authorities may include disclosure to a foreign authority that is working with the public health authority.

USES AND DISCLOSURES RELATED TO COMMUNICABLE DISEASES
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

DISCLOSURES FOR HEALTH OVERSIGHT ACTIVITIES
We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, and inspections. These activities are necessary for the government to monitor the health care system, the delivery of health care, government benefit programs, other government regulatory programs and civil rights laws.

DISCLOSURES OF ABUSE OR NEGLECT
We may disclose your protected health information to a public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to a governmental entity or agency authorized to receive such information. In such cases, the disclosure will only be made in accordance with **Ohio** law.

DISCLOSURES TO THE FOOD AND DRUG ADMINISTRATION
We may disclose your protected health information to a person or company required by the Food and Drug Administration (FDA) to report adverse events, product defects or other problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements; or to conduct post-market surveillance, as required.

DISCLOSURES FOR LAWSUITS AND DISPUTES
If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court order or administrative order. We may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

DISCLOSURES TO LAW ENFORCEMENT
We may release protected health information if asked to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons, or similar process. Other related disclosures may include disclosures relating to individuals who are Armed Forces personnel, to national security and intelligence agencies, as well as disclosures to authorized federal officials for the protection of the President of the United States or other authorized persons or foreign heads of state.

DISCLOSURES TO CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION
We may disclose protected health information about you to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties required by law. We may also disclose protected health information about you to a funeral director in order to permit the funeral director to carry out legal duties, and may do so if death is reasonably anticipated. Your protected health information may also be disclosed for certain organ donations to which you may have agreed.

DISCLOSURES FOR RESEARCH
We may disclose your protected health information to researchers when their research has been approved and protocols have been established to ensure the privacy of your information. We may also disclose a limited set of your information, as allowed under the law, for research purposes.

DISCLOSURES RELATED TO CRIMINAL ACTIVITY
We may disclose your protected health information, consistent with federal and **Ohio** laws, if we believe that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, or if it is necessary for law enforcement authorities to identify or apprehend an individual.

DISCLOSURES FOR WORKERS' COMPENSATION
We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

Right to Inspect and Copy. You have the right to inspect and copy protected health information that may be used to make decisions about your medical care. Usually this right includes both medical and billing records. You must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. Your request to inspect and copy your information may only be denied in very limited circumstances and you have a right to request that any such denial be reviewed.

Right to Request Restrictions. You have the right to request that we restrict the use and disclosure of your protected health information for treatment, payment and health care operations. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to 4750 E. Galbraith Rd., Suite 215, Cincinnati, Ohio 45236. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

Right to Confidential Communications. You also have the right to request to receive private health information communications by alternative means or at alternative locations. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to 4750 E. Galbraith Rd., Suite 215, Cincinnati, Ohio 45236. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you have the right to request that your protected health information be amended. Only the health care entity (e.g., doctor, hospital, clinic, etc.) that created your protected health information is responsible for amending it. For more information regarding the procedures for submitting such a request, contact 4750 E. Galbraith Rd., Suite 215, Cincinnati, Ohio 45236.

Right to an Accounting of Disclosures. You have a right to an accounting of disclosures of your protected health information, for purposes other than treatment, payment or health care operations by The Women's Plastic Surgery Centre or any of the people or companies who perform treatment, payment or health care operations on our behalf. To request this list of disclosures we made of protected health information about you, you must submit a request in writing to 4750 E. Galbraith Rd., Suite 215, Cincinnati, Ohio 45236. Your request must state a time period which may not be longer than six (6) years prior to the date of your request and may not include dates before April 16, 2003. Your request should indicate the form in which you want the list (for example, on paper or electronically).

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time.

* To obtain a paper copy of this Notice, contact our office Manager at (513) 891-5610.

CHANGES TO THIS NOTICE

The Women's Plastic Surgery & Rejuvenation Centre reserves the right to change this notice. We reserve the right to make the revised or changed Notice effective for protected health information we already have about you, as well as any information we create or receive in the future.

COMPLAINTS

If you believe your privacy rights have been violated and/or that The Women's Plastic Surgery & Rejuvenation Centre has not followed this policy, you may file a complaint with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

OTHER USES OF PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information not covered by this notice or the laws that apply to The Women's Plastic Surgery & Rejuvenation Centre will be made only with your written permission ("authorization"). If you provide us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the medical treatment or other services that we have provided to you.

QUESTIONS?

If you have any questions regarding this notice, please contact The Women's Plastic Surgery & Rejuvenation Centre office staff at (513) 891-5610.

THE WOMEN'S PLASTIC SURGERY & REJUVENATION CENTRE
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

_____ _____

Date Signature

«Person_First_Name» «Person_Middle_Name» «Person_Last_Name»

TheWomen's Plastic Surgery & Rejuvenation Centre
4750 E. Galbraith Road
Suite 215
Cincinnati, OH 45236

Signature On File

I am being seen at the Women's Plastic Surgery & Rejuvenation Centre (WPSC) and I understand that it is my responsibility to verify that the physician I am seeing at WPSC is a participating physician with my insurance company and/or managed care network. I understand that I will be responsible for payment in full for any services my insurance company denies payment for, due to non-participation of the physician providing services for WPSC.

I understand that if my insurance company requires a referral authorization from my primary care physician, I agree to obtain this referral authorization prior to my visit with a physician of WPSC. I understand that if I fail to obtain a valid referral authorization prior to my visit, I will be responsible for payment in full for any services rendered without valid referral authorization.

I understand that all co-payments are due at the time of service per my insurance contract with the participating physician of WPSC.

I understand that I am financially responsible for all services including those not covered under the provision of my insurance policy contract. I acknowledge that my insurance company may not cover annual examinations or routine preventative healthcare services; therefore, I will be fully responsible for any balance due in full if payment is not received.

Name:

Signature: _____ Date: _____