AUTHORIZATION FOR EXAMINATION

Provider: Kamran Khoobehi, MD / Jules A. Walters, III, MD / Sophia V. Mai, MD

Name: _____

Address: _____

Cell Phone: _____ **Alternate Phone**: _____

DOB: _____ **How did you hear about us?:** _____

Email: _____ **Referring Physician:** _____

Preferred Method of Contact: ( ) cell phone ( ) home phone ( ) email ( ) mail

I, _____, represent to the physicians and the staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

- I authorize the release of any medical information for the purpose of processing insurance claims on my behalf.

- I authorize payments of medical benefits directly to the doctor for services provided to me.

- A copy of this authorization form shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration.

- I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize that taking of photographs at the discretion of my surgeon and under such conditions as may be approved by him/her.

- Do we have your permission to:

1. Leave a message on your answering machine at **home** ( ) Yes ( ) No … or **cell phone**? ( ) Yes ( ) No

2 . Discuss your medical condition with another member of your household? ( ) Yes ( ) No

If yes, with whom:_____Relationship: _____

3. I authorize use of the photographs taken to be used for educational purposes and/or on the website: ( ) Yes ( ) No

4. I would like to receive correspondence via email regarding services or products in which I have indicated an interest. Approximately one promotional email per month is sent to keep our patients informed of special events and special pricing. Yes ( ) No ( )

Emergency Contact: Name: _____ Phone: _____

SIGNATURE:_____ DATE: _____

If patient is a minor:

Legal Guardian's Signature: _____

Printed Name: _____ Date: _____

Medical/Surgical History - Information for use by
Dr. Kamran Khoobehi / Dr. Jules A. Walters, III / Dr. Sophia V. Mai

PATIENT NAME:
DATE:
Reason for today's consultation: _____

Age: _____ Ht: ___' ____" Wt: _____ Have you lost more than 20 lbs in the last few months? _____
If yes, how much weight have you lost? _____ over what period of time? _____

Occupation: _____

Please list all medications/supplements you are currently taking or have used in the past 6 months:
MEDICATIONS/SUPPLEMENTS:
Name of Medication _____ Dosage _____ How long on this? _____
Name of Medication _____ Dosage _____ How long on this? _____
Name of Medication _____ Dosage _____ How long on this? _____
Please list all allergies to Drugs: _____

Are you allergic to Latex? □ Yes □ No **Are you allergic to Tape?** □ Yes □ No
Have you ever used LSD/Speed/Cocaine/Marijuana □ Yes □ No If yes, please circle
Are you a smoker? □ Yes □ No If yes, how much do you smoke per day? _____ Are you an ex-smoker? □ Yes □ No
Do you drink alcohol □ Yes □ No If yes, how much per day _____ per wk _____
Is there any possibility you could be pregnant at this time? _____ How many full term pregnancies have you had? ____

List all surgeries you have had; please include plastic surgery procedures:
1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Please check any of the following medical conditions you have or have had in the past: □ none
□ blood clot □ hepatitis □ diabetes □ blood transfusion □ glaucoma □ dry eyes □ lung disease □ TB □ asthma or wheezing □ emphysema □ bronchitis □ irregular heart beat □ chest pain □ heart attack □ stroke □ epilepsy □ High Blood Pressure □ intestinal ulcers or bleeding □ depression requiring medication □ MVP □ alcohol addiction □ drug addiction
List any other serious or chronic illness or condition: _____

Ability to Heal
Does your skin appear fragile or burn easily? □ Yes □ No
Do you form thick or raised scarring from a cut or burn? □ Yes □ No
Do you wax or use depilatories on your face? □ Yes □ No
Do you ever get cold sores? □ Yes □ No

Female Questions
Do you have regular periods? □ Yes □ No Are you going through menopause? □ Yes □ No
Are you pregnant or breastfeeding? □ Yes □ No How many pregnancies have you had? _____

Have you or any of your immediate family members had unusual reactions to anesthesia, such as muscle weakness, jaundice, breathing problems or unexpected fevers □ Yes □ No If yes, please circle.

Have you ever seen a cardiologist □ Yes □ No Are you still under the care of a cardiologist □ Yes □ No
Date of last EKG _____
Patient Signature _____ Date _____

KHOOBEHI
& ASSOCIATES

HIPAA Consent Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patients, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

Print Name: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

**Copy available upon request. **

ADVANCED PLASTIC SURGERY
PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

As a patient, you have the right to:

1. Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
2. Personal and informational privacy within the law.
3. Information concerning your diagnosis, treatment, and prognosis, to the degree known; confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
4. Sale of Private Health Information (PHI) is prohibited.
5. It is the duty of the organization to notify any patient of a breach of unsecured Private health Information (PHI)
6. The Patient has a right to restrict disclosure of PHI where the patient paid "out of pocket".
7. The opportunity to participate in decisions involving your health care unless contraindicated by concerns for your health.
8. Make decisions about medical care including the right to accept or refuse medical or surgical treatment and the right to initiate advance directives such as a living will or durable power of attorney. If you already have a living will or other directive or you wish to initiate one, please speak with a nurse.
9. Information concerning implementation of any advance care directive.
10. Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability. The Center adheres to all federal and state rules, regulations and policies to promote a nondiscriminatory environment for all of our surgical guests.
11. Receive an itemized bill for all services.
12 Know the identity and professional status of individuals providing service to you.
13. Report any comments concerning the quality of services provided to you during the time spent at the facility and receive fair follow-up on your comments.
14. Choose which facility you have your procedure performed in.

Patient Responsibilities

As a patient, you are responsible for:

1. Providing to the best of your knowledge accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate practitioner(s).
2. Following the treatment plan recommended by the primary practitioner involved in your case.
3. Providing for an adult to transport you home after surgery and an adult to be responsible for you at home for the first twenty four (24) hours after surgery.
4. Indicating whether you clearly understand a contemplated course of action and what is expected of you.
5. Your actions if you refuse treatment, leave the facility against the advice of the practitioner, and/or do not follow the practitioner's instructions relating to your care.
6. Assuring that the financial obligations of your health care are fulfilled as expediently as possible.
7. Providing information about and/or copies of any living will, power of attorney or other directive that you desire us to know about.

I have read and understand my rights and responsibilities as a patient of

_____ _____

Patient Signature Date

For complaints or grievances please contact:

Cheryl White, Administrator
OR
Department of Health & Hospitals
Health Standards Section, P.O. Box 3767
500 Laurel Street, Suite 100
Baton Rouge, LA 70821
225.342.0138

KHOOBEHI
& ASSOCIATES

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

DOCTOR:
PATIENT NAME:

I consent to the taking of photographs or videotaping of me or parts of my body, by Dr. Khoobehi, Dr. Walters, Dr. Mai or his/her designee. I understand that such photographs may be published by Khoobehi & Associates, Dr. Khoobehi, Dr. Walters, Dr. Mai or his/her designee, in any print, visual, electronic or social 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 I will not be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Khoobehi, Dr. Walters, Dr. Mai I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

____ **REFUSED**

____ **PERMISSION TO USE PHOTOS**

_____ _____
Patient Name Date

WITNESS/PHYSICIAN: _____

I have read the above 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 public education.

_____ _____
Patient/Guardian Date