MOTAKEF PLASTIC + RECONSTRUCTIVE SURGERY

Please answer all of the questions as accurately as possible.

Name: _____ DOB: _____ Age: _____

Primary Care Provider: _____ Referring Provider: _____

Reason for Consultation: _____

Last Physical Exam: _____

Allergies: _____

Pharmacy/Location: _____

Previous Surgery or Major Illness (please give dates):

_____

_____

_____

_____

Medications (including non-prescription):

_____

_____

_____

_____

Have you ever had any significant complications after surgery? No _____ Yes _____

If yes, please explain: _____

PAST MEDICAL HISTORY: Have you had any of the following? Please Circle:

Epilepsy/seizures	Yes	No		Asthma	Yes	No		Anesthetic reactions	Yes	No
Anemia	Yes	No		Tuberculosis	Yes	No		Kidney Disease	Yes	No
Diabetes	Yes	No		Heart Disease	Yes	No		Hepatitis	Yes	No
Cancer	Yes	No		Hypertrophic Scars/Keloids	Yes	No		Stroke	Yes	No
AIDS/HIV+	Yes	No		Mitral Valve Prolapse	Yes	No		Blood Clot/DVT	Yes	No
Thyroid Disease	Yes	No		High Blood Pressure	Yes	No		Psychiatric Treatment	Yes	No

REVIEW OF SYSTEMS: Do you currently have or have had within the past year any of the following? Check all that apply:

Fatigue		Nosebleeds		Fever		Dizziness		Numbness	
Weight Loss/Gain		Rapid Heartbeat		Shortness of Breath		Recent Infection		Chronic Cough	
Skin Rash		Skin Lesion		Easy Bruising		Easy Bleeding		Wheezing	
Abdominal Pain		Nausea/Vomiting		Diarrhea		Constipation		Hernia	
Vision Changes		Watering Eyes		Dry Eyes		Glasses		Contact Lenses	
Muscle Pain		Swollen Feet		Neck Pain		Joint Pain		Back Pain	
Weight Loss		Weight Gain/Loss		Diabetes		Seizure		Anxiety/Depression	

SOCIAL HISTORY:

Smoking (type/amount per day) _____ Alcohol (type/amount per day) _____

If former, date quit: _____ Height: _____ Weight: _____

FAMILY HISTORY: Has any blood relative had any of the following?

Breast Cancer	Yes	No		Stroke	Yes	No		Diabetes	Yes	No
Blood Clot/DVT	Yes	No		High Blood Pressure	Yes	No		Anesthetic Reactions	Yes	No
Cancer (type)	Yes	No		Heart Disease	Yes	No		Bleeding Disorder	Yes	No

FOR WOMEN ONLY:

Date of last mammogram: _____ Number of pregnancies: _____

Number of children: _____ Did you breastfeed: _____

ASPIRIN USE: Do you use Aspirin or NSAIDS (Advil, Motrin, Ibuprofen) regularly? _____

If so, please indicate dosage and frequency: _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Signature: _____ Date: _____

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PATIENT INFORMATION:

Name: _____

SSN#: _____ DOB: _____

Street Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email Address: _____ Gender: Male / Female

Are you a student: _____ If yes, are you fulltime? _____ Marital Status: S M D Sep W

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

REFERRAL SOURCE: _____ Google _____ Social Media _____ Family Member

_____ Friend _____ Physician _____ Other (please specify)

If patient is a minor, please complete the following on the financially responsible party:

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____

PRIMARY INSURANCE INFORMATION (if using insurance):

Name of Insurance: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's SS#: _____ Policy Holder's DOB: _____

Policy Number: _____ Group Number: _____

SECONDARY INSURANCE INFORMATION (if using insurance):

Name of Insurance: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's SS#: _____ Policy Holder's DOB: _____

Policy Number: _____ Group Number: _____

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EMERGENCY CONTACT INFORMATION:

In case of emergency notify: _____

Relationship: _____ Phone Number: _____

I authorize you to give me reasonable and proper medical care by today's standards. I, the patient, or responsible party, authorize release of medical information for the purpose of processing medical claims.

Signature: _____ Date: _____

MOTAKEF PLASTIC + RECONSTRUCTIVE SURGERY

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I,_____, hereby acknowledge that I have received and understand the Notice of Privacy Practices of Motakef Plastic + Reconstructive Surgery.

_____ _____

Date Signature of Patient or Patient's Representative

_____

Relationship to Patient

PERSONAL RELEASE OF INFORMATION

I,_____, do hereby authorize a representative from Motakef Plastic + Reconstructive Surgery to speak with the following person(s) regarding my medical information.

Name	Relationship	Phone Number	Medical Care	Financial	Appointments

I,_____, do NOT wish for any medical information to be released to any representative on my behalf.

_____ _____

(Signature of Patient) (Date)

_____ _____

(Witness) (Date)

OFFICE AND FINANCIAL POLICIES

FINANCIAL RESPONSIBILITY: All professional services are the responsibility of the patient/guarantor. If we are a participating provider for your insurance company, we will request the appropriate deductible and copayment at the time services are rendered. Payment is expected at the time of service. Please be prepared to pay your portion. You are responsible for the account and services provided.

BILLING/COLLECTIONS: Monthly statements are mailed for accounts with unpaid balances. A finance charge of 1.50% per month (equal to an annual percentage rate of 18%) on unpaid balances will be assessed. All delinquent accounts, which are not paid in full within 60 days, will be turned over to our collection agency. In the event your account is sent to collections, a 22% service fee will be added. The patient/guarantor is responsible for any and all collection fees, attorney charges and/or court costs. An auto dialer may be used to contact you regarding your balance on the phone number you provide.

APPOINTMENTS: Please give our office as much notice as possible if you will be unable to keep your appointment.

SURGERY (Covered by your insurance): You will be responsible for your copayment, deductible and/or coinsurance. You must confirm your surgery two weeks prior to your date of surgery. If we do not receive confirmation, your procedure will be cancelled.

COSMETIC PROCEDURES: Payment in full is due two weeks prior to your scheduled procedure. You must confirm your surgery two weeks prior to your date of surgery. If we do not receive confirmation or payment, your procedure will be cancelled.

REFUNDS: Refunds are processed once a month at the end of the month. All requested refunds are subject to a 10% processing fee regardless of reason for cancellation.

There is a $30 charge for all returned checks.

Please notify our staff of any changes to your address, phone number or insurance coverage. We are always available to answer questions you may have concerning our policies. We encourage open communication between the patient and our office to avoid any misunderstandings.

ASSIGMENT AND RELEASE: I hereby authorize my insurance company to pay benefits directly to the physician. I also authorize Motakef Plastic + Reconstructive Surgery to release any information required to process all claims. I am financially responsible for non-covered services.

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Effective July 1, 2020

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

It is the intent of this Notice of Privacy Practices ("Notice") to inform individuals and patients of their privacy rights regarding uses and disclosures of their protected health information ("PHI") as required and permitted under applicable law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This notice describes how protected health information may be used for treatment, payment or other operations involved in obtaining treatment from and providing payment to Motakef Plastic + Reconstructive Surgery ("Practice") for services rendered by its physicians. Protected health information is information about a patient that may be used to identify them, such as name, address or social security number.

Statements of Use and Disclosure:

- *Treatment*: The Practice will use PHI for the provision, coordination and/or management of healthcare and related services. Those services include, but are not limited to, the treatment of chronic and acute illnesses and the facilitation of specialized services.
    - Example: Your physician will routinely use information about you for the treatment of an illness. That information may be used to prescribe medications through a pharmacy or forwarded to another physician for additional consultations or treatment necessary for your health. Your PHI may be used in ordering laboratory or other diagnostic tests.
- *Payment*: The Practice will use PHI where appropriate to facilitate payment for treatment or healthcare related services rendered by the Practice.
    - Example: When a Practice physician renders a service to you that are to be paid by a health plan, a claim for that service must be created. The claim will contain information about you to include the type of treatment provided by your physician with a diagnosis justifying the treatment. Depending on a diagnosis or treatment, the Practice may request additional information about you before a payment for service is issued. If a specific test, procedure or hospital stay is recommended for your treatment, the Practice may request additional information about you. Any disclosures for payment process through a financial institution or consumer credit agency relating to the collection of past due balance will not include any information about any diagnosis or condition you may have or any treatment you may have received.
- *Operations*: The practice will use PHI as needed to maintain its operations.
    - Example: PHI may be used in the Practice for management purposes, quality control programs and compliance training and/or auditing. PHI will be disclosed as required by law in order to avoid a serious or imminent threat to someone's health or safety. Operations within the Practice that utilize PHI may be found on patient sign-in sheets or when the nurse calls a patient's name from the waiting area.

Other disclosures allowed by law:

- The Practice may utilize PHI in various activities that involve a third party or "Business Associate." Under all circumstances a contract will be used with a third party or "Business Associate" requiring the same legal standards as those imposed on the Practice for protecting and securing a patient's private PHI.
    - Example: The Practice may from time to time use a billing service, which may involve the disclosure of PHI.
- We may use your PHI for treatment, payment or healthcare operations in an emergency situation despite any inability from you to object or accept if the physician or the Practice believes there is an imminent threat to your health.
- The Practice may use your PHI to notify or inform a member of your family, a close friend or someone of your choosing about any information concerning your health or condition. If you are unable to agree to or object to a disclosure necessary for your care, your physician will use his/her best judgment in determining the best person to disclose this information.
- We may disclose your PHI if your physician has reason to suspect you have been a victim of abuse, neglect or domestic violence.
- Subject to certain requirements, we may also disclose PHI without your authorization for public health purposes, auditing purposes, research studies, funeral arrangements, organ donation and worker's compensation purposes.
- Additionally, we may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other disclosures required or permitted by law:

- The Practice may disclose PHI to such federal agencies as the FDA and/or law enforcement officials for law enforcement purposes or as ordered by a court of law without your written consent or authorization.
    - Example: PHI may be disclosed if such information is considered relevant to a criminal investigation or PHI may be given to the Centers for Disease Control for the sake of public health to limit the spread of a communicable disease. These types of disclosures will only be made as permitted or required by law.
    -

Other Laws:

- To the extent that state laws are more stringent than HIPAA regarding the use or disclosure of your PHI, that law is followed. Examples of specific disclosure rules may include:
    - Physicians, hospitals and other health facilities must provide the health department, upon request, access to their medical records, tumor registries and other special disease record systems as necessary for its investigations.
    - In responding to a request for medical information from an insurer, a physician may rely on the carrier's representation that the patient has authorized release of the information.
    - Specific disclosure rules apply to genetic information; sexually transmitted diseases; mental health; and cancer reports.

Patient Authorization:

- The Practice will not disclose a patient's PHI other than disclosures previously mentioned without a signed authorization.
- A signed authorization permits all disclosures separate from disclosures made for treatment, payment or healthcare operations. A patient may revoke the authorization in writing at any time. The moment the authorization is revoked all future disclosures will stop; however, any disclosures already made in reliance of the signed authorization may not be undone.

Statement of Individual Rights:

- A patient may request restrictions on specific uses or disclosures of PHI. However, the Practice is not required to agree to a requested restriction.
- A patient has the right to request confidential communications of PHI such as sending mail to an address other than to our home. The Practice will attempt to honor all reasonable requests.
- A patient has the right to inspect and receive copies of their PHI.
- A patient has a right to request the amendment of their PHI if it is believed that information in the record is incorrect or missing. However, the Practice has the right to refuse that request under certain circumstances.
- A patient has the right to request an accounting of disclosures of the PHI other than disclosures made for treatment, payment and healthcare operations.
- Regardless of whether the Notice was originally sent as a paper copy or an electronic copy, a patient has the right to obtain a paper copy of this Notice from the Practice at any time upon request.

Our Legal Duty:

We are required by law to protect the privacy of your information, provide notice about our information practices and follow the information practices that are described in the Notice. The Practice reserves the right to change or revise its privacy practices at any time. Notification of those changes will be provided in a new Notice and provided to all patients with copies available to any person upon request. If you have any questions, at any time, regarding permitted uses or disclosures of your PHI, or if you have questions regarding the Notice of Privacy Practices, please contact our Practice's compliance officer Nazilla at 714-941-9055.

Complaints: If you feel that we have violated your privacy rights or if you disagree with a decision we made about access to your records, you may issue a complaint to the Practice's compliance officer, without fear of retribution from physicians or staff of the Practice. As the patient or person who believes the Practice is not complying with a requirement of the Privacy Rule within HIPAA, you may file a written complaint either on paper or electronically with the US Department of Health and Human Services.