PLASTIC SURGERY VEGAS

ANSON • EDWARDS • HIGGINS • SILVER • TAM

Areas of Concern

Patient's Name ______________________ ______________________ __________

Last First Date

What are your main concerns for today's visit?

____

____

____

____

____

____

Please check the problem areas that concern you. Include anything you wish to discuss, even if it is not the main reason for your visit.

Face/Eyes/Neck

- ☐ Aging Face/Neck
- ☐ Aging Brow/Forehead
- ☐ Excess Eyelid Skin
- ☐ Botox
- ☐ Facial Fillers (Juvederm, Voluma, Restylane, Sculptra, ETC)
- ☐ Wrinkles/Fine Lines
- ☐ Kybella
- ☐ Skin Texture
- ☐ Skin Pigment
- ☐ Dark Circles
- ☐ Laser Treatments
- ☐ Chemical Peels
- ☐ Eyelash Growth (Latisse)

Ears

- ☐ Prominent
- ☐ Ear Lobes

Nose

- ☐ Difficulty Breathing
- ☐ Shape or Bump
- ☐ Crooked

Breast/Chest

- ☐ Breast Size
- ☐ Breast Asymmetry Correction
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Breast Implant Revision
- ☐ Pectoral Implants (Men)
- ☐ Nipple/Areola Concerns
- ☐ Gynecomastia

Excess Skin

- ☐ Abdomen
- ☐ Thighs
- ☐ Arms

Liposuction

- ☐ Abdomen
- ☐ Bra Rolls
- ☐ Hips/Flanks
- ☐ Inner Thighs
- ☐ Outer Thighs
- ☐ Knees
- ☐ Calves
- ☐ Coolsculpting

Gynecological

- ☐ Excess Labia Tissue

Skin

- ☐ Scars
- ☐ Moles
- ☐ Acne
- ☐ Rashes
- ☐ Warts

Other Concerns

- ☐ Excess Sweating (Botox)
- ☐ Hand Treatments
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________

Provider Recommendations:

____

____

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____

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____

I verify that I have provided all of my medical and surgical history to ensure my physician has all the important information to provide the safest care. I will update any new information that occurs in-between visits to include new diagnoses, new medications, subsequent surgeries and any hospitalizations.

______________________________ ______________________________

Signature Date

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Medical + Surgical History

Patient's Name ______________________ ______________________ ______________
Last First Date

Height: ____________ Weight: ____________ DOB: ____________ Age: ____________

Have you had any previous plastic surgery? ☐ Yes ☐ No Were you satisfied with your results? ☐ Yes ☐ No

List ALL previous surgeries and approximate dates: ____

____

____

____

Who is your Primary Care Physician? ____________________________ Last Exam? ____________________

What Specialists do you see? ____

List ALL medications you take (include prescriptions, over the counter, vitamins, supplements, herbs, etc.):

____

____

Describe ALL allergies and what occurs during the reaction (include prescriptions, over the counter, vitamins, supplements, herbs, etc.):

____

____

____

Do you smoke, vape or use any form of nicotine including patches? ☐ Yes ☐ No

Number of years? ____ Packs/Amount per day? ____ If you quit smoking, when did you quit? ________________

Do you smoke or ingest Marijuana products? ☐ Yes ☐ No How often/amount: ______________________

Do you drink alcohol? ☐ Yes ☐ No How often/amount: ______________________________________

Do you take aspirin, NSAIDS, (Motrin, Ibuprofen, Aleve, Advil, etc.)? ☐ Yes ☐ No How often? ______________

Have you ever been told you need antibiotics for surgery due to a heart murmur? ☐ Yes ☐ No

Do you have any implanted devices (implants of any kind, pacemaker, joints, shunts or pump)? ☐ Yes ☐ No

Any personal or family history of bleeding or clotting disorder (DVT= deep vein thrombosis, PE= pulmonary embolism):
☐ Yes ☐ No Explain: ____

Any personal or family history of breast cancer? ☐ Yes ☐ No Who? ______________________________

____

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Medical + Surgical History Continued

Patient's Name ______________________ ______________________ ______________

Last First Date

Are You Currently Taking: ☐Birth Control Pills ☐Hormone Replacement (Testosterone, Growth Hormone, Estrogen)
Are You Currently: ☐Menopausal ☐Peri-Menopausal ☐Still Menstruating
Could You Be Pregnant? ☐Yes ☐No
Number Of Pregnancies: ______ Number Of Births:______ Unexplained Miscarriages:______
Tubal Ligation? ☐Yes ☐No Hysterectomy? ☐Yes ☐No
When Was Your Last Mammogram? ________________

Check below if you have now **or** have ever had in the past any of these conditions or symptoms:

- ☐ Diabetes
- ☐ Large weight loss/gain
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ MVP
- ☐ Rheumatic Fever
- ☐ Circulation Problems
- ☐ Stroke
- ☐ Lung Disease
- ☐ Asthma, Emphysema
- ☐ Persistent Cough
- ☐ Tuberculosis
- ☐ Night Sweats
- ☐ Bloody Sputum
- ☐ Abnormal Chest X-Ray
- ☐ Liver Disease
- ☐ Hepatitis/Jaundice
- ☐ Kidney Disease/Stones
- ☐ Uninary Problems
- ☐ Ulcers
- ☐ Crohns/Colitis
- ☐ Constipation
- ☐ Gastric Reflux
- ☐ Skin Cancer
- ☐ Melanoma
- ☐ Basal Cell
- ☐ Squamous Cell
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Keloids
- ☐ Cold Sores/Herpes
- ☐ Ever taken Accutane
- ☐ Steroid Therapy
- ☐ Bleeding Disorder
- ☐ Epilepsy/Seizures
- ☐ Thyroid Problem
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Bulimia
- ☐ Anemia
- ☐ Cancer
- ☐ Depression
- ☐ Anxiety
- ☐ Glaucoma
- ☐ Ever taken Phen-phen
- ☐ Serious dry eyes
- ☐ Alcoholism
- ☐ Prescription drug problem
- ☐ Non-prescription drug problem

Is There Anything Else We Should Know About You That We Haven't Asked?

____
____
____
____
____
____
____
____

For Research Purposes:
Do You Know What Sleep Wrinkles Are? ☐Yes ☐No
Do You Think You Have Sleep Wrinkles? ☐Yes ☐No
Please Estimate What Percentage Of The Time You Sleep In These Positions?
______ Back ________ Stomach ______ Side (right) ______ Side (left)

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Patient Registration Information

Patient's Name ____________________ ____________________ __________
Last First Date

Birthdate: ___/___/___ Age: ______ Gender: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced

E-mail: ____________________

Address: ____
Street & Apt # City State Zip

Cell Phone: __________ Home Phone: __________ Work Phone: __________

Which phone do you prefer we use to contact you? ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Any restrictions for contacting you? (Ok to call at work? Leave message at home?,etc.) ________________

May we use your email to send useful information, updates, promotions and event info? We promise not to abuse it! ☐ Yes ☐ No

We offer 2 methods of appointment reminders, please check your preference (one): ☐ Text Message ☐ Email

For minors, who is the authorized adult or responsible party? ____________________

Patient's Employer: ____________________ Occupation: ____________________

Address: ____
Street & Suite # City State Zip

Emergency Contact: ____________________ Relationship to Patient: ____________________

Home Phone: __________ Work Phone: __________ Other Phone: __________

Address: ____
Street & Apt # City State Zip

Insurance Information
Do you have medical insurance? ☐ Yes ☐ No Insurance Provider ____________________
*Although we do not take insurance, this information will assist in coordinating your care.

Pharmacy Information
In the event we need to send a prescription to your pharmacy electronically, please provide your pharmacy information:

Pharmacy _______________ **Cross Streets** ____________________ **Phone** __________

Referral Information
Who referred you to our practice? ____________________

May We Thank Them Using Your Name? ☐ Yes ☐ No

If Not Referred How Did You Hear About Us? ☐ Website __________ ☐ Magazine __________

☐ Other _______________

Authorization & Acknowledgement

____ I consent to examination and general treatment by the physicians/practitioners of this office. Other consents will be required for specific procedures.

____ I understand that office charges are payable on the day of service.

____ I understand that photography is a necessary part of planning and evaluating for recommendations and treatments. I authorize the taking of photographs. These photographs will be used for documentation and planning only. An additional consent will be required for any other use.

Insurance Information (Required by Law)

Please note that the office is required to have all patients sign an agreement that they understand that our office has opted out of Medicare. Our provider's **have been excluded** from Medicare under 1128, 1156, or 1892 of the Act. In addition, our office is not contracted with any private insurance companies.

____ I understand that no payment from Medicare shall be received by either myself, my beneficiary, or any physician/practitioner of this office for any services renders. I accept full responsibility for payment for all services or items furnished.

____ I understand that no Medicare limits apply to what will be charged for items or services furnished by any physician/practitioner of this office.

____ I agree not to submit a claim to Medicare or to ask any physician/practitioner of this office to submit a claim or other documentation to Medicare on my behalf.

____ I understand that I am entering into this contract knowing that I have the right to obtain Medicare-covered items and services from physicians.practitioners who have not opted out of Medicare and that I am not compelled to enter into a contract such as this with physicians/practitioners who have opted out.

____ I understand that the office and its physicians/practitioners have opted out from Medicare for a period of two years, at which time, they will continue to request to opt-out.

____ I understand in cases of emergency that I am not required to enter into such an agreement and that emergency care may be provided if necessary. The services provided at this office are considered cosmetic however, and the nature of this practice is non-emergent.

____ I understand this document will be updated annually and be kept as part of my medical record so long as required by the State of Nevada. It will be made available to the Center for Medicare & Medicaid Services in the event a copy of this agreement is requested.

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____ In addition to all of the items above related to Medicare, I understand that no payment from any private insurance company shall be received or accepted by the office for any services rendered.

____ I understand that at no time will prior authorization, claims, or documentation be submitted from the office to my insurance company on my behalf.

____ I understand the office will not accept any contracted rate or deduction in payment and that I am fully responsible for the charges for any service or item given by the physician/ practitioner.

IRS & Cash Reporting (Required by Law)

____ I understans the office is required to file Form 8300 with the IRS for all patients who pay $10,000 or more in cash during the year for single or related medical procedures. When used for medical care, cash means currency and coins, not cashier's checks, bank drafts, traveler's checks, money orders or personal checks. For more information: http://www.irs.gov/Business/Small-Businesses-&-Self-Employed/FAQs-Regarding-Reporting-Cash-Payments-of-Over-10000-Form-8300

Notice of Privacy Practices (Required by Law)

____ I understand that the office has Privacy Practices in place that provides information about how they may use and disclose my protected health information. I have the right to receive and review the Notice before signing this acknowledgment. As provided in the Notice, if any terms change, an updated copy will be made available online and in the office.

It is alright to communicate information about me/my appointments, test results, etc. with the following individuals:

____

Name Relationship Phone Number

____

Name Relationship Phone Number

By signing this form, I acknowledge that I understand the general policies regarding treatment, insurance, cash and my protected health information. I may request a copy of this notice.

______________________________ ______________

Signature Date

______________________________ ______________

Witness Date

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Notice of Privacy Practice
Information Regarding Your Confidential Health Information
(Required By Law)

PATIENT RIGHTS

This document provides information about how we may use and disclose protected health information about you.

RESTRICTIONS

You have the right to request restrictions on certain uses and disclosures of your health information. Our practice will make every effort to honor reasonable restriction preferences.

CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you in a certain way. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION

You have the right to read, review and receive a copy of your health information, including your complete chart and billing records. If you would like a copy of your health information, please let us know. We may charge you a reasonable fee to duplicate and assemble your copy.

AMEND YOUR INFORMATION

You have the right to ask us to update or modify your records if you believe your health records are incorrect or incomplete. We will be happy to accommodate you so long as this office maintains this information. In order to standardize this process please provide us with your request in writing and describe your reason for change. Your request may be denied if the health information was not created by our office, is not part of your records, or if the records containing your health information are determined to be accurate and complete.

DOCUMENTATION OF HEALTH INFORMATION

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations.

REQUEST A PAPER COPY OF THIS NOTICE

You have the right to obtain a copy of this notice of Privacy Practices directly from our office at any time.

POLICY AND PROCEDURE

We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure our patients have access to a copy of the revised notice online and in our office.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. Please let us know of your concerns or complaints in writing.

In connection with the medical services received from Anson, Edwards & Higgins Plastic Surgery Associates, and its medical staff, information concerning our patient's medical conditions and treatment will only be disclosed as required to:

A. Any third-party payer covering medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies
F. As otherwise required by law

WITH AUTHORIZATION

Other than where Federal, State or local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization at any time, except to the extent that we have already made a use or disclosure based upon your authorization.

VERBAL AUTHORIZATION

We may also use or disclose your information to care givers or family members that are directly involved in your care with your verbal permission.