PLASTIC SURGERY ASSOCIATES
26800 Crown Valley Pkwy. Suite 410
Mission Viejo, CA 92691
Ph (949) 645-3333 Fax (949) 364-2299

NEW PATIENT FORM

Thank you for choosing our office. In order to serve you properly, **PLEASE PRINT** the following information.			
Name:			
Address:		City/State/Zip:	
SSN:	Date of Birth:	Marital Status:	Gender:
Home Ph:	Work Ph:	Cell Ph:	Email:
Employer:		Address:	
Occupation:		Full/Part/Student/Retired:	
Emergency Contact Name:	Relationship:	Phone:	
If patient is a child, who may authorize treatment:		Relationship:	
Person financially responsible for treatment IF NOT SELF:			
Address of person financially responsible:		Phone:	
How did you hear about us:			
Insurance Information			
Insured Party (Primary):			
Primary Insurance:		Address:	
Policy #:		Group #:	
Secondary Insurance:		Address:	
Policy #:		Group #:	
Pharmacy Information			
Pharmacy Name:			
Address:		Phone:	

If you authorize release of your medical information to anyone besides your insurance carrier, please give the name: _____
May we leave a message on your home or cell phone? YES NO

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.	
Patient, Parent or Guardian Signature:	Date:

Plastic Surgery Associates **PH (949) 645-3333 Fax (949) 364-2299**

(Please Print Legibly and Fill in All Fields)

Health Information as of (today's date): _____

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ (Feet) _____ (Inches) Weight: _____ (Lbs.)

Current Physician(s): _____

List all Surgeries (Hospitalizations and date):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each)

AIDS /HIV	Y	N	Epilepsy/Seizures	Y	N	Kidney Problems	Y	N
Arthritis	Y	N	Facial Pain	Y	N	Pneumonia	Y	N
Asthma	Y	N	Fever Blisters	Y	N	Sinus Problems/Infections	Y	N
Bronchitis	Y	N	Goiter/Thyroid	Y	N	Stroke	Y	N
Cancer	Y	N	Hay Fever/Allergies	Y	N	Tonsillitis	Y	N
Depression	Y	N	Headaches/Migraine	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Heart Trouble	Y	N	Ulcers	Y	N
Dizziness/Vertigo	Y	N	Hepatitis	Y	N	Sleep Apnea	Y	N
Ear Infection	Y	N	High Blood Pressure	Y	N	Blood Clots/DVT	Y	N

Please explain any Yes answers and give date of occurrence:

Are you or could you become pregnant? Yes No Date of last period? _____
Do you smoke? Yes No If yes, how much? _____ Pack(s)/day How long? _____ Years
Do you drink alcohol? Yes No If yes, how much? _____ How often? _____
Do you use recreational drugs? Yes No If yes, describe: _____
Do you have bleeding or bruising problems? Yes No If yes, describe: _____
Do you have problems with scarring? Yes No If yes, describe: _____
Do you have any history of problems with anesthesia? Yes No If yes, describe: _____

List the name of all medications you are presently taking or have taken within the last. Please include dosage and frequency:

List all drug and/or latex allergies:

The above information is accurate and complete to the best of my knowledge.

Signature: _____ **Date:** _____

INSURANCE COVERAGE STATEMENT

PLASTIC SURGERY ASSOCIATES of ORANGE COUNTY
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To our ER patients: (Please initial each line)

_____Our doctors may **NOT CONTRACTED** with your insurance company. The insurance plan you have is a contract between you and the insurance company.

_____When our doctor's services are needed and the ER doctor requests our doctors as **"SPECIALISTS"**, it is because our doctors are **'ON CALL'** for the hospital emergency room, in order to aid in taking care of your emergency medical needs. The ER doctor does not call doctors in to the ER based on whether or not they are part of your specific insurance plan.

_____As a courtesy to you, our billing department will file an insurance claim for your emergency services if you provide the information.

_____There will most likely be some out of pocket expense for you, the insured, after your insurance company has paid
your claim.

_____Any balance that is not covered will be your responsibility.

_____Should you feel the amount paid by your plan was insufficient; you may file a grievance or appeal with your insurance company. They need to know the **DETAILS OF YOUR EMERGENCY** in order to re-consider additional payment for a non-contracted doctor in an **EMERGENCY** situation.

_____If payment arrangements need to be made, please contact our billing department at 949-645-3333

To our referred patients: (Please initial each line.)

_____Our doctors may not be contracted with your insurance company.

_____This means there will be a greater "Out of Pocket" expense for you, when making the choice to use one of our
Doctor's for your surgical needs.

_____You may also have a separate "Out of Network Deductible" that has to be met. You can contact your insurance
company to verify what benefits, if any, your insurance plan provides for out of network doctors.

_____Since we are not contracted with all insurance companies, they may send payment for the doctor directly to you. These payments are due to the provider of your medical care. Please send these payments on to your doctor.

By initialing and signing this statement, you acknowledge you have read and understand our office position in regard to our doctor's being contracted with insurance companies.

_____ _____
Patient or Guarantor Date

_____ _____
Witness Date

HIPAA NOTICE OF PRIVACY PRACTICES

PLASTIC SURGERY ASSOCIATES OF ORANGE COUNTY
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This notice describes how medical information about you may be issued and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1) Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

2) Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

3) Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

4) Healthcare Operations

We may use or disclose, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by law, Public Health issues as required by law, Communicable Diseases: health Oversight: Abuse Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation. Research: Criminal Activity and National Security: Worker's Compensation: Inmates: required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

5) Your Rights

Following is a statement of your rights with respect to your protected health information.

6) You have the right to inspect and copy your health information

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to the law that prohibits access to protected health information.

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7) You have the right to request a restriction of your protected health information
This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information will not be restricted. You then have the right to use another healthcare Professional.

8) You have the right to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

9) You may have the right to have your physician amend your protected health information if we deny your request for amendment, you have the right to file statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

10) Complaints
You may complain to us or to the secretary of health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Print Name _____

Signature _____ Date _____