

PATIENT REGISTRATION FORM

Welcome to Freed Plastic Surgery
In order to serve you properly, we will need the following information.

TODAY'S DATE _____

PATIENT'S NAME (last) _____ (first) _____ (m.i.) _____

IF CHILD, PARENTS NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ (work / cell) _____

BIRTHDATE _____ SEX _____ SOCIAL SECURITY # _____

OCCUPATION _____

WHAT IS YOUR CHIEF COMPLAINT/CONCERN? _____

PLEASE CHECK THE FOLLOWING CONCERNS OR AREAS YOU WOULD BE INTERESTED IN RECEIVING
MORE INFORMATION ABOUT, FROM OUR MEDICAL SPA:

Skin concerns, uneven pigment, brown spots, fine lines and wrinkles _____

Lines and wrinkles around the mouth and cheeks or thinning lips _____

Lines in the forehead, between the eyes as well as the "crow's feet" on the sides of the eyes _____

Facial veins, redness or pigmentation issues _____

Laser Hair Removal _____

Mineral Makeup _____

Other: _____

WHOM MAY WE THANK FOR REFFERRING YOU? _____

**Please provide us with your e-mail address if you are interested in receiving appointment confirmations,
information on events, new products and procedures, and specials.**

EMAIL ADDRESS _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

X _____ DATE _____
Signature of patient or parent if minor

PATIENT REGISTRATION FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

* Please fill out the Insurance Information section only if you are planning to go through insurance.

***INSURANCE INFORMATION** (Non-cosmetic Procedures ONLY)

PATIENT STATUS:
 Single Married Widowed Employed Retired Unemployed Full-time Student

PRIMARY INSURANCE _____ IDENTIFICATION# _____

PATIENT'S RELATIONSHIP TO INSURED: Self Spouse Child Other _____

INSURED'S BIRTHDATE _____

SECONDARY COVERAGE _____ IDENTIFICATION# _____

***ALL HMO'S (health maintenance organizations) require prior-authorization from a primary care physician before being seen.**

PRIMARY CARE DOCTOR _____

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY INSURANCE COMPANY.

Do you smoke? If so, the type and amount _____

If former smoker, date quit _____

Weight _____ Height _____

Drug Allergies _____

List previous surgeries or major illnesses and dates _____

List any medications you are taking. Including non-prescription drugs, vitamins and herbals

X _____
 Signature of patient or parent if minor

 Date

PATIENT REGISTRATION FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

FAMILY HISTORY

Has any blood relative ever had the following?

High Blood Pressure.....	No	Yes	Melanoma.....	No	Yes	Stroke.....	No	Yes
Depression.....	No	Yes	Heart Disease.....	No	Yes	Kidney Disease.....	No	Yes

PAST MEDICAL HISTORY

Have you ever had the following?

Heart Disease.....	No	Yes	Cancer.....	No	Yes	Stomach Ulcer.....	No	Yes
Arthritis.....	No	Yes	Glaucoma.....	No	Yes	Kidney Disease.....	No	Yes
Rheumatic Fever.....	No	Yes	Asthma.....	No	Yes	Thyroid Disease.....	No	Yes
Anemia.....	No	Yes	AIDS or HIV+.....	No	Yes	Bleeding Tendency..	No	Yes
Tuberculosis.....	No	Yes	Stroke.....	No	Yes	Mitral Valve Prolapse...	No	Yes
Diabetes.....	No	Yes	High Blood Pressure	No	Yes			
Hepatitis.....	No	Yes						

REVIEW OF SYSTEMS

Do you have now or have you had in the past year?

Weight Change.....	No	Yes	Joint or muscle pain.....	No	Yes	Chronic Cough.....	No	Yes
Dry Eyes.....	No	Yes	Swollen Lymph Nodes...	No	Yes	Jaundice.....	No	Yes
Skin Rash.....	No	Yes	Swollen Feet/Ankles.....	No	Yes	Easy Bleeding.....	No	Yes
Chronic Diarrhea.....	No	Yes	Rapid Heart Beat.....	No	Yes	Easy Bruising.....	No	Yes
Seizures.....	No	Yes	Depression.....	No	Yes	Chest Pain.....	No	Yes

Women Only

Approximate date of last mammogram _____ Number of full term pregnancies _____

Did you breast feed? _____ Breast lump or discharge noted? _____

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

X _____
Signature of patient or parent if minor

Date

**FREED PLASTIC SURGERY MEDICAL CENTER
INSURANCE POLICY**

We have entered an age of extreme complexity in regards to the various insurance policies that each insurance company provides. Because of this, it has become necessary for our office to place the responsibility of understanding the requirements of your particular insurance policy on you. This includes, but is not limited to, knowing which facilities can be used for laboratory, hospitalization, or outpatient surgery. Also, it is critical that you notify our staff of any insurance changes you may have.

Please be aware that you are responsible for co-payments, deductibles, non-covered services and/or amounts that insurance denies. If you have HMO insurance, we ask that you obtain a referral from your primary care physician before you schedule an appointment with our office. You may be held financially responsible if a referral/authorization is not obtained prior to your visit. Upon request, a payment arrangement may be discussed with our financial coordinator and reviewed for implementation.

After your consultation with Dr. Freed, our Insurance Coordinator will contact your insurance company to determine if prior-authorization is required for the proposed procedure. **It can take up to 45 business days for your insurance company to process an authorization request.** Please do not schedule any further appointments or surgery prior to insurance approval.

Our staff is happy to assist you in any way that we can. However, if you are planning on utilizing your insurance company for any or all of the payment to Dr. Freed, then please note that you are ultimately responsible for understanding your policy completely.

Please sign below stating that you understand this policy. Thank you for choosing Dr. Freed for your medical care. We are committed to providing the best possible care.

Patient Signature

Date

Printed Name

PATIENT CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby give my consent for Freed Plastic Surgery, A Medical Corporation, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare options (TPO).*

I have the right to review the Notice of Privacy Practices prior to signing this consent. Freed Plastic Surgery reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Freed Plastic Surgery, A Medical Corporation's Privacy Officer at 3180 Bell Road Suite 200, Auburn, CA 95603

With this consent, Freed Plastic Surgery may call my home or another alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Freed Plastic Surgery, A Medical Corporation may mail to my home or another alternative location, any items that may assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Confidential".

I have the right to request that Freed Plastic Surgery, A Medical Corporation restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, Freed Plastic Surgery, A Medical Corporation may use my PHI during Quality Assurance meetings.

By signing this form, I am consenting to Freed Plastic Surgery A Medical Corporation's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Freed Plastic Surgery, A Medical Corporation will decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patients Name or Legal Guardian Printed

Date

PHOTOGRAPHY CONSENT FORM

Before and after photographs are an important evidence as to the success of your operation. Dr. Freed does not use these photographs for any purpose unless he has your permission. However, many patients who are contemplating surgery, find looking at before and after pictures to be very useful. For this reason we would like to have your permission to use these photographs for patient education. Occasionally Dr. Freed uses them for lectures or talks on plastic surgery, to post on internet, or for marketing purposes. **However, Dr. Freed will only use them if he has documented permission from you.** Please circle the appropriate option.

I allow do not allow.....Dr. Freed to utilize my photographs for educational purposes.

I allow do not allow.....my photographs to be used on Dr. Freed's website

I allow do not allow.....my photographs to be used for marketing and advertising.

I have read the above statement and allow Dr. Freed to use my before and after photographs for the purposes indicated above.

Signature of Patient or Legal Guardian

Patients Name or Legal Guardian Printed

Date

OFFICE PROCEDURE AND SURGERY CANCELLATION POLICY

Please take time to read the following information regarding our surgery scheduling and rescheduling policy.

We realize that a situation may arise that could force you to postpone your surgery. Please understand that such changes affect not only Dr. Freed and our staff, but other patients as well. Before scheduling a surgery, please review carefully, then sign and date this form to show that you have read and understand this policy.

*****SURGERY START-TIME FOR THE AMBULATORY CENTER**

Surgeries in the ambulatory center are done between the hours of 7:00AM – 2:00PM. Patients are notified of their check-in and surgery start-time at their pre-op appointment with Dr. Freed one week prior to surgery. Please be aware that we are a medical facility performing multiple individualized surgeries and we may need to adjust our surgery schedule based on varying conditions/situations that may arise. Assigned surgery times are subject to change by Dr. Freed and our anesthesiologist up to 24 hours before surgery. While we wish we could accommodate everyone’s preferred start time, we ask that patients please understand we cannot guarantee surgery time, and that they and their transportation remain flexible on the scheduled surgery day during the ambulatory center hours. Thank you.

SCHEDULING SURGERY OR AN IN-OFFICE PROCEDURE

To schedule your surgery or a cosmetic procedure as an in-office procedure with Dr. Freed, we require that you pay a \$500.00 booking fee. The remaining balance will be due in full, two weeks prior to your procedure. A 5% cash discount is offered off the professional fee if these fees are paid by cash, cashier’s check, or money order. Because of processing fees that are incurred when scheduling and coordinating procedures, this \$500.00 booking fee is non-refundable if cancelled.

RESCHEDULING SURGERY

It is important that when you schedule your surgery with Dr. Freed you have thoroughly checked out your personal calendar to make sure that your scheduled surgery date is ideal for you. ***There is a \$100 charge for each time a surgery is rescheduled. This fee will not be applied towards your surgery and will be added as a charge to your surgical quote.*** This fee helps cover the administrative and staffing costs that it takes to reschedule your surgery and corresponding appointments along with any supplies, products, and staff personnel that have been specifically booked or ordered for your original surgery date.

CANCELLING SURGERY

If surgery is cancelled and not rescheduled 14 business days or more prior to your surgery, your \$500.00 booking fee will not be refunded.

If surgery is cancelled OR rescheduled within 2-14 business days prior to surgery then you will be charged 50% of your surgery fee along with the \$500 non-refundable fee that was paid at the time of scheduling your surgery.

If surgery is cancelled OR rescheduled in less than 48 hours you will be charged the full amount of your surgery cost.

I have read, understood, and accept the above policies.

Patient: _____ Date: _____

Witness: _____ Date: _____

FREED PLASTIC SURGERY
Medical Information Release Form
(HIPAA Release Form)

Name: _____ D.O.B. _____

Release Information

I authorize the release of information including the diagnosis, record; examination rendered to me and claims information. This information may be released to:

- Spouse _____
- Child(ren) _____
- Other _____

Information is NOT to be released to anyone.

Best Number to Leave a Phone Message On

- Home _____
- Work _____
- Cell/Mobile _____

If unable to reach me:

- Your office may leave a detailed message
- Your office may leave a message asking me to return the call
- _____

This release of information will remain in effect until terminated by me in writing.

Signed: _____ Date: _____

Witness: _____ Date: _____

Agreement Form of Email Communication with Freed Plastic Surgery & Patient

Secure electronic messaging is always preferred to insecure email for more sensitive PHI, but under specific circumstances, insecure email communication containing protected health information (PHI) may take place between Dr. Freed or one of his staff and a patient. This email communication may be used if both parties agree on this communication method and **this form is completed and signed by both the provider and the patient or the patient's personal representative (if appropriate).**

A copy of this form and all email communication will be filed in the patient's Medical Record and a hard copy of this form will be provided to the patient. This agreement is limited to communications using the email addresses listed below.

Provider Awareness: Standard email is not a secure means of communication, so as the provider I will use the minimum necessary amount of protected health information when responding to your questions or communicating information to you. In no event will my communications include highly sensitive PHI such as information relating to HIV/AIDS, mental health or substance abuse.

Patient Awareness: Please note that most standard email does not provide a secure means of communication. There is some risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax is an always an alternative that is available to you.

By completing this form, the provider and I understand and are willing to accept the risks involved with insecure email communication of my protected health information.

Date: _____

Patient's Name (print name): _____

Patient's email address (print): _____

Patient's Signature: _____

Provider's Name (print name): _____

Provider's email address (print): _____

Provider's Signature: _____