Print Reset

Freed Plastic Surgery

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, PARENT'S NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ (work/cell) _____

BIRTHDATE _____ SEX SOCIAL SECURITY #_____

OCCUPATION_____

PHARMACY _____

WHAT IS YOUR CHIEF COMPLAINT/CONCERN? _____

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

INSURANCE INFORMATION *(non-cosmetic procedures ONLY)*

PATIENT STATUS: *(please circle)*:

Single ☐ Married ☐ Widowed ☐ Employed ☐ Retired ☐ Unemployed ☐ Full-time Student ☐

PRIMARY INSURANCE _____ Identification #_____

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

INSURED'S BIRTHDATE_____

SECONDARY COVERAGE_____ Identification #_____

***ALL HMOs** *(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.

Whom may we thank for referring you? _____

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

EMAIL ADDRESS _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

RELATIONSHIP TO PATIENT _____

SIGNATURE OF PATIENT *or parent if minor* _____ DATE _____

PATIENT REGISTRATION FORM

FAMILY HISTORY—*Has any blood relative ever had the following:*

High Blood Pressure ..... No Yes
Depression ..... No Yes
Blood Clots ..... No Yes
Cancer ..... No Yes
Heart Disease ..... No Yes
Stroke ..... No Yes
Kidney Disease ..... No Yes

PAST MEDICAL HISTORY—*Have you ever had the following:*

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

REVIEW OF SYSTEMS—*Do you have now or have you had in the past year:*

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

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, hormone replacement and birth control:

I verify that the above information is true and accurate to the best of my knowledge.

SIGNATURE OF PATIENT *or parent if minor* _____ DATE _____

PATIENT REGISTRATION FORM

PLEASE CHECK THE FOLLOWING CONCERNS OR
AREAS YOU WOULD BE INTERESTED IN RECEIVING INFORMATION 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 concerns
- ☐ Laser hair removal
- ☐ Mineral makeup
- ☐ CoolSculpting fat reduction
- ☐ Thinning lashes
- ☐ Other:

Freed Plastic Surgery

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 10-30 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

Freed Plastic Surgery

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

Freed Plastic Surgery

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

_____ _____

PATIENT'S NAME OR LEGAL GUARDIAN PRINTED DATE

Freed Plastic Surgery

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.

CANCELING 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.

INSURANCE CASES

If surgery (insurance) is cancelled or rescheduled less than 14 days prior to the surgery date a $100.00 fee is charged. **The fee is charged to the patient, not the insurance company.**

RETURNED CHECK FEE $25.00

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

Patient: _____ Date: _____

Witness: _____ Date: _____

Freed Plastic Surgery

HIPPA OMNIBUS RULE

PATIENT ACKNOWLEDGMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First name only ☐ Proper surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step-parents, grandparents and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY **APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell phone confirmation ☐ Email confirmation ☐ Text message to my cell phone
☐ Work phone confirmation ☐ Home phone confirmation ☐ **Any of the above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell phone confirmation ☐ Email confirmation ☐ Text message to my cell phone
☐ Work phone confirmation ☐ Home phone confirmation ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

☐ Phone message ☐ Text message ☐ Email
☐ **Any of the above** ☐ **NONE of the above (opt out)**

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party renumeration from these affiliated companies. We, under our current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RECORDS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

_____ _____
SIGNATURE OF PATIENT / GUARDIAN PATIENT'S NAME PRINTED

_____ _____
LEGAL REPRESENTATIVE/GUARDIAN RELATIONSHIP OF LEGAL REPRESENTATIVE/GUARDIAN

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

☐ It was emergency treatment ☐ I could not communicate with the patient ☐ The patient refused to sign

☐ The patient was unable to sign because _____

☐ Other (please describe) _____

Signature of Privacy Officer _____

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: _____

Freed Plastic Surgery

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: _____