ALCHEMY 43

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440 N. CANON
BEVERLY HILLS, CA 90210
(310) 734-7943

Patients Name: ____
First   Middle Initial   Last

Address: ____
Street & Apt #   City   State   Zip Code

Email Address: ______________________   May we send email to this address? __Yes __No

Reason for Visit: ______________________   Referred By: ______________________

SS#: ____________________   Birth Date: ________________   Age: __________

Male ____   Female ____   ___ Single ___Married to ____________Other __________

Home Phone: ________________   May we leave a message for you at home?   ___ Yes ___ No
Work Phone: ________________   May we leave a message for you at work?   ___ Yes ___ No
Cell Phone: ________________   May we send a text message?   ___ Yes ___ No
Preferred method of contact: ___ Home   ___ Work   ____ Cell

In case of emergency, contact: ____________   Relationship: ____________________
Home Phone: ________________   Work/Cell: ____________________

Employer: ______________________   Address ______________________
Occupation: ______________________

Primary Health Insurance
Name of Insurance Company: ______________________________________
Name of Insured: ________________   Birth Date: ____________   SS#: ________________
Employer of Insurance: ____________   Policy ID #: ____________   Group: ________________

Secondary Health Insurance
Name of Insurance Company: ______________________________________
Name of Insured: ________________   Birth Date: ____________   SS#: ________________
Employer of Insurance: ____________   Policy ID #: ____________   Group: ________________

Payment Policy
I understand that all charges are payable on the day of service, I authorized Art & Science Plastic Surgery to bill my insurance company. Regardless of insurance coverage. I am for all charges being paid in a timely manner. I understand that my contract is be between Art & Science Plastic Surgery and myself, irrespective of any insurance coverage.

Art Science Plastic Surgery, has a 24 hour cancellation / rescheduling policy.
If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged $150.00.
This policy is in place out of respect for our doctors and our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

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Age __________ Weight ____________ Height _____________ B/P __________ (taken in office)

PERSONAL HISTORY:

Have you ever had the following conditions? (Circle all that apply)

Abnormal Bleeding	Fainting Spells	Liver Disease
Abnormal Clotting	Gastric Reflux	Psychiatric Diagnosis
Acid Regurgitation	Heart Attack	Seizures
Angina	Heart Disease	Stroke
Asthma	Hepatitis	Snoring
Diabetes	Herpes	Sleep Apnea
Cancer	High Blood Pressure	OTHER _______________
Chest Pain	Hypertension	
Emphysema	Kidney Disease	

Weight Change (Past 12mos.) ☐No ☐Yes

____

Have you ever had a transfusion? ☐No ☐Yes YEAR________________

Have you been tested for HIV? ☐No ☐Yes YEAR________________ Results: __ Positive__ Negative

Contact Lenses ☐No ☐Yes Hearing Aid ☐No ☐Yes Removable Dentistry☐No ☐Yes

FAMILY HISTORY:

Have any blood relatives ever had the following conditions? (Circle all that apply) Please indicate family member.

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other:

SURGICAL HISTORY:

Please list All Prior operations	Date	List any complications

HAVE YOU HAD: Local Anesthesia ☐No ☐Yes General Anesthesia ☐No ☐Yes Spinal/Epidural ☐No ☐Yes
List any complication/reactions you experienced to any/all anesthesia.

____

Medications: Please list ALL medications and/or Dietary supplements including:

Prescription Drugs	Non-Prescription Drugs (Vitamins, Herbs, etc.)

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Regular or baby aspirin ☐No ☐Yes Dosage & Frequency________________________

NSAID (Advil, Motrin, Ibuprofen) ☐No ☐Yes Dosage & Frequency________________________

Cortisone ☐No ☐Yes Dosage & Frequency________________________

Drug Allergy: (Please list ALL allergies and describe reactions (i.e. Shellfish, Latex, Penicillin, etc...)

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

Latex Allergy ☐No ☐Yes Type of reaction ____________________

Tape Allergy ☐No ☐Yes Type of reaction ____________________

Social History:

Do you currently use any tobacco or nicotine products? ☐No ☐Yes
If yes, what type? ____________________How long? __________ How much? __________

Have you **ever** used tobacco products? ☐No ☐Yes
If yes, what type? ____________________How long? __________ How much? __________

Alcohol Consumption: __________Never (Do not consume alcohol) ________ Light (1-2 drinks a week)
___Moderate (4-6 drinks a week) ___Daily(7-10 drinks a week) ___Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? ☐No ☐ Yes If yes, when did you stop heavy drinking? __________

Do you use other recreational drugs? If yes, please circle: cocaine, heroin, marijuana, other__________

Are you feeling hopeless about the present/future? ☐No ☐Yes

Do you currently have thoughts of harming yourself? ☐No ☐Yes

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ________________________________ and assign directly to Art Science Plastic Surgery., Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

________________________________ ____________________
Signature of Insured/Guardian Date

________________________________ ____________________
Patient's Signature Date

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HIPAA Information and Consent Form

Patient Name: ______________________________

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ______________________, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: ______________________________ Date: ______________

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PHOTOGRAPHIC RELEASE

I HEREBY GIVE PERMISSION to Art Science Plastic Surgery and/or Associate(s) or any assistant they may designate, to take photographs of me or my body parts in connection with the plastic surgery procedure(s) to be performed by Art Science Plastic Surgery and/or for diagnostic purposes. I agree that these photographs will remain their property and a part of my permanent medical record.

I PROVIDE THIS AUTHORIZATION as a voluntary contribution in the interests of patient education. I understand that such photographs shall become the property of Art Science Plastic Surgery and may be retained by Art Science Plastic Surgery or released by Art Science Plastic Surgery for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to publication in medical journals and textbooks, physician photo books, physician website, social media liv interaction feed or for the purpose of informing the medical profession, the general public, or a patient about plastic surgery procedures and methods.

I FURTHER AUTHORIZE them to use such photographs and videos for teaching purposes. It is specifically understood that I shall not be identified by name. I understand that in some circumstances the photographs may portray features that will make my identity recognizable, even in instances where every effort is made to conceal my identity.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**").

I release and discharge Art Science Plastic Surgery and all parties acting under his license and authority from all rights that I may have to the photographs and videos from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above authorization and release, and fully understand the terms.

Patient Printed Name____________________________________

Patient Signature______________________________________

Witness Signature______________________________________

Date____________________________

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN 30 DAYS OF THE DATE OF MY SIGNATURE BELOW STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200, Attention: Publication Department, Sacramento, CA 95814 or at www.cmanet.org. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from as confirmed by my initials immediately below.

Earlier effective date: ____________________ Patient's Initials ____________

ARTICLE 7: I have read and understood all of the information in this pamphlet, including the Introduction to the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

____ Dated: ____________

(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: ______________________________

PHYSICIAN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 5 above.

____ Dated: ____________

(Physician or Duly-Authorized Representative)

Art Science Plastic Surgery

____________________ ____

Title—e.g., Partner, President, etc. Print name of Physician, Medical Group, Partnership or Association

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