MORPHO
PLASTIC SURGERY

# COSMETIC REGISTRATION PACKET:
# NEW PATIENT REGISTRATION

| | | |
|---|---|---|
| **Today's Date:** | | |
| **Name:** *Last* | *First* | *MIddle* |
| How do you like to be addressed: | | |
| **Date of Birth:** | **Social Security Number:** | |
| **Address:** *Street* | | |
| *City* | *State* | *Zip* |
| **Email Address:** | | |
| **Preferred Contact Number:** ❑ Cell ❑ Home ❑ Work | | *Cell Phone:* |
| *Home Phone:* | | *Work Phone:* |
| **Marital Status:** ❑ Married ❑ Single ❑ Divorced | | **Spouse's Name:** |
| **Employment Status:** ❑ Employed ❑ Home Maker ❑ Not Employed ❑ Student ❑ Retired | | |
| **Employer:** | | |
| *Street* | | |
| *City:* | *State:* | *Zip:* |
| *Company Tel:* | | *Company Fax:* |
| **Primary Care Physician:** | | **Did he refer you?** ❑ Yes ❑ No |
| *Specialty:* ❑ Family Practice ❑ Internist ❑ Ob/Gyn ❑Pediatics ❑Other _____ | | |
| *Street* | | |
| *City:* | *State:* | *Zip:* |
| *Telephone* | | *Fax* |

What is the reason for your visit today? _____

_____

_____

_____

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## COSMETIC REGISTRATION PACKET:
## MEDICAL HISTORY FORM (CONTINUED)

**How is your general health?** ❑ Good ❑ Average ❑ Poor **Most recent physical examination?** _____

**Current Medical Problems:**

❑ No Current Medical Problems

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Anemia | ❑ Y | ❑ N | Depression | ❑ Y | ❑ N | Hypothyroidism | ❑ Y | ❑ N |
| Arthritis | ❑ Y | ❑ N | Diabetes | ❑ Y | ❑ N | Kidney Disease | ❑ Y | ❑ N |
| Asthma | ❑ Y | ❑ N | Glaucoma | ❑ Y | ❑ N | Mitral Valve Prolapse | ❑ Y | ❑ N |
| AIDS/HIV | ❑ Y | ❑ N | Heart Disease | ❑ Y | ❑ N | Rheumatic Fever | ❑ Y | ❑ N |
| Bleeding Disorder | ❑ Y | ❑ N | Hepatitis | ❑ Y | ❑ N | Stomach Ulcer | ❑ Y | ❑ N |
| Breast Cancer | ❑ Y | ❑ N | High Blood Pressure | ❑ Y | ❑ N | Stroke | ❑ Y | ❑ N |
| Cancer | ❑ Y | ❑ N | Hyper-thyroidsim | ❑ Y | ❑ N | | | |

**Other:**

_____

_____

_____

_____

**Previous Surgeries (Type / Date / Surgeon / Complications or difficulties):**

_____

_____

_____

_____

_____

_____

**Previous Plastic Surgeries (Type / Date / Surgeon / Complications or difficulties):**

_____

_____

_____

_____

_____

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## COSMETIC REGISTRATION PACKET:
## MEDICAL HISTORY FORM (CONTINUED)

**How is your general health?** ❑ Good ❑ Average ❑ Poor **Most recent physical examination?** _____

**Current Medical Problems:**

❑ No Current Medical Problems

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Anemia | ❑ Y | ❑ N | Depression | ❑ Y | ❑ N | Hypothyroidism | ❑ Y | ❑ N |
| Arthritis | ❑ Y | ❑ N | Diabetes | ❑ Y | ❑ N | Kidney Disease | ❑ Y | ❑ N |
| Asthma | ❑ Y | ❑ N | Glaucoma | ❑ Y | ❑ N | Mitral Valve Prolapse | ❑ Y | ❑ N |
| AIDS/HIV | ❑ Y | ❑ N | Heart Disease | ❑ Y | ❑ N | Rheumatic Fever | ❑ Y | ❑ N |
| Bleeding Disorder | ❑ Y | ❑ N | Hepatitis | ❑ Y | ❑ N | Stomach Ulcer | ❑ Y | ❑ N |
| Breast Cancer | ❑ Y | ❑ N | High Blood Pressure | ❑ Y | ❑ N | Stroke | ❑ Y | ❑ N |
| Cancer | ❑ Y | ❑ N | Hyper-thyroidsim | ❑ Y | ❑ N | | | |

**Other:**

_____

_____

_____

_____

**Do you smoke?** ❑ Yes ❑ No How many packs per day? _____ How many years? _____

**Do you drink alcoholic beverages?** ❑ Yes ❑ No

**Do you use recreational drugs?** ❑ Yes ❑ No

**Do you have a bleeding disorder or bleed easily?** ❑ Yes ❑ No

**Do you have any drug allergies?** ❑ Yes ❑ No If yes, please list medication and reaction to medication:

_____

_____

_____

**Current Medications (including vitamins, herbal, and non-prescription medications):**

_____

_____

_____

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## COSMETIC REGISTRATION PACKET:
## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have a certain right to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessment and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

Patient Signature Date

_____

Print Patient Name

_____ _____

Patient Witness Signature Date

_____

Print Witness Name

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## COSMETIC REGISTRATION PACKET:
## FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy that we ask you to read, agree to, and sign prior to any treatment.

- **Payment is due at the time services are rendered, including co-payment and deductibles.** We do bill insurance plans as a courtesy; however, it is not a guarantee of payment. We accept cash, check, Visa, MasterCard, or American Express.
- **It is your responsibility to verify with your insurance plan/carrier prior to each appointment that Dr. Perry Liu is a participating provider.** Please Verify if any services and procedures require pre-authorization. Some plans require pre-authorization or referrals from the patient's primary care physician.
- **Written or verbal Authorizations from insurance plans or management groups are not a guarantee of payment.** The insurance carriers review all claims after services are rendered and authorizations can be denied at the time of review. Denied claims become the patient's responsibility.
- **Statements are mailed after the insurance company has paid their portion.** The account is then payable within 30 days. Overdue accounts are subject to a $15 fee. Accounts 90 days in arrears will be subject to collection by an external agency unless financial arrangements are made with our billing office.
- All supplies dispensed, which are not billable to insurance, must be paid for at the time they are dispensed.
- We recommend you verify with your insurance carrier whenever our office refers you to outside laboratories, hospitals, physical therapy, or tests to insure that you do not require any pre-authorization.

**I HAVE READ THE ABOVE AGREEMENT AND AGREE OT THE TERMS AND CONDITIONS AS SET FORTH BY AVANT AESTHETICS.**

_____ _____

Patient / Responsible Party Signature Date

_____

Print Patient / Responsible Party Name

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# COSMETIC REGISTRATION PACKET:
# MEDICAL RECORDS PHOTOGRAPHIC CONSENT

## OVERVIEW

This consent form authorizes AVANT AESTHETICS to take before and after treatment photographs for the purpose of documenting progress and results of specific treatments. Your photos will be used as a part of your permanent medical record. All patients must initial this section in order to receive any medical services.

## PURPOSE

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. Your surgery may be photographically documented before, during, and after the procedure. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent. By initialing this section, I am agreeing that I have fully read and understand the Medical Records Photographic Consent.

_____

Please Initial

## PHOTOGRAPHIC CONSENT

For various reasons, we are often asked to show before and after photos of patients. Many patients, happy with their results, have given permission to use their photos anonymously or publicly. All photos will be shown accurately and with integrity.

Please initial **one**:

_____ I give consent to use my before and after photos **for all forms of marketing and media**.

_____ I give consent to use my before and after photos **for all forms of marketing and media (anonymously)**.

I recognize that prospective patients, such as myself, will ask to look at before and after photographs in the process of choosing a surgeon and/or provider and evaluating specific procedures. I hereby certify that I have read the foregoing and fully understand its meaning and effect.

By signing below, I give my consent and authorization for the above stated purposes and other usage initialed above.

_____ _____

Patient Signature Date

_____

Patient Printed Name

# PHYSICIAN-PATIENT ARBITRATION AGREEMENT

**Article 1:** Agreement to Arbitrate: 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 rights to have any such dispute decided In a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2:** All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service 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. In the case of any pregnant mother, the term "patient* herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

**Article 3**: Procedures and Applicable law: A demand for arbitration must be communicated in writing to all parties- Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This Immunity shall supplement, not supplant any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement. Including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication In accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

**Article 4:** General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the dale notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim In accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

**Article 5:** Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

_____
Please Initial

**Article 6:** Retroactive Effect: If patient Intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Please Initial

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.

I understand that I have the right to receive a copy of this arbitration agreement By my signature below, I acknowledge that I have received a copy.

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.

By:_____ _____
Patient's or Patient Representative's Signature Date

_____ _____
Patient Or Representative's Name Relationship to Patient

By: _____ _____
Physician's or Authorized Representative's Signature Date

_____ _____
Physician/Healthcare Provider Authorized Representative's Name (if Applicable)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's me

# IDENTIFICATION AND INSURANCE INFORMATION

**Please provide our staff with a copy of the following:**

- **Government Issued ID**
  - **Please note that your medical file/chart will be registered under your legal name.**
  - **When signing forms, please sign with your legal name instead of your common name or alias**