AISHA WHITE, MD | QUINTESSENCE PLASTIC SURGERY

DEMOGRAPHICS

Today's Date: _____ SSN#: _____ Driver's License #: _____

Name: _____ DOB: _____ / _____ / _____ AGE: _____
Last First

Home Address:

_____
Street Apt. #

_____
City State Zip Code

Home Phone:(_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Male: _____ Female: _____ Marital Status: Married Single Divorced Widowed

Employer: _____ Occupation: _____

Best Time and Number to reach You? _____ **Email:** _____

INSURANCE

Primary Insurance Carrier: _____ Member ID: _____ Group #: _____

Policy Holder: Self Spouse Parent/Guardian

Secondary Insurance Carrier: _____ Member ID: _____ Group #: _____

Policy Holder: Self Spouse Parent/ Guardian

EMERGENCY CONTACT

Name: _____ Relation: _____

Home Phone:(_____) _____ Pager/Cell: (_____) _____ Work Phone: (_____) _____

GUARDIAN INFORMATION

Name: _____ Relation: _____

DOB: _____ / _____ / _____ SSN#: _____ Driver's License #: _____

Home Phone:(_____) _____ Pager/Cell: (_____) _____ Work Phone: (_____) _____

VISIT INFORMATION

Reason for visit:

_____

Is the problem related to personal Injury? YES NO Date of Injury: _____

How did you hear about our practice? _____

Primary Care Physician: _____ Referring Physician: _____

AUTHORIZATOIN

Consent for treatment: I authorize Dr. Aisha White, MD, MBA at Quintessence Plastic Surgery to provide me with reasonable and proper medical care according to today's standards.

Financial Responsibility, Authorization to Release Information, Assignment of Benefits: I authorize Quintessence Plastic Surgery to release information in connection with my treatment to my insurance company or companies, my employer or any third-party payer at such time as information is requested. I authorization assignment of benefits to Quintessence Plastic Surgery**. I understand and agree that I am financially responsible for any and all charges incurred.**

Patient or Guardian Signature: _____ **Date:** _____

MEDICATIONS

Name:	Dosage:	Frequency:

Preferred Pharmacy: _____ **Address:** _____

ALLERGIES

___ Aspirin	___ Iodine	___ Sedatives
___ Sulfa Drugs	___ Narcotics	___ Tetracycline
___ Codeine	___ Penicillin	___ **No Known Drug Allergies**
___ Erythromycin	___ Latex	**Other:** _____
___ Anesthesia	___ Tape	**Other:** _____

SOCIAL HISTORY

Do you smoke/use tobacco or nicotine products?	NO YES Daily amount: _____ ****If yes, it is <u>MANDATORY</u> to <u>QUIT SMOKING 4 weeks before and 4-6 weeks after surgery.</u> If you cannot comply, please let us know.** ____ Yes, I can stop smoking _____ No, I cannot quit smoking **Signature**_____
Do you drink alcoholic beverage?	NO YES Daily amount: _____
Do you use recreational drugs?	NO YES Name of drug(s)_____

PERSONAL HEALTH HISTORY

Do you presently have or have you experienced the following? If so, please circle all that apply:

Hypertension	Emphysema	ESRD	Sickle Cell	Hepatitis
Heart Disease	Lung Cancer	Breast Cancer	Bleeding Disorder	Cold Sores
Heart Attack	Stroke	Ovarian Cancer	Anemia	Shingles
Arrhythmia	TIA	Radiation	Clotting Disorder	Sinus Problems
Pacemaker	Seizures	Skin Cancer	DVT	Arthritis
Asthma	Thyroid Disease	Melanoma	PE (pulmonary embolus)	High Cholesterol
COPD	Diabetes	Liver Disease	Reflux (GERD)	
Bronchitis	Kidney Disease	Body Dysmorphia	Stomach Ulcers	
Depression	Bipolar	Anorexia/Bulimia	Schizophrenia	
Anxiety	Alcohol Abuse	Drug Abuse	HIV/AIDS	

FOR WOMEN:

Are you pregnant? Yes No Unsure If yes, # of weeks: _____ Are you breastfeeding? Yes No

**** Please note, you <u>CANNOT</u> have surgery if you are pregnant****

Age of Menstrual: _____ Age of first pregnancy: _____ Number of pregnancies: _____ Number of Children: _____

Last Mammogram Date: _____/_____/_____ Bra Size: _____ Do you have breast lumps? Yes No

REVIEW OF SYSTEMS

___ Weight Change	___ Rapid Heart Beat	___ Chest Pain
___ Chronic Cough	___ Shortness of Breath	___ Dry Eyes
___ Breast Mass	___ Nipple Discharge	___ Back Pain
___ Swollen Feet/Ankle	___ Easy Bleeding	___ Skin Rash
___ Joint/ Muscle Pain	___ Swollen Lymph Node	___ Numbness

Please list any Other Serious Medical Conditions that you have experienced: _____

_____

List *ALL OPERATIONS* you have ever had in the past:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Anesthesia Problems? (include nausea/ vomiting, slow to wake up or high temperature): _____

_____

FAMILY HISTORY

Condition:	Family Member:
Skin Cancer	
Melanoma	
Heart Disease	
Bleeding Disorder	
Clotting Disorder	
Anemia	
Bone/ Joint Disorder	
Rheumatoid Arthritis	
Breast Cancer	
Ovarian Cancer	
Other:	

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date:** _____

QUINTESSENCE PLASTIC SURGERY

OFFICE POLICIES

Please initial the following:

- I understand that Quintessence Plastic Surgery and Dr. White will not bill insurance for cosmetic surgical procedures or aesthetic treatment services. _____
- Payment is due in full prior to cosmetic services rendered (Please see cosmetic procedure financial policy). _____
- I authorize the release of my medical records to insurance companies and authorize the release of any medical information necessary to process my insurance claim. _____
- If my medical insurance needs to be billed, I then authorize my insurance benefits to be paid directly to Dr. White. I also realize I am responsible to pay non-covered services and/or the balance not paid by insurance. I assume full responsibility for my balance regardless of the status of my insurance claim. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay a claim in full, I understand that I am responsible for payment of charges for services rendered. _____
- If computer imaging is used in my evaluation, I understand that the alteration is purely for the purpose of illustration and discussion and in no way, constitutes an expressed or implied warranty as to my final results and appearance. _____

Missed Appointments / Late Cancellations Policy

We feel the practitioner/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the same courtesy. We understand that unforeseen circumstances occasionally occur and you will be unable to keep your scheduled appointment. Please see our missed/ cancelled appointment guidelines below.

If you are unable to keep your scheduled appointment, we require a 24-hour notice (1 full business day) so that we may accommodate the needs of another patient. If an appointment is cancelled or rescheduled within 24 hours of the reserved appointment time, **Quintessence Plastic Surgery** may charge the patient $25 cancellation/no show fee.

Patient's Name: _____

Signature: _____ **Date:** _____

(To acknowledge receipt of Missed Appointments/Late Cancellations Policy, and Office Policies')

QUINTESSENCE PLASTIC SURGERY

NOTICE OF PRIVACY POLICY

Certain government regulations, known as Health Insurance Portability and Accountability Act of 1996 (HIPAA), require medical providers to explain their privacy and security policy so that information obtained by us about you is used appropriately.

*How we may use and disclose Protected Health Information (PHI) about you:

- Treatment, management and coordination of your health care needs.
- Payment of any and all medical claims.
- Normal operation of our business, such as quality review and training of our staff.
- Communication from our office, such as to contact you to verify appointments, or to leave a message on voicemail with test results or to answer questions.
- As required by law, to include but not limited to Public Health activities, abuse issues and legal proceedings.

*Your rights regarding PHI about you:

- You have the right to request restrictions.
- You have the right to receive confidential communications.
- You have the right to inspect and copy PHI about you (a charge may apply for copies received).
- You have the right to request that we amend your PHI.
- You have the right to receive an accounting of disclosures.
- You have the right to obtain a paper copy of our complete Notice of Privacy Practices.

Restrictions Requested:

_____

_____

_____

Signature: _____ **Date:** _____

(To acknowledge receipt of Notice of Privacy Policy)

**This is not a complete listing of our Privacy Practices. Please ask to see our complete Notice of Privacy Practices.

***We reserve the right to make changes to this Notice and make such changes effective for all PHI we may already have about you. We will post any and all changes in a prominent location, and provide you a copy upon request.

QUINTESSENCE PLASTIC SURGERY

COSMETIC PROCEDURE FINANCIAL POLICY

Payment Information & Options:

A 20% *Non-Refundable* deposit is required at the time of scheduling, and the remaining balance is due at least 2 WEEKS PRIOR to the procedure date (typically collected upon arrival at the pre-op appointment). We provide a number of payment options which may be used individually or combined:

- Cash, Check, Visa, MasterCard, AMEX
- PAYMENT: If payment is made less than two weeks before surgery, your options for payment are limited to cash, credit card or cashier's check. Personal checks will *NOT* be accepted within two weeks of surgery.
- $50 service charge for each returned check.

Patient Cancellation and Rescheduling Policy:

We understand you may decide to postpone your surgery. We request your courtesy and understanding that changes in a surgical schedule affect not only Dr. White, the procedure/OR staff, but other patients and their families as well.

- If cancellation is more than two weeks prior to the date of surgery, surgical fees will be refunded, less the 20% deposit. We will apply the 20% deposit *ONE TIME ONLY within (30) days* toward the rescheduled procedure.
- If cancellation is less than two weeks prior to the date of surgery, 50% of the surgical fees will be refunded.
- There is a $350 rescheduling fee for *ALL* procedures re-scheduled within 7 days of surgery. It is incredibly difficult to fill a surgical spot within a week of surgery.

Revision Policy:

- Surgery fees are inclusive of all pre-and post-surgery related visits as well as revision surgery deemed necessary by the original surgeon *within 6 months* of the initial procedure.
- There is a $350 rescheduling fee for procedures re-scheduled within 7 days of surgery.
- Hospital fees for anesthesia, medication, and facilities associated with revision surgery are not included in this fee estimate.

Insurance & Other Expenses:

- Elective cosmetic surgery procedures are not covered by insurance. Therefore, Quintessence Plastic Surgery will not bill insurance.
- Some expenses (if necessary) may be covered by insurance: prescription medication, advance lab work, EKG, and additional fees related to post-surgical complications.
- Out of pocket expenses: Garments may be recommended for select procedures.
- *Hospital Procedures:* Dr. White is confident with the amount of time she has estimated for your procedure and length of stay. However, in the event this estimated time is exceeded, or unforeseen complications arise, you may be billed for additional facility and anesthesia care costs.

* Please note: if any tissue is sent for pathology, Quintessence Plastic Surgery does not quote out pricing for pathology. Please be advised that you will recieve a seperate bill for this portion.

I have read and understand the above information:

Patient's Name: _____

Signature: _____ **Date:** _____

(To acknowledge receipt of Cosmetic Procedure Financial Policies)

QUINTESSENCE PLASTIC SURGERY

PATIENT CONSENT TO RECEIVE TELEPHONE MESSAGES AND/OR MAIL

Do we have your permission to:	YES	NO	Comment
Call you at home or another number that you provided?	( )	( )	_____
Leave a message on your home answering machine?	( )	( )	_____
Leave messages with persons answering your home telephone?	( )	( )	_____
Call you at work and leave a message?	( )	( )	_____
Leave messages on your cell phone?	( )	( )	_____
Contact you by e-mail	( )	( )	_____
Discuss your appointment information with another person? Name: _____	( )	( )	_____
Mail an appointment reminder, test result, or other report to your home?			

Please specify any restrictions: _____

Patient's Name: _____

Signature: _____ **Date:** _____

QUINTESSENCE PLASTIC SURGERY

AUTHORIZATION TO RELEASE MEDICAL PHOTOGRAPHS

I, _____[patient name], herby acknowledge that Quintessence Plastic Surgery will take pre-, intra-, and post- operative/treatment photographs.

I acknowledge that the Photographs may be stored in electronic and/or paper medical records and used in my clinical care related to surgeries by the Authorized Parties.

I hereby _____ Authorize _____ Do Not Authorize the Authorized Parties to use the Photographs for professional medical purposes including but not limited to testing and credentialing, educational purposes for other physicians and patients, and for medical presentations, teaching, and or medical journal articles.

I hereby _____ Authorize _____ Do Not Authorize the use of Photographs attached to this authorization by the Authorized Parties for marketing purposes, including publication in brochures, newsletters, and websites of any one or more Authorized Parties.

I understand that I will not be entitled to any payment or other form of compensation as a result of any use of Photographs, which shall be the property of the Authorized Partied, I understand that my clinical care will not be affected by my choice to authorize or not authorize use of the Photographs above. I hereby release and hold harmless the Authorized Parties of and from any and all claims, demands, damages or causes of action in connection with the use of Photographs, I hereby authorized.

Patient's Name: _____

Signature: _____ **Date:** _____

AISHA WHITE, MD | QUINTESSENCE PLASTIC SURGERY

I authorize the disclosure of all relevant protected information for the purpose of review and evaluation in connection with a financial dispute. I authorize Dr. Aisha White and Quintessence Plastic Surgery, the record custodian of all covered entities under HIPAA, to disclose full and complete protected medical information to credit card companies, second party payers, or any financial institutions involved in the financial dispute, including the following:

- All medical records, meaning every page in my record, including but not limited to face sheets, questionnaires, policies, consents, office notes, history and physical, consultation notes, emergency room treatment, inpatient treatment, outpatient treatment, reports, order sheets, test results, radiology records, pathology records, progress notes, nurse's notes, pharmacy/prescription records, social worker records, treatment plans, admission records, discharge summaries, requests for records, outside records received from other medical providers that are part of the Quintessence Plastic Surgery medical record system, correspondence, billing statements, photographs, and videos.
- Telephone messages, email messages, social media message, letters, and any other correspondence from the patient, legal guardian, any person authorized by the patient or legal guardian to give or receive correspondence, or any person involved in the financial transaction.
- All disability, Medicaid, Medicare, or commercial insurance records that are relevant to the dispute.
- All billing records, including all statements, insurance claim forms, itemized bills, records of billing to third party payers, and payment or denial of benefits.
- All employment, personnel, or wage records.

I understand that information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol abuse, and drug abuse. I authorize the release or disclosure of this type of information.

_____ _____

Patient Name Date

_____ _____

Patient Signature or Name and Signature of Legal Representative Date

_____ _____

Witness Signature Date