

Kouros Azar, M.D.

PLASTIC AND RECONSTRUCTIVE SURGERY

425 Haaland Drive, Suite 200
 Thousand Oaks, CA 91361
 (805) 373-7073

Today's date:						
PATIENT INFORMATION						
Patient's Last Name:		First Name:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		E-mail:		Birth date: / /	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			City:		State:	
ZIP Code:			P.O. Box:			
Drivers License # (include state):		Social Security Number:		Home phone:		Cell Phone:
Any restrictions contacting you?				Preferred contact number:		
Occupation:		Employer:			Employer phone:	
Is it okay to call you at: <input type="checkbox"/> Work <input type="checkbox"/> Home						
How did you hear about our practice?						
Other family members seen here:						
IN CASE OF EMERGENCY						
Name of local friend or relative:				Relationship to patient		
Home phone:				Cell Phone:		
The above information is true to the best of my knowledge.						
<i>Patient/Guardian signature</i>				<i>Date</i>		

Insurance Information

Primary Insurance Company _____

Claims Address _____

Telephone Number _____

ID # _____ Group # _____

Subscriber (primary insured) _____

Subscriber SS# _____ Subscriber Birth Date _____

Subscriber's employer _____

Relationship of Patient to subscriber _____

Secondary Insurance Company _____

Claims Address _____

Telephone Number _____

ID # _____ Group # _____

Subscriber (primary insured) _____

Subscriber SS# _____ Subscriber Birth Date _____

Subscriber's employer _____

Relationship of Patient to subscriber _____

Assignment of Insurance/Medicare Benefits

I hereby give consent for medical or surgical treatment to the physician to care for myself or I am duly authorized by the patient as his/her guarantor to give consent for such treatment. Dr Azar is ONLY contracted with Medicare, no other insurance.

I understand that charges are payable on the day service is rendered. I authorize Dr. Azar to bill my insurance company. I hereby authorize payment directly to the physician of any medical / surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent to release to authorized persons of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Azar and myself. In the event of collection action, I shall be responsible for any legal fees incurred as a result of the collection action.

Patient (or Responsible Party)

Signature Date

MEDICAL HISTORY FORM

PATIENT NAME: _____ AGE: _____ DATE: _____

PRIMARY CARE PHYSICIAN: _____

REASON FOR CONSULTATION : _____

HEALTH PROBLEMS OR CONDITIONS: _____

OPERATIONS:

TYPE	DATE	COMPLICATIONS

MEDICATIONS: (including vitamins and herbal supplements)

TYPE	DOSAGE AMOUNT	TAKEN HOW OFTEN

ALLERGIES: NO YES (please provide details below)

TOBACCO USE: NO YES How many per day _____

ALCOHOL USE: NO YES How many per day _____

Do you bruise or bleed easily? (with cuts, tooth extraction, pregnancy, surgery) NO YES

Do you have a family history of bleeding problems? NO YES

Have you ever had a blood transfusion? NO YES

Are you opposed to receiving a blood transfusion? NO YES

Have you had a bad reaction while being put to sleep for surgery? NO YES

Have any of your family members ever had problems with anesthesia? NO YES

Are you pregnant? NO YES

Is it possible you could be pregnant? NO YES

Are you allergic to latex? NO YES

Are you allergic to tape? NO YES

Have you had a cortisone injection in the last year? NO YES

Regular aspirin use? NO YES

Regular use of Ibuprofen, Advil, Motrin? NO YES

HAVE YOU EVER BEEN EXPOSED TO:

INTRAVENOUS DRUGS	<input type="checkbox"/> NO	<input type="checkbox"/> YES	HIV	<input type="checkbox"/> NO	<input type="checkbox"/> YES
INFECTIOUS DISEASES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	BLOOD TRANSFUSION	<input type="checkbox"/> NO	<input type="checkbox"/> YES
TB	<input type="checkbox"/> NO	<input type="checkbox"/> YES	LIVER TRANSPLANT	<input type="checkbox"/> NO	<input type="checkbox"/> YES
HEPATITIS	<input type="checkbox"/> NO	<input type="checkbox"/> YES			

OTHER HEALTH PROBLEMS OR CONDITIONS, CURRENT OR PAST: please provide details

Anesthetic Complications	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Anemia	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Asthma	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Bruise or Bleed Easily	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Blood Clots in Legs or Lungs	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Cancer	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Diabetes	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Endocrine / Hormone Disorder	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Heart Disease / High Blood Pressure	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
HIV (AIDS)	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Hypertension	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Infections / Immune System Disorder	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Kidney Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Liver Disease / Hepatitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Lung Disease / Asthma	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Neurological Disease / Seizures	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Psychiatric / Mental Disorder	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Stomach / Intestinal Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____

EMOTIONAL HISTORY:

Do you have any significant emotional problems? NO YES (please explain)

Have you ever had Psychiatric/Psychological Care? NO YES (please explain)

Have you ever been diagnosed with Body Dysmorphic Disorder? NO YES

FAMILY MEDICAL HISTORY

Do any of your relatives have any of the following? (if yes, who)

Tuberculosis	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Cancer	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Diabetes	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Epilepsy	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Heart Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES
High Blood Pressure	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Lung Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Kidney Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Blood or Bleeding Disorder	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Asthma	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Mental Disorder	<input type="checkbox"/> NO	<input type="checkbox"/> YES

I certify that I am a mentally competent adult at least 18 years of age, and that I have read this form and answered all questions truthfully and to the best of my knowledge. I am responsible to notify the office and the physician if any changes occur in my medical condition. If I fail to keep the doctor informed of my full medical history, I may be at an increased risk for complications or unexpected results from the planned treatments.

Witness _____ Patient _____

I certify that I am a mentally competent parent or legal guardian of the minor or mentally incompetent patient, and that I have read this form and answered all questions truthfully and to the best of my knowledge.

Witness _____ Parent or Legal Guardian _____

Medical History reviewed and discussed with Kouros Azar, M.D. _____

PRIVACY POLICY

It is the policy of Dr. Azar's practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will –

- Adhere to the standards set forth in the Notice of Privacy Practices
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for any uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will
 - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patients' individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
 - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
 - Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if she/he believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will –
 - Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals
 - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff at our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary actions, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personal rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

PLEASE INITIAL _____

*These Guidelines for Policy Adherence may not be explicitly stated in the Privacy Rule. Some are based on our interpretation of the "minimum necessary" standard and our experience in practice management. If stated in the Privacy Rule, it is so indicated by the notation (Regulation) at the end of the Guidelines.

PHOTOGRAPH RELEASE AND CONSENT

I authorize for perpetuity the use of my photographs, videotapes and case information in the following commercial/educational settings: My surgeon's office patient education materials; my surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my surgeon participates; television programs in which my surgeon participates; and my surgeon's personal website or websites; design websites or pages; and lectures and multimedia presentations given by my surgeon for the general public.

I release and discharge Dr. Azar and all parties acting under his license and authority from all rights I may have in the photographs and from any claim that I may have relating to such use and publication, including any claim for payment in connection with distribution or publication of the photographs. I also authorize for perpetuity my surgeon's professional associations to use my photographs and case information in fulfilling its mission of public education, in any of the following settings; Patient education brochures available for purchase; education videotapes available for purchase; lectures and slide presentations available for purchase; information submitted by professional associations to consumer periodicals and magazines for publication; television programs about plastic surgery; cases that he has presented on the websites designated by my surgeon. I understand and accept that I may be recognized for my likeness or case history. Nevertheless, I authorize for perpetuity Dr. Azar and/or his representative to use my photographs, videotapes and case information in educational and scientific settings including lectures and multimedia presentations for an office of medical professions at which members of the press may be present, and medical, surgical and scientific journal articles.

PLEASE CHECK ONE:

I grant this consent as a voluntary contribution and certify that I have read the above authorization and release and fully understand its terms. I am authorizing use of my medical photographs as described above.

I decline to have photographs shown for any and all above uses.

Patient's Signature

Date

Witness' Signature

Date

CANCELLATION POLICY
Office Procedures and/or Surgery

Policy for non-surgical procedures:

- We will collect payment for certain non-surgical procedures at the time of scheduling to secure appointment.
- Cancellations on the same day of the procedure will result in a charge to your account of 100% of that procedure.
- Scheduled treatments on prepaid packages will result in deduction of treatment from series if appointment is cancelled with 3 days.
- All balances must be paid prior to scheduling any future appointments.

Policy for surgical procedures:

Surgery scheduling requires planning and coordination between our office, the surgery center, your anesthesiologist and additional surgeons, if applicable. Please understand the importance of respecting our cancellation policy.

Payment for surgery must be received in full by check or credit card, two weeks prior to your surgery date.

- Cancellation 8-14 days prior to surgery will result in a 35% loss of all fees
- Cancellation one week or less from your procedure date will result in 50% loss of all fees
- Cancellation 1 day or less from your procedure date will result in 100% loss of all fees

I have read, understand and accept the above policies.

Patient

Date

Witness

Date

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's
Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and
authorize _____ to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment,
condition, or dates: _____

All healthcare information

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient
Signature: _____ Date
Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.