WE DO NOT ACCEPT INSURANCE FOR SURGERY

Name: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone:_____ Work Phone: _____

Cell Phone:_____ Email: _____

May we contact you at home? ❑ **Yes** ❑ **No** *May we contact you via Email?* ❑ **Yes** ❑ **No**

Date of Birth:_____Height:_____Weight:_____

Have you ever had cosmetic surgery? ❑ **Yes** ❑ **No** *If Yes, please complete the following:*

Type of Surgery:_____ Date of Surgery: _____/_____/_____

Physician name:_____

How long have you been thinking of having cosmetic surgery?

❑ 6 months ❑ 1 year ❑ 2 or more years

Do you have a history of, or do you suffer from, any of the following:

❑ Heart Disease ❑ Diabetes ❑ High Blood Pressure

❑ Allergies ❑ Smoking ❑ Depression

Are you in good health? ❑ **Yes** ❑ **No** *If No , please explain:* _____

_____

Do you know of any reason that would disqualify you from having cosmetic surgery?

❑ **Yes** ❑ **No** *If Yes, please explain:* _____

_____

Were you referred to us by your physician? ❑ **Yes** ❑ **No**

Name of referring physician: _____

❑ Referred by friend / relative Name of referring friend / relative:_____

❑ Television ❑ Radio ❑ Newspaper ❑ Magazine ❑ Internet

Other: _____

WHAT TYPE OF COSMETIC SURGERY ARE YOU CONSIDERING?

❑ Breast Augmentation ❑ Breast Lift ❑ Breast Reduction

Tummy Tuck: ❑ Mini ❑ Full

Liposuction: ❑ Abdomen ❑ Thighs ❑ Hips ❑ Arms ❑ Chin
❑ Other Areas _____

Eyelids: ❑ Upper ❑ Lower

❑ **Nose Reshaping**

Face Lift: ❑ European Mini ❑ Full Face ❑ Neck ❑ Forehead

❑ **Hollywood Booty**

Body Lift: ❑ mini ❑ Full

Other: _____

_____

When do you plan to have your surgery? Month_____ Year_____

Are you employed? ❑ **Yes** ❑ **No**

Employer:_____ City _____

What type of work do you do? _____

Have you made arrangements for time off from your job or profession for your surgery and recovery? ❑ **Yes** ❑ **No**

I plan to pay for my surgery by: ❑ **Cash** ❑ **Credit Card** ❑ **Financing***
❑ **Other** _____

*Please complete the attached financing application.

COST OF COSMETIC SURGERY

Each patient fee is based upon you, individually. No two patients are alike-even twins. The same rule applies to plastic surgeons. The education, skill and ability of your surgeon should be of utmost importance to you when considering cosmetic surgery.

Please list any questions that you have in the space below:

_____

_____

_____

_____

Signature _____ Date:_____

REGENCY MEDICAL GROUP, PLLC
42450 West Twelve Mile Road, Suite 100
Novi, MI 48377
248-735-3800 Fax 248-734-2435
StarPlasticSurgery.net

Medical History Screening (Patient to complete)

Name _____ Date _____

Age _____ Date of birth _____

(Circle One)

Soc Sec #: _____ Male Female

List all medications that you take including supplements and herbs

_____

_____

_____

_____

List all medication allergies

_____

_____

Do you have any of the following medical problems?

	Yes	No	Comments
High blood pressure			
Heart problems			
Lung problems (ie asthma, emphysema)			
Diabetes or blood sugar problems.			
Anemia or low blood count			
Kidney problems			
Blood clots or bleeding problems			
Liver problems			
Stomach problems			
Chest pain			
Seizures			
Cancer			
Depression or anxiety			

Have you ever had a problem with anesthesia?			
Do you smoke?			
Do you drink alcohol?			
Do you use street drugs?			
Family history of breast cancer			

List all previous surgeries you have had.

Please list your medical doctors name and phone number.

Who will assist with your care after surgery? Name, relationship and phone number.

Signature: Date:

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1 and/or page 5.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research. **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner or funeral director when a person dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

ADDITIONAL INFORMATION

- We Never market or sell personal information!
- We do not create or manage a hospital directory; do not create or maintain psychotherapy notes; and do not create and will not share substance abuse treatment records without your written permission, unless required by law to do so.

- EFFECTIVE DATE OF NOTICE: June 1, 2015. This Notice replaces any prior versions of our Notice of Privacy Practices.
- OUR PRIVACY OFFICIAL (contact with any questions, problems or complaints):

Peggy Giusta
Phone: (248) 735-3800
Email: info@starplasticsurgery.net

* * * * * * * * * * * * * * *

Acknowledgement of Receipt:

Please sign below to acknowledge receipt of a copy of this Notice of Privacy Practices. Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____ Date_____