Advanced Aesthetic Associates
9250 North 3rd Street, Suite 1003
Phoenix, AZ 85020
(480)752-7874
www.aaaplasticsurgery.com

Patient Information Form

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

DOB: _____ Age: _____ Gender: _____

Social Security Number: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our clinic?

☐ www.aaaplasticsurgery.com ☐ Patient/Friend: _____
☐ Web Search Engine ☐ Dr. Referral: _____
☐ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Name: _____ Policy #: _____ Group ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber Name _____ DOB: _____

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Secondary Insurance

Name: _____ Policy #: _____ Group ID: _____

Subscriber Name _____ DOB: _____

If you **do not** have insurance, have you applied for AHCCCS? (circle) YES NO

Workers Compensation

Name: _____ Claim # _____

Will there be a lawyer involved? (circle) YES NO Law Firm Name and Number: _____

Assignment and Release

I, _____, have insurance coverage and assign directly to Aesthetic, Facial and Oculoplastic Surgeons 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. 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

Acknowledgments

INSURANCE

By signing this form, I am acknowledging that I have been advised that the office of Pablo A. Prichard, MD and Remus Repta, MD is not a contracted provider with my insurance company. I understand that I am expected to pay for services at the time of service and that I am financially responsible for any charges incurred by me and/or my dependents.

In addition, I acknowledge that I have been advised that since Pablo A. Prichard, MD and Remus Repta, MD are not contracted, my insurance company will send all correspondence and payments to me. I further acknowledge that any checks I receive by my insurance company for services rendered by Pablo A. Prichard, MD and/or Remus Repta, MD shall be endorsed and forwarded directly to the physician.

Furthermore, I agree to make monthly payments towards my account upon receipt of the first statement sent by my physician. I also agree to assist the office to obtain the higher benefits from my insurance company. I understand the balance of my account is ultimately my responsibility.

_____ _____

Signature of Insured / Guardian Date

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APPOINTMENT AND SURGERY CANCELLATION
If you call at least 24 hours prior to the time of your appointment or scheduled surgery to cancel or reschedule there will be no charge, otherwise it is considered a "no-show" and you will be charged a fee of $100.00 in addition to any deposits already paid.

NON-SUFFICIENT FUNDS
If your check is returned for non-sufficient funds it will be necessary for us to pass on a $35.00 NSF fee from the bank.

_____ _____

Signature of Insured / Guardian Date

Section I - Medical Problems or Conditions Now Under Treatment by a Physician: ☐None

1. _____
2. _____
3. _____
4. _____
5. _____

Section II Surgery (Operations and Cosmetic Surgery): ☐ None

	Type	Date	Complications or Difficulties
1.			
2.			
3.			
4.			
5.			

Any history of radiation therapy or previous exposure to radiation? ☐Yes ☐No ☐ Uncertain

Section III Previous Admissions to Hospital: ☐ None

	Reason	Date	Complications or Difficulties
1.			
2.			
3.			
4.			

Section IV Difficulties with Local or General Anesthesia: ☐ None

Explain: _____

Section V Bleeding Problems: ☐ None

Do you have a family history of bleeding problems? _____
Do you bruise or bleed easily? (With cuts? Tooth extraction? Pregnancy? Surgery?) Explain

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_____

_____

Section VI Allergies

Are You Allergic to Any Medications? ☐ None Known

Please List: Allergy: _____ Reaction: _____

_____ _____

_____ _____

Section VII Medications, Vitamins or Herbal Supplements You Take Now:

	Type	Dosage Amount, if Known	Take How Often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Section VIII Consumption of the Following:

Tobacco	☐ Never	☐ Current: Amount Daily	_____	Amount Weekly	☐ □□□□□□□
Alcohol	☐ Never	☐ Amount Daily	_____	Amount Weekly	_____
Other	☐ None	☐ Amount Daily	_____	Amount Weekly	_____
Aspirin	☐ None	☐ Amount Daily	_____	Amount Weekly	_____

Section IX Family History

Any family history of medical problems/illnesses or bleeding problems?

Mother: _____

Father: _____

Brother(s): _____

Sister(s) _____

Children: _____

Section X Have You Ever had a Blood Transfusion:

☐ Yes ☐ No

Section XI Have You Ever Been Exposed To: *(check all that apply)* ☐ None

☐ Intravenous/Recreational Drugs ☐ Infectious Diseases ☐ TB

☐ HIV/AIDS ☐ Hepatitis ☐ Other _____

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☐ Blood Transfusion ☐ Liver Transplant ☐ Other _____

Section XII History of Epilepsy/Seizures or Any Mental Illnesses: ☐ None

Explain: _____

Section XIII Childhood Medical History:

Had all "baby shots"	☐ Yes	☐ No	☐ Uncertain
Had polio immunizations	☐ Yes	☐ No	☐ Uncertain
Had rheumatic fever	☐ Yes	☐ No	☐ Uncertain

Section XIV Review of Systems:

Any Medical Problems with Any of the Following? (If yes, please explain)

☐ Head _____
☐ Eyes _____
☐ Ears, Nose, Throat _____
☐ Thyroid _____
☐ Lungs _____
☐ Heart _____
☐ Blood Pressure _____
☐ Digestive System _____
☐ Liver _____
☐ Muscles _____
☐ Reproductive Organs _____
☐ Kidneys, Bladder _____
☐ Unsightly Scar _____
☐ Disease Affecting Immune System
☐ Other _____

Section XV Women's Health History ☐ N/A

Are You Pregnant? ☐ Yes ☐ No ☐ Uncertain
Age of Menarche _____ Age of Menopause _____
Number of children _____ How were they delivered _____
Last mammogram (date) _____
Previous breast biopsies/surgeries, or other female organ surgery (date/reason/treatment):

_____
_____
_____

Any personal or family history of breast cancer? ☐ Yes ☐ NO (explain) _____

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Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical/Billing Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

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 U.S. 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 manger 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: _____

Authorization to Release Medical Imaging Records

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I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery.

This authorization is provided as a voluntary contribution in the interests of public education. I understand that such imaging records shall become the property of American Society of Plastic Surgery (ASPS) and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

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 further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA. Neither I, nor any member of my family, will be identified by name in any publication, but I understand that in some circumstances, the images may portray features that will make my identity recognizable.

I authorize the release of my imaging records to be used without compensation for the purposes of advertising in our office photo album and in office seminars for prospective patients. These imaging records may also posted on our website or be used in print or television advertising.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Prichard or Dr. Repta. In addition, I understand that I have the right to inspect and copy the information that I have authorized to be disclosed.

I release and discharge Dr. Prichard, Dr. Repta and Dr. Andres, ASPS, and all parties acting under their license and authority from all rights that I may have in the imaging records and 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 imaging records.

I understand that I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Advanced Aesthetic Associates, PLLC at 9250 North 3rd Street, Suite 1003 Phoenix, AZ 85020. A revocation shall not affect any release of information made prior to revocation in reliance upon this authorization.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____ _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____
Signature Date

_____ _____
Witness Signature Date