Celestial
Plastic and Reconstructive Surgery

1 PATIENT INFORMATION

Date _____

Patient: _____

Address: _____

_____
City State Zip

Sex: ☐ F ☐ M Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SSN _____

Occupation _____

Spouse's Name _____

Children's Names and Ages _____

_____

How did you hear about us? _____

_____

Primary Medical Doctor _____

Other treating physicians _____

Employer/Occupation _____

2 CONTACT INFORMATION

Telephone Numbers: Home _____

Cell _____ Work _____

Email _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____ Work/Cell _____

3 APPOINTMENT POLICY

We require 24-hour cancellation notice for all consultation and treatment appointments with our office. Failure to notify our office of the need to cancel at least 24 hours prior to the scheduled appointment will result in cancellation fees as follows: Doctors: $100; Other providers: $50.

Initials _____

4 FAMILY HISTORY

FATHER	Alive ☐ Deceased ☐	Present health or cause of death
MOTHER	Alive ☐ Deceased ☐	Present health or cause of death

Check illnesses which have occurred in any of your blood relatives:

☐ Bleeding tendency ☐ Heart disease ☐ High blood pressure ☐ Diabetes ☐ Stroke

☐ BREAST CANCER ☐ OTHER CANCERS

List affected relatives: Type Affected Relative

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

5 INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER _____

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____

Ins. ID# _____ Group # _____

SECONDARY INSURANCE CARRIER _____

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____

Ins. ID# _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the company specified above and assign directly to Celestial Plastic & Reconstructive Surgery (CPRS) all insurance benefits, if any, otherwise payable to me for services rendered, and I understand that she is not a member of my health insurance company. 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 insurance submissions.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Celestial Plastic & Reconstructive Surgery for any services furnished me by CPRS. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Responsible Party Signature

_____ _____

Relationship to Patient (if not "Self") Date

Celestial
Plastic and Reconstructive Surgery

All information is strictly confidential.

6 MEDICAL HISTORY

Please list any medical conditions and previous surgeries you have had:

Year Diagnosed	Condition	Treatment, Including Surgery

Have you had any adverse reaction to anesthesia or surgical complications? If so, please describe:

_____

_____

7 MEDICATIONS/ALLERGIES

List medications you are currently taking (please include herbs or homeopathic meds):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy Name_____ Phone_____

List allergies to medications or substances _____

_____

_____

8 HEALTH HABITS

HEALTH HABITS

Check which substances you use and describe how much you use.

☐ Caffeine _____

☐ Drugs _____

☐ Tobacco _____

☐ Other _____

EXERCISE

Do you do the following weekly or more often:

☐ Yoga/Pilates ☐ Weightlifting ☐ Running ☐ Swimming

☐ Other activity _____

HEIGHT _____

WEIGHT _____

9 SIGNATURES

I certify that the above information is correct to the best of my knowledge. I will not hold the staff of Celestial Plastic & Reconstructive Surgery responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that I have received the Notice of Privacy Practices.

Signature _____ Date _____

Reviewed By _____ Date _____

Name: _____

Welcome to our practice!

What is the reason for your upcoming consultation?

_____

What additional services would you like to learn about? Please check all that apply.

❑ Acne	❑ Brow Lift	❑ Breast size
❑ Skin care products	❑ Drooping eyelids	❑ Breast shape
❑ Facial fine lines/wrinkles	❑ Under eye bags	❑ Breast Implant Correction
❑ Thin lips	❑ Nose size or shape	❑ Breast Reconstruction
❑ Eyelash Fullness or thickness	❑ Facial fullness/drooping	❑ Tummy Tuck
❑ Chemical peel	❑ Mole removal	❑ Upper Arm lift
❑ Cellulite Reduction	❑ Neck wrinkles	❑ Thigh Lift
❑ Spider Veins	❑ Ear size or shape	❑ Butt Lift
❑ Facial redness	❑ Dermatology – Skin exam	❑ Liposuction
❑ Brown spots/age spots/freckles	❑ Aesthetician – facials	❑ Red or raised scars
❑ Laser Hair Removal	❑ Microdermabrasion	❑ Vaginal rejuvenation

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	*2*	*3*	*4*	*5*

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	*2*	*3*	*4*	*5*

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes: how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law; and your rights to access and control your Protected Health Information. "Protected health information" ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your PHI will be used, as needed, to obtain payment for your health care services. For example, your health plan may require that your relevant PHI be disclosed to the health plan to obtain approval for treatment.

Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk were you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures

Other uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights with Respect to Your PHI

- **You have the right to request a restriction of your PHI.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
- **You have the right to have your physician amend your PHI**. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI**.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

PRIVACY PRACTICES ACKNOWLEDGEMENT

This sheet is a supplement to the materials provided. Please refer to these handouts for more complete information. I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

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

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* 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 health care 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 content.

Name:

_____

Signature:

_____

Relationship to patient, if applicable:

_____

Date:

_____

PRIVACY PRACTICES ACKNOWLEDGEMENT
REGARDING COMMUNICATIONS

By signing this form, you acknowledge that you have been informed that Celestial Plastic & Reconstructive Surgery (CPRS) provides information about how we may use and disclose your Protected Health Information (PHI). We encourage you to read the "Notice of Privacy Practices" that is also in this packet.

CPRS may use the following methods of communication regarding information related to my personal health, treatment or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

Please circle below:

Y N Contact me by phone at home _____

Y N Contact me at Work _____

Y N Contact me on my Cell _____

Y N CPRS staff may leave a message on my voicemail

Y N CPRS staff may speak to anyone who answers the phone

Y N I would like to receive newsletters and special offers by email

Y N CPS staff may leave a message for me at my work phone number

Y N Contact me at the email I provided

Y N Contact me by text message

Y N CPRS may mail me correspondence at my home address

I hereby provide Celestial Plastic & Reconstructive Surgery staff permission to speak with the following people regarding my PHI. I also hereby grant permission to release treatment/billing information as necessary to facilitate treatment and/or payment of services provided to people listed below:

Name_____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Questions or concerns about our Privacy Notice or Practices should be directed to the Erica@celstialplasticsurgery.com

Name _____ Date _____

Signature _____ (Patient/Parent/Conservator/Guardian)

Celestial
Plastic and Reconstructive Surgery

AUTHORIZATION FOR THE USE OF PHOTOGRAPHS

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

Before and after photos are also an important tool for educating patients about what to expect from their procedures, and our office is often asked to show before and after photos of patients. Many patients give permission to use their photos anonymously.

Please consider the following and either authorize or deny use of your photos for each situation. Your name or other identifying data will never be revealed along with the photos. We appreciate your consideration.

Patient Name

_____

I authorize the anonymous use of my photographs for Celestial Plastic & Reconstructive Surgery in the situations I have checked below:

	In office to show patients	For the Internet & Social Media	In printed materials
Photographs of my face	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Photographs of my body	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

I understand that every attempt will be made to represent me and Celestial Plastic & Reconstructive Surgery accurately and with integrity and dignity in all media. I hereby certify that I have read the foregoing and fully understand its meaning and effect.

Patient Signature: _____ Date: _____