National Center for Plastic Surgery
7601 Lewinsville Rd Suite 400
McLean, VA 22102
(703) 287-8277

New Patient Information Form

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.			
Name:			
Address:		City/State/Zip:	
SSN:	Date of Birth:	Marital Status:	Gender
Home Ph:	Work Ph:	Cell Ph:	Pager:
Email:		Other:	
Employer:		Address:	
Occupation:		Full/Part/Student/Retired Other:	
Emergency Contact Name:		Relationship:	
ER Contact Home Ph:		ER Contact Work Ph:	
How did you hear about us:			
If patient is a child, who may authorize treatment:		Relationship:	
Person financially responsible for treatment if not Self:			
Address:		Phone:	
Method of Payment:	Cash	Credit Card	Insurance complete below
Primary Subscriber:		Date of Birth:	
Insurance:	Policy No:	Group No:	
Secondary Insurance:		Address:	
Policy No:		Group No:	
Workers Compensation, treatment authorized by:		Claim#:	
If you authorize release of your medical information to anyone besides your insurance carrier, please give the name:			
If you have a telephone answering machine at home, may we leave messages there: YES NO			

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.
Patient, Parent or Guardian Signature: Date:

NATIONAL CENTER FOR PLASTIC SURGERY

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Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Physician(s): _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes			
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

Do you use recreational drugs? No Yes If yes, describe: _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

Do you have any history of problems with anesthesia? No Yes If yes, describe: _____

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how to get access to this information.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, is kept properly confidential. This Act gives the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPSS, the following is an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your Protected Health Information for the following purposes.

Treatment: Providing, coordinating, or managing health care and related services by one or more health care providers. This includes the physical examination, scheduling other exams or appointments with other providers, calling in prescription refills, physician-to-physician discussions for coordination of care and physician to staff discussion for coordination of care. We will also call to remind you of appointments or treatment alternatives or other health-related benefits and services that may be of interest to you and may leave messages for you.

Payment: Such activities as obtaining reimbursement for services, confirming billing or collection activities, and utilization review. An example of this would be sending a bill to your insurance company for payment.

Health care operations: Include the business aspects of running our practice on a daily basis. These functions include, the entire staff having access to your file at some point in the provision of health care to you to obtain authorization of medications or medical procedures, filing of paperwork, recording phone messages or vitals from your visit, confirming your appointments with our office, scheduling your appointments with our office and obtaining the medical compliant for your visit, writing referrals for other physicians, and dictating notes to an outside source for your visit.

Requirements of law: Any activities where release is required by law, including a judicial setting and any health oversight regulatory and law enforcement agencies that by law are entitled to review any or all elements of your health information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except that we have already taken actions relying on your authorization.

We reserve the right to update these practices at any given time. You will them be required to review and acknowledge the material changes and many be required to consent to changes not otherwise supported by the law or the regulations.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information in certain situations.
- The right to amend your protected health information in certain situations.
- The right to receive an account of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of February 24, 2003, and we are required to abide by the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written complaint with our office, and/or with the Department of Health & Human Services about violations of the provision of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The US Dept of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SE
Washington, DC 20201
202-619-0257 or 1-877-696-6775

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

_____ _____

Date Signature

Patient Initials: _____