

**Malhotra Center for Plastic Surgery, PC**

**Acknowledgement of Receipt of Notice of Privacy Practices.** Effective date: January 18, 2010

The undersigned acknowledges receipt of Malhotra Plastic Surgery Notice of Privacy Practices

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Consent for use and disclosure of your health information:**

By signing this form you are documenting that we have informed you that this office may use and disclose all your health information in our possession, collectively call protected health information. The uses and disclosures by this office are protected health information and are necessary and will be used by this office in connection with your treatment, or obtaining payment for treatment and services that this office provides to you. Please carefully review this notice.

You have the right to review our notice of privacy practices form prior to signing the consent. Please be advised that the notice of privacy practices form may be revised by this office from time to time. Such revisions will be made available to you by contacting the office manager of the Malhotra Center for Plastic Surgery,PC. I understand that I may request in writing to restrict the use of how my private health information is used to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my restrictions, but if agreed then you are bound to abide by such restrictions

By signing below, I hereby authorize my health information, as more specifically described as a medical records or protected health information, to be used or disclosed at my request for the following purposes:

**Please check below who you authorize to disclose your health information to.**

Dr. Malhotra’s Staff **(This box is required)**

Primary care or referring physician

Spouse or immediate family members

I understand that I may revoke this authorization in writing except if this office has taken action in reliance upon this authorization or this authorization was given as a condition of obtaining insurance coverage and the insurance company has the right to contest a claim made under the insurance policy.

I understand that my protected health information that is used or disclosed is subject to re-disclosure by the persons you have disclosed it to and the privacy of my protected health information will no longer be protected. I authorize the use and disclosure of protected health information in accordance with the terms of this authorization.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

*office employees only: I attempted to obtain the patient signature and acknowledgment of this notice of privacy practices, but was unable to do so as documented below:*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*initials*

\_\_\_\_\_  
*reason*

## ASSIGNMENT OF BENEFITS AND SIGNATURE ON FILE

I request that payment of authorized Medicare, commercial insurance, or any other health insurance be made either to me or on my behalf directly to Dr. Malhotra of Malhotra Center for Plastic Surgery, PC for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare, or private health insurance carrier and its agents any information needed to determine these benefits or the benefits payable for relates services.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_

If you think your bill is wrong or if you need more information write us on a separate sheet at 900 E. Michigan Ave, Jackson, MI 49201. We must hear from within 60 days of sending you your first bill on which the error appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, give us the following information:

- Your name and account number.
- The dollar amount of the suspected error.

You do not have to pay any amount in question while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. While we suggest your question, we cannot report you as delinquent or take any action to collect the amount you question.

## STATEMENT OF FINANCIAL RESPONSIBILITY

We render services on the assumption that your charges may not be paid by your insurance company. Patients who carry any form of medical or surgical insurance should know that they are responsible for payment of all services rendered. If you have any questions, we suggest that you receive advance confirmation from your insurance company.

DISCLOSURES required by the federal Truth and Lending Act: The patient (or responsible party) is here advised and agrees: A) That the full amount of (their) fees, costs and expenses for COSMETIC SURGERY are due and payable 3 weeks before surgery, and that patients' will incur additional costs for revision or touch up surgery. Patients who cancel surgery for non-medical reasons less than 48 hours before their surgery will lose a portion of their fees. B) That the full amount of (their) fees, costs and expenses for NONCOSMETIC SURGERY are due and payable within sixty days of date of service, and if not paid in full at that time, there shall be imposed thereafter a FINANCE CHARGE of 1% per month (ANNUAL PERCENTAGE-12%) on the unpaid balance outstanding on the last business day of the month. Returned checks will be assessed a \$50.00 NSF fee in addition to your own bank fees.

**No Shows:** Patients must cancel their appointments in advance if they cannot attend, otherwise their account will be billed a \$50.00 "no show" charge.

I, the undersigned, realize that all medical and surgical charges incurred by me or my dependents for services rendered are my financial responsibility. Any fees necessary to collect this account are payable by me.

Signed \_\_\_\_\_

Date \_\_\_\_\_

## Malhotra Center for Plastic Surgery, PC

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Referring physician/Primary Care: \_\_\_\_\_ Insurance \_\_\_\_\_

Reason for visit: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

### **Medical HISTORY:** Have you ever had:

Abnormal Bleeding: Yes No	Asthma: Yes No	Hypertension: Yes No
Abnormal Clotting: Yes No	Diabetes: Yes No	Sleep Apnea: Yes No
Acid Regurgitation: Yes No	Fainting Spell: Yes No	Snoring: Yes No
Anemia: Yes No	Heart Problem: Yes No	Ibuprofen use: Yes No
Angina: Yes No	Hepatitis: Yes No	Tested + for HIV: Yes No

Please list your medical problems: \_\_\_\_\_

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Previous Surgery:

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List your medications:

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Drug Allergy: Yes No  
Latex Allergy: Yes No  
Regular Aspirin Use: Yes No

List drug(s) and reaction: \_\_\_\_\_  
Tape Allergy: Yes No  
NSA (Advil, Motrin, Ibuprofen): Yes No

### **FAMILY HISTORY:**

Abnormal Bleeding: Yes No	Coronary Surgery: Yes No	Kidney Disease: Yes No
Abnormal Clotting: Yes No	Diabetes: Yes No	Tuberculosis: Yes No
Anesthetic Problems: Yes No	Heart Attack: Yes No	Other Serious Illness: Yes No
Cancer: Yes No	Hypertension: Yes No	

Please describe questions with a "Yes" answer:

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### **SOCIAL:**

Smoke: Yes No Amount: \_\_\_\_\_ Alcohol: \_\_\_\_\_ per week  
Married: Yes No Your Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

### **REVIEW OF SYSTEMS:**

Cold Sores or recent fever	Yes No	Irregular Heart Beat:	Yes No
Double vision	Yes No	Vomiting:	Yes No
Apnea:	Yes No	Difficult Voiding:	Yes No
Shortness of Breath:	Yes No	Seizure:	Yes No
Depression or Psychiatric treatment:	Yes No	Current Pregnancy:	Yes No
Blood Clots:	Yes No	Breast cancer:	Yes No
Walking/balance problems:	Yes No	Immune system problems:	Yes No

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**Female PATIENTS ONLY:** Last menstrual period \_\_\_\_\_ Did you breast feed? Yes No Birth control: Yes No

# Malhotra Center for Plastic Surgery, PC

## Patient Photography Consent

Patient Name \_\_\_\_\_

I consent to the taking of photographs by Dr. Pramit S. Malhotra or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. [Pramit S. Malhotra](#). I further authorize Dr. [Pramit S. Malhotra](#) to release to the American Society of Plastic Surgeons® (“ASPS®”) such photographs. I hereby also grant permission for the use 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 The American Board of Plastic Surgery, Inc.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of Dr. [Pramit S. Malhotra](#) and may be retained by Dr. [Pramit S. Malhotra](#) or released by Dr. [Pramit S. Malhotra](#) for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, Web sites, patient demonstration purposes for the purpose of informing the medical profession, the general public, and prospective patients about plastic surgery procedures and methods. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information, but will not affect the health care services I presently receive, or will receive, from Dr. [Pramit S. Malhotra](#). I understand that I have the right to inspect and copy the information that I have authorized to be disclosed and to revoke this authorization in writing at any time.

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 Dr. [Pramit S. Malhotra](#) 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.

I release and discharge Dr. [Pramit S. Malhotra](#), ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs 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 photographs.

We take our reputation in the community very seriously. If you have not obtained satisfactory results we require that you discuss it with our office. Internet defamation would result in damages sought by our practice. The Malhotra Center for Plastic Surgery collects email addresses for marketing purposes. We may use your email to extend special offers by us or third parties.

I certify that I have read the above Authorization and Release and internet posting policy and fully understand its terms. Signature \_\_\_\_\_ Date \_\_\_\_\_

Exceptions: \_\_\_\_\_

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: \_\_\_\_\_

**Malhotra Center for Plastic Surgery, PC  
Demographics**

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Sex: M F

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip Code: \_\_\_\_\_

Phone numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

E-mail address: \_\_\_\_\_ Marital status: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Insurance Information of Policy Holder:**

Primary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Name (Policy Holder) \_\_\_\_\_ SS# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

**Cosmetic Surgery Patients:**

Confidentiality is very important to our practice so we ask that you provide one phone number where we can reach you to leave a message in the event of a scheduling change.

Phone: (\_\_\_\_) \_\_\_\_\_

**Please circle your areas of Interest:**

Botox	Liposuction	Tummy Tuck
Breast Augmentation-	Breast Lift	Eyelid Surgery
Facelifts	Forehead Lifts	Chin Surgery
Nose surgery	Male breast reduction	Skin Care/Peels

Other: \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Phone# \_\_\_\_\_