Malhotra Center for Plastic Surgery, PC
Demographics

Last Name: ________________First Name__________________ Sex: M F Date: _____________

Date of Birth: ___________Age: ______________Social Security #: ________________________

Address: _______________________________________ City/Zipcode:______________________

Phone numbers: Home__________________Work_________________Mobile________________

Email address:_______________________________ Marital status: _____________

How did you hear about us: ____ (radio,internet,friend, etc)

Emergency Contact Name: _______________________Emergency Contact Phone Number:______________

Occupation: ______________Employer_______________

Primary Care Physician (name) _________________________________(telephone) (______)______________

Cosmetic Surgery Patients:

Confidentiality is very important to our practice; however, we do require one phone number where we can reach you and leave messages in the event of a scheduling change. The best number would be (circle one):

home phone work phone mobile

Do you have an event (reunion etc.) that you are trying to get ready for?________________(date)

Our practice has frequent promotions. Please circle any areas of interest you have. May we send information to your home and email address? Yes __________ No

Botox	Restylane	Skin care	Lunchtime Peels
Breast Lift	Eyelid Surgery	Breast Augmentation	Tummy tuck
Facelifts	Mini-facelifts	Forehead Lifts	Chin Surgery
Liposuction	Nose surgery	Male breast reduction	

Malhotra Center for Plastic Surgery, PC

HIPPA notice of privacy practices Effective date: December 28, 2006

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. If you any questions about this notice, please contact the office manager at the Malhotra Center for Plastic Surgery, PC 603 Lansing Avenue, Jackson, MI. 49202 Phone: 517-789-9800.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services received at this office. We need this record to comply with certain legal requirements. This noticed applies to all of the records of your care generated by this office, whether made by your physician or office employee.

This notice will tell you about the ways in which we may use and disclose your medical information. This notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:
1. Make sure that medical information that identifies you is kept private;
2. Give you this notice of our legal duties and privacy practices with respect to medical information about you ; and
3. Follow the terms of the notice that is currently in effect.

How this office May Use and Disclose Your Medical Information:
The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned.

1. Treatment: Means providing, coordinating, or managing healthcare related services by one or more healthcare providers. An example of this would include a physical examination.
2. Payment: Means such activities obtaining reimbursement for services, confirming coverage, billing our collection, activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
3. Healthcare operations: Include the business aspects of running our practice to make sure that all of our patients receive quality care.
4. We may also use or disclose your medical information for appointment reminders, to recommend treatment alternatives, to explain health related benefits or services, for research purposes, as required by law for federal, state, and local purposes, to avert a serious threat to health, your safety, to governmental or health oversight agencies, for lawsuits or disputes, and for law enforcement purposes.
5. We may also create and distribute. The identified health information by removing all references to individually identifiable information.
6. Any other 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 to the extent that we have already taken actions or are relying on your authorization.

Your rights regarding your medical information.
You have the following rights with respect to your protected health information:

1. The right to inspect and copy your protected health information.
2. The right to amend your protected health information.
3. The right to receive an accounting of disclosures of protected health information.
4. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at an alternative location.
5. 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. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
6. The right to obtain a paper copy of this notice from us upon request.

We reserve the right to revise this notice. Any revised notice will be effective for medical information we already have about you as well as any information received in the future. We will offer you a copy of any revised notice.

Complaints
If you believe your privacy rights have been violated, you may file complaint with this office, by contacting office manager, or with the secretary of the department of Health and Human Services. This must be done in writing and there will be no penalty to you in any way for filing a complaint.

Last Updated: **[Insert Date]**

Other uses of medical information that are covered by this notice of privacy practices, will be made only with your written authorization. You make revoke such authorization in writing at any time. If you revoke your authorization we will no longer use or disclose medical information about you.

Last Updated: [Insert Date]

By signing below acknowledge that I received a copy of this notice of privacy practices to view and may request a copy to take
with home.

____

Patient signature date

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

____

Date initials reason

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 protect health information and are necessary and will be used by this office in connection with your treatment, or obtaining payment fo 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 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 restri the use of how my private health information is used to carry out treatment, payment, or healthcare operations. I also understan 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:

The specific persons/class authorized to use my protected health information: **Please check boxes below**

☐ Physician,office staff, nursing staff (Dr. Malhotra, Staff of Malhotra Center for Plastic Surgery, PC)
Exceptions ____________________

The person or class to whom this office may use or disclose my protected health information **to**:

☐ Primary care or referring physician___________(if different from demographic sheet)

☐ Spouse and immediate family members______________(**list exceptions**)

This authorization shall expire in 10 years **unless** other date specified __________ (date)

I understand that I may revoke this authorization in writing except if this office has taken action in reliance upon this authorizat or this authorization was given as a condition of obtaining insurance coverage and the insurance company has the right to conte 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 disclosur of protected health information in accordance with the terms of this authorization.

____

Patient signature date

Last Updated: [Insert Date]

ASSIGNMENT OF BENEFITS AND SIGNATURE ON FILE

I request that payment of authorized Medicare, Medicaid, 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 and Medicaid Services ,Medigap insurer, 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:__________________________ Medicare number if applicable:_______________

If you think your bill is wrong or if you need more information write us on a separate sheet at 603 Lansing Ave, Jackson, Mich. 49202. 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 regarding coverage, 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 $25.00 bounced check 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 $25.00 "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: ___________________________________ __ **Birthdate:** ________________ **Age:**____

Referring physican/primary care doctor:___________________________Insurance carrier __________
Reason for visit:_______________________________How did you hear about us?________________

Medical HISTORY: Have you ever had:

Abnormal Bleeding: Y o N o
Abnormal Clotting: Y o N o
Acid Regurgitation: Y o N o
Anemia: Y o N o
Angina: Y o N o

Asthma: Y o N o
Diabetes: Y o N o
Fainting Spell: Y o N o
Heart Problem: Y o N o
Hepatitis: Y o N o

Hypertension: Y o N o
Sleep Apnea: Y o N o
Snoring: Y o N o
Ibuprofen use Y o N o
Tested + for HIV: Y o N o

Please list your medical problems: ____

Previous Surgery, approximate year and type of procedure:
____

List your medications ____

Drug Allergy: Y o N o
Latex Allergy: Y o N o
Regular Aspirin Use: Y o N o
Cortisone Injections Past Year: Y o N o

List drug(s) and reaction:______________________
Tape Allergy Y o N o
NSA (Advil, Motrin, Ibuprofen): Y o N o
Height: ______________ Weight:_______________

FAMILY HISTORY: Have any blood relatives every had the following problems:

Abnormal Bleeding: Y o N o
Abnormal Clotting: Y o N o
Anesthetic Problems: Y o N o
Cancer: Y o N o

Coronary Surgery: Y o N o
Diabetes: Y o N o
Heart Attack: Y o N o
Hypertension: Y o N o

Kidney Disease Y o N o
Tuberculosis: Y o N o
Other Serious Illness: Y o N o

Please describe questions with a “Yes” answer: ____

SOCIAL
Smoke: Y o N o Amount: _________________ Alcohol: _______per week
Married: Y o N o Occupation: _______________ Employer________________

REVIEW OF SYSTEMS

Cold Sores or recent fever Y o N o
Double vision Y o N o
Apnea: Y o N o
Shortness of Breath: Y o N o
Depression or Psychiatric treatment: Y o N o
Blood Clots: Y o N o
Walking/balance problems: Y o N o

Irregular Heart Beat: Y o N o
Vomiting: Y o N o
Difficult Voiding: Y o N o
Seizure: Y o N o
Current Pregnancy: Y o N o
Breast cancer: Y o N o
Immune system problems: Y o N o

Comments: ____

Female PATIENTS ONLY: Last menstrual period _____ Did you breast feed? Yes No Birth control: Yes N

Last Updated: **[Insert Date]**

Malhotra Center for Plastic Surgery, PC
Authorization for Release of Patient Photograph

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 or one of his/her associates 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.

Neither I, nor any member of my family, will be identified by name in any publication. 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 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. Pramit S. Malhotra .

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation.

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.

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

Last Updated: [Insert Date]