BIRMINGHAM INSTITUTE OF PLASTIC SURGERY
Patient Information Form

Mr, Mrs, Miss, Ms, Dr	Due to the new governmental privacy laws (HIPAA), we ask that you list how you would like to be addressed in order for us to insure your privacy. Please address as:_____		
Patient First Name:	Middle Initial:	Last Name:	
If minor, Parent/Guardian Name:		Relationship:	
Address:		Zip Code:	
City:	State:	Single Married Divorced Other	Social Security #:
Date of Birth:	Spouse Name:		Patient Gender: Female Male
Phone Number:	Work Phone:		Cell Phone:
Do we have your permission to leave a message on your answering machine regarding appointments or test results: Yes No Other (please specify) **Pts Initials _____**			
E-mail address:			
Emergency Contact:	Relationship:	Phone #:	
I authorize the above named person to receive personal information regarding my medical care should he/she call with a question or concerns: Yes No **Pts Initials _____**			
Appointment with: Dr Vasileff Dr Ozolins			
Primary Insurance:	Subscriber:		
Subscriber Address if different from Patient's:			
Subscriber Date of Birth:	Patient's relationship to Subscriber: Self Spouse Child Other Dependent		Subscriber Gender: Male Female
Contract #:	Group #		
Do you have Medicare? Yes No	If Yes, is it: Primary Secondary	If Medicare is Secondary, Why?	
Secondary Insurance:	Subscriber:		
Subscriber Address if different from Patient's:			
Subscriber Date of Birth:	Patient's relationship to Subscriber: Self Spouse Child Other Dependent		Subscriber Gender: Male Female
Contract #:	Group #		
I acknowledge I have been given a copy of the financial arrangements and privacy information. We reserve the right to take photos prior to surgery to assist preoperatively and to review the results post operatively with the patient. We reserve the right to use photographs for assisting with insurance prior-authorization, and for educational purposes, including American Society of Plastic Surgery Board Examinations **Pts Initials _____**			
Patient Signature:	Today's Date:	Chart #	

BIRMINGHAM INSTITUTE OF PLASTIC SURGERY
Patient History Form

Patient Name: _____ Today's Date: _____ Chart # _____

Referred By: _____ Reason for Visit: _____

_____

In this time of rapidly expanding medical knowledge and increasing specialization there exists a very real risk of the physician not being aware of the general health and medical background of the patient. Such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age: _____ Height: _____ Weight: _____

Please list ALL medications you are currently taking or have taken in the past 6 months **(include all prescription drugs, over the counter drugs [Aspirin, ibuprofen, glaucoma drops, pain pills, vitamins, etc)**

	Medication Name	Amount	Frequency
1.			
2.			
3.			
4.			

List all **ALLERGIES** _____

Is there a possibility that you are pregnant? Yes No Have you ever used (please circle) LSD, Speed, Cocaine, Marijuana, None
Are you a smoker? Yes No How much per day? _____ How long have you been smoking? _____
Ex smoker? Yes No When did you quit? _____ How much were you smoking? _____
How much caffeine per week? _____ How much alcohol do you drink per week? _____

Please circle all medical conditions you now have or have had in the past:

Bleeding Tendency	Hepatitis	Hypertension	Diabetes	Blood transfusions
Glaucoma	Dry Eyes	Lung Disease	TB	Asthma/Wheezing
Emphysema	Bronchitis	Irregular Heart Beat	Chest Pain	Heart Disease
Heart Attack	Stroke	Epilepsy	Heart Burn	Intestinal ulcers
Depression	Mental Illness	Drug/Alcohol Addiction	Shortness of Breath	Muscle Spasms

List all previous surgeries (including plastic surgery): 1. _____

2. _____ 3. _____

4. _____ 5. _____

Have you ever had Local Anesthetic? Yes No Novocain for dental work? Yes No General Anesthesia? Yes No

Any problems with any type of anesthesia? _____

Do you have (circle): Loose/chipped teeth Caps Dentures Contact lenses

Have you ever seen a cardiologist? Yes No Cardiologist Name: _____

Date of last EKG: _____ Date of Last Mammogram: _____

I verify that the above information is correct.

Patient Signature: _____ Date: _____

BIRMINGHAM INSTITUTE OF PLASTIC SURGERY

525 Southfield Rd
Birmingham, MI 48009-1620
248-644-0670

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

1. Your Protected Health Information (PHI) may be used or disclosed by those within our office who have a necessary reason to access the information, or we may use or disclose your PHI to those outside our office who have a need to know your information in order to provide you with health care services related to your treatment, payment or health care operations. We will make reasonable efforts to limit the use and disclosure of your PHI to the minimum necessary.
   - **What is Treatment Related?** We may use and disclose your PHI for use by staff, physicians, or other health care professionals involved in your care that may provide you with treatment, evaluation, diagnostic, and other health care services. Examples are, but not limited to: other physicians who are treating you, pharmacies, or laboratories.
   - **What is Payment Related?** We will use your PHI as necessary to assist you in paying for your health care services. Examples are, but not limited to: providing insurance companies with information about the dates of service, services provided, and your medical condition, in order for them to make a decision regarding coverage, or payment.
   - **What is Health Care Operations Related?** We may use/disclose your PHI in order to conduct ordinary and reasonable business operations for our office on a day-to-day basis. Examples include, but are not limited to: budgeting, accounting, and managing our staff in performing their duties, and training residents, or medical students.

2. We reserve the right to take photos prior to surgery to assist preoperatively and to review the results post operatively with the patient. We reserve the right to use photographs for assisting with insurance prior-authorization, and for educational purposes, including American Society of Plastic Surgery Board Examinations.

3. We are permitted or required to use or disclose PHI without the individual's written consent or authorization in certain circumstances. Two examples are, but not limited to, Public Health requirements, Food and Drug Administration, Federal or State Law requirements, such as court orders, and Victims of Abuse, Neglect or Domestic Violence (§164.512).

4. We will not make any other use or disclosure of a PHI without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written. **However,** you may not revoke your authorization regarding release **prior** to the date of your revocation.

5. We may contact you at home/work to remind you of an appointment, and leave reminders on your voice mail, connected to your home phone number or cell phone number unless you request otherwise.

6. We will also request that you sign-in upon visiting our office and may call your name in the waiting room unless you request otherwise.

7. You as a patient have the right to:

   - Inspect and copy your medical information that may be used to make decisions about your care.
   - Request an amendment to your medical records if you feel they are incorrect or incomplete. We may deny your request and will notify you of the reason for our denial.

- Request an accounting of disclosures. This is a list of disclosures for other than treatment, payment or health care operations.
- Request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. All requests must be in writing. However, we have the right to deny the restriction or limitation. If we do agree to the restriction or limitation, we will comply with your request unless the information is needed to provide you with emergency care.

8. We will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.

9. We reserve the right to change the terms of its notice and to make new notice provisions effective for all PHI that it maintains.

10. Revisions of our Notice of Privacy Information Practice will be posted in the office. Copies may also be obtained at any time from our office.

11. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. All complaints should be in writing, state the nature of the complaint, and how to contact you. No retaliatory action will be made against any individual who submits or conveys a complaint.

12. We are required by law to maintain the privacy of your PHI and to provide you with this Notice of Privacy Information Practices

You May Contact:

Birmingham Institute of Plastic Surgery
Heidi Dale
525 Southfield Road
Birmingham, MI 48009
248-644-0670

Secretary of Health and Human Services
The US Department of Health and Human Services
200 Independence Avenue, S.W.
Washington D.C. 20201
1-877-696-6775

FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care. If you have medical insurance we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment is due at the time service is rendered unless we participate with your insurance and we are aware you have coverage for the visit. It is the patient's responsibility to submit claims to insurances we do not participate with. An itemized statement will be given for each visit so you may submit for reimbursement.

We participate with Medicare, and Beaumont Health Insurance, and accept assignment of benefits. This means we will accept what the insurance company deems reasonable and customary. ***You will be responsible for any copays, deductibles, and non-covered services. Payment of co-pays, and non-covered services are expected at the time of service or a $10 service fee will be added to each statement sent. Any unanticipated fees must be paid upon receipt of the first statement; or an additional $10 service fee will be added for each subsequent statement sent. Should problems arise affecting your timely payment of this account, we encourage you to contact us promptly for assistance.***

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.

I have read and understand the financial arrangements. I authorize my physician to submit my medical claims to my insurance for payment of services rendered.

Patient Signature: _____ Date: _____

The effective date of this notice is October 1, 20
This notice has been updated April 1, 2003
This notice has been updated February 16, 2006