Center for Plastic Surgery at Castle Rock

I. Patient Health Information

Name _____

Today's Date _____

Address _____

City _____ State _____ Zip_____

Phone Number _____ Cell____ Home ____ Work ____

Emergency Contact _____ Relation _____

Phone Number _____

Email Address _____

Date of Birth _____/_____/_____ Age _____

Social Security Number (will need for surgery) _____

Marital Status Single____ Married _____ Divorced ____ Widowed _____

Employer _____

Occupation _____

Primary Care Physician _____

Phone Number _____

Alternate Physician (OBGYN/Neurologist/Oncologist/etc.)_____

Phone Number _____

Referral Source _____

II. Reason for Visit (circle all that apply)

Cosmetic
Face/Skincare
Breast
Abdomen
Buttocks/Lower extremity
Other: _____

Reconstructive
Breast Reconstruction
Skin Cancer/Lesion
Scars
Wound
Other: _____

III. Health Insurance Information (when applicable)

Insurance Company _____

Policy Holder's Name _____

ID _____ Group _____

IV. Past Medical History

Present Height _____ Weight _____

Please circle if you have had/have any of the following medical problems:

	Details
Asthma	
Bleeding Disorder	
Breast Cancer	
Cancer	
Chest pain/tightness	
Diabetes	
Eczema	
Endocrine/Immune Problems	
Eye Problems	
Gastrointestinal Problems	
Genitourinary Problems	
Heart Disease	
Heart Murmur	
Hepatitis	
High Blood Pressure	
Hives	
Kidney Stones	
Musculoskeletal Problems	
Nasal Problems	
Neurological/Emotional Problems	
Other Medical Conditions	
Skin Cancer/Disease	
Stroke	
Thyroid Disorder	
Tuberculosis	
Ulcers	
Urinary Tract Infection	

Have you ever had cold sores? No Yes Most recent outbreak?_____

Have you ever taken Accutane? No Yes When?_____

V. Surgical History

Surgery/Hospitalization	Date/Year	Anesthesia Complications?	Notes

VI. Family History

If your family has no medical history, check here _____
If adopted, check here _____

	Afflicted Family Member	Notes
Autoimmune disorders		
Colon Cancer		
Diabetes		
Glaucoma		
High Blood Pressure		
High Cholesterol		
Liver Disease		
Lung Cancer/Disease		
Malignant Melanoma		
Obesity		
Premature Coronary Heart Disease		
Skin Cancer		
Thyroid Disease		

VII. Allergies and Medications

Allergy	Reaction	Notes

Medication	Dosage	Prescribed By?	Notes

VIII. Social History

a. Alcohol use:
Never _____ Occasionally/Socially _____ Daily _____ History of Abuse _____

b. Tobacco use:
Never _____
Former smoker _____ Quit when? _____# Packs/day _____
Duration of smoking _____

c. Illegal Drug/ Marijuana use (if any): None ☐

_____

d. STD History (if any): None ☐

_____

e. Number of Children (if any): _____Date(s) _____

IX. Female Questions (when applicable)

	Yes	No	N/A
Do you have regular periods			
Are you going through menopause			
Are you pregnant/lactating			
During pregnancy, did you ever get hyperpigmentation or masking?			

X. Additional

The web is becoming a key way patients learn about our practice. Do you participate in any of the following? (check all that apply)

Yelp ☐

Facebook ☐

Twitter ☐

Angie's List ☐

RealSelf ☐

Blogging ☐ If yes, where can we see it? http://_____

Signature _____

My signature certifies that I have completely and accurately filled out the information on this form. I understand that inaccuracies in this information may be detrimental to my care and potentially result in severe medical consequences

Center for Plastic Surgery
at Castle Rock

NOTICE OF PRIVACY PRACTICES
(for your use)

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within the organization for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of the organization receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a pubic health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by the organization to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You may be contacted by the organization for the purposes of raising funds to support the organization's operations.
- You have the right to restrict the use of your confidential healthcare information. However, the organization may chose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The organization is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- The organization will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to the organization if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the organization:

  ATTN: Center for Plastic Surgery at Castle Rock
  David J Archibald, M.D. & Paul H Rhee, M.D., F.A.C.S.
  2352 Meadows Blvd. Ste 209
  Castle Rock, CO 80109
  All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.
- For further information about this Privacy Notice, please contact: (303) 268-2222
- Requests for further information about the matters covered by this notice may be directed to the administrator of the facility

Financial Policy and Patient Consent Form

Center for Plastic Surgery at Castle Rock, ("CPS") recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning payment for professional services.

1. PAYMENT: Payment is expected at the time of service. If your deductible has not been met, or a percentage is your responsibility, we require payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. If not paid within 60 days, **CPS** will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

2. SELF PAYMENT (PRIVATE, CASH PAYMENT): If you have no insurance coverage for a medical issue, we ask that you coordinate your care with our business office prior to your visit. We require full payment, at the time of service, unless prior arrangements have been made with our business office.

3. MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit without a referral authorization your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. By signing below, patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non-covered or not authorized by the plan.

4. MEDICARE: CPS physician(s) are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You will be asked to sign a waiver form, called an "Advanced Beneficiary Notice" which states that you understand that you will be responsible for these charges.

5. COSMETIC CONSULTS: CPS has opted not to charge a fee for cosmetic consults, however, if prior authorization for a medical procedure is submitted to your insurance company by our business office than the consultation is no longer free. The office consultation will be billed to your insurance company and will be subject to your insurance benefits, including any out of pocket cost you may owe. It will be your responsibility to pay any out of pocket cost for the office consultation even in the event that your insurance company denies authorization for the medical procedure.

CPS firmly believes that a good patient/physician relationship is based upon understanding and open communication. It is our hope that the above policies will allow us to provider the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (303) 268-2222.

Patient Name (Please Print)	Patient Date of Birth
Signature (Insured / Guardian)	Date

David J Archibald, M.D. & Paul H Rhee, M.D., F.A.C.S.
AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name:_____

Date of Birth:_____

1. I authorize _____The Center for Plastic Surgery_____to disclose my health information.
2. Individual or entity authorized to receive my health information: Primary care physician, referring provider and all other medical providers involved with your care.
3. Purpose for which disclosure is to be made:
   Communication with your medical providers regarding your care.
4. Information to be disclosed:

_X_ Practitioner Summary	_X__ Emergency Room Report	_X__ X-ray Records
_X_ History & Physical Exam	_X__ Laboratory Report	_X__ Consultation
_X_ Office Chart Notes	_X__ Radiology Report	_X__ Rx
_X_ All Medical Records	_X__ Medical Clearance Report	

5. Referring physicians will receive information on care provided following your visits or any other physician you designate.

Designated other Physician:_____

6. Our current policy is to call your home or cell phone for appointment reminders and for follow up medical care. If you do not want us to call your home, please provide us with an alternate plan to contact you. Alternate plan:_____
   _____
7. I understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Paul H Rhee, M., D., F.A.C.S. & David J Archibald, M.D., its employees, and my physician(s) from all liability arising from this disclosure of my health information.
8. I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revocation request.
9. I understanding that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

_____ _____

Signature: Patient or Legal Representative Date Signature of Witness Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of this facility's health care operations. The Notice of Privacy Practices also describes my rights and the facility's duties with respect to my protected health information. The Notice of Privacy Practices is available in the office of Paul H Rhee, M.D., F.A.C.S. & David J Archibald, M.D. located at 2352 Meadows Blvd Suite 290, Castle Rock, CO 80109.

_____

Signature of Patient or Personal Representative

_____

Date