

# AESTHETIC PLASTIC SURGERY AND SKIN CARE CENTER

(215) 572-7744

Patient Information as of \_\_\_\_\_ (enter today's date)  
(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name** \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street & Apt # City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Any restrictions for contacting you?  No  Yes E-mail \_\_\_\_\_

Contact Drivers License # \_\_\_\_\_  
Restrictions: \_\_\_\_\_ (include State)

Age \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

**Patient's Employer** \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Is it okay to call you at work?  Yes  No

Address \_\_\_\_\_  
Street & Suite # City State Zip

**Emergency Contact**  
(Not in your household) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street & Apt # City State Zip

**Primary Health Insurance Company** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

**Insured:** Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Health Insurance Company** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

**Insured:** Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. and myself.

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

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 \_\_\_\_\_

**AESTHETIC PLASTIC SURGERY AND SKIN CARE CENTER  
NOTICE OF PRIVACY PRACTICES**

**Effective Date: February 1, 2010**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**WHO WILL FOLLOW THIS NOTICE?**

This Notice describes the practices of Aesthetic Plastic Surgery and Skin Care Center and the practices that will be followed by all of workforce members who handle your medical information.

**OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION**

Aesthetic Plastic Surgery and Skin Care Center understands that medical information about you and your health is personal. We are committed to protecting medical information about you. We maintain our records and conduct our treatment environment with a goal of providing the highest level of protection for your medical information, while still providing you with the highest level of medical care. This Notice applies to all of the records of your medical care which are received or created by Aesthetic Plastic Surgery and Skin Care Center.

Your other medical treatment providers (e.g., doctors, hospitals, home health agencies, etc.) may have different policies or notices regarding the use and disclosure of your medical information.

This Notice will tell you about the ways in which Aesthetic Plastic Surgery and Skin Care Center may use and disclose medical information about you. Your medical information, also referred to as "protected health information," is that information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health information and related health care services.

In this Notice, we also describe your rights and certain obligations Aesthetic Plastic Surgery and Skin Care Center has regarding the use and disclosure of your protected health information. We are required by law to:

- \* make sure that medical and other information that identifies you (protected health information) is kept private;
- \* give you this Notice of our legal duties and privacy practices with respect to protected health information about you; and
- \* follow the terms of the Notice that is currently in effect.

**USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

By becoming a patient of Aesthetic Plastic Surgery and Skin Care Center, you are giving consent for this practice to use your protected health information for certain activities, including treatment, payment and other health care operations. Sometimes, you may hear these three activities referred to as "TPO."

First of all, we may use and disclose protected health information about you so that Aesthetic Plastic Surgery and Skin Care Center and its medical professionals can treat you. For example, we may use your past medical information in order to diagnose your present condition or we may provide information regarding your medical condition to another doctor to whom we refer you for additional care. We may also use and disclose protected health information about you so that we may be paid for the medical treatment we provide you. For example, we will submit protected health information about you to your insurance company in order to receive payment for services we have provided to you. We may also use and disclose protected health information about you for Aesthetic Plastic Surgery and Skin Care Center's health care operations, in other words, those other tasks that we need to perform to make sure that you are provided the highest quality of medical care. For example, we may use your protected health information to evaluate how we can better meet your needs or we may provide protected health information about you to an auditor who reviews our books so that we can keep our license to provide medical services in **Pennsylvania** .

## **OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

The following uses of your protected health information may be made without any additional authorization from you. (Not every use or disclosure is listed, but be assured that all uses and disclosures made by this practice are only those which are permitted under the law):

### **USES AND DISCLOSURES FOR APPOINTMENT REMINDERS**

We may use and disclose your medical information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing at The Colonade, 100 Old York Road, Jenkintown, PA 19046. We will accommodate all reasonable requests.

### **USES AND DISCLOSURES TO OTHERS INVOLVED IN YOUR HEALTH CARE**

We may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your medical care. If you are unable to agree or object to this disclosure, we may disclose such information as necessary if we determine that it is in your best interests based on our professional judgment. We may also use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and

to coordinate uses and disclosures to family or other individuals involved in your health care.

#### USES AND DISCLOSURES IN EMERGENCY SITUATIONS

We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician will attempt to obtain your acknowledgment of this Notice as soon as reasonably practicable after the delivery of treatment.

#### USES AND DISCLOSURES FOR HEALTH-RELATED BENEFITS OR SERVICES

From time to time, «Practice\_Name» may use and disclose protected health information to tell you about certain health-related benefits or services that may be of interest to you.

#### USES AND DISCLOSURES REQUIRED BY LAW

We will use or disclose protected health information about you when required to do so by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if the law requires us to do so, of any such uses or disclosures. We must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the law.

#### USES AND DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES

We may disclose your protected health information for public health activities and disclosure for such purposes will be to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for purposes such as controlling disease, injury or disability. Disclosures to public health authorities may include disclosure to a foreign authority that is working with the public health authority.

#### USES AND DISCLOSURES RELATED TO COMMUNICABLE DISEASES

We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

#### DISCLOSURES FOR HEALTH OVERSIGHT ACTIVITIES

We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, and inspections. These activities are necessary for the government to monitor the health care system, the delivery of health care, government benefit programs, other government regulatory programs and civil rights laws.

#### DISCLOSURES OF ABUSE OR NEGLECT

We may disclose your protected health information to a public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to a governmental entity or agency authorized to receive such information. In such cases, the disclosure will only be made in accordance with **Pennsylvania** law.

#### DISCLOSURES TO THE FOOD AND DRUG ADMINISTRATION

We may disclose your protected health information to a person or company required by the Food and Drug Administration (FDA) to report adverse events, product defects or other problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements; or to conduct post-market surveillance, as required.

#### DISCLOSURES FOR LAWSUITS AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court order or administrative order. We may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

#### DISCLOSURES TO LAW ENFORCEMENT

We may release protected health information if asked to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons, or similar process. Other related disclosures may include disclosures relating to individuals who are Armed Forces personnel, to national security and intelligence agencies, as well as disclosures to authorized federal officials for the protection of the President of the United States or other authorized persons or foreign heads of state.

#### DISCLOSURES TO CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION

We may disclose protected health information about you to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties required by law. We may also disclose protected health information about you to a funeral director in order to permit the funeral director to carry out legal duties, and may do so if death is reasonably anticipated. Your protected health information may also be disclosed for certain organ donations to which you may have agreed.

#### DISCLOSURES FOR RESEARCH

We may disclose your protected health information to researchers when their research has been approved and protocols have been established to ensure the privacy of your information. We may also disclose a limited set of your information, as allowed under the law, for research purposes.

#### DISCLOSURES RELATED TO CRIMINAL ACTIVITY

We may disclose your protected health information, consistent with federal and **Pennsylvania** laws, if we believe that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, or if it is necessary for law enforcement authorities to identify or apprehend an individual.

#### DISCLOSURES FOR WORKERS' COMPENSATION

We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

## YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

**Right to Inspect and Copy.** You have the right to inspect and copy protected health information that may be used to make decisions about your medical care. Usually this right includes both medical and billing records. You must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. Your request to inspect and copy your information may only be denied in very limited circumstances and you have a right to request that any such denial be reviewed.

**Right to Request Restrictions.** You have the right to request that we restrict the use and disclosure of your protected health information for treatment, payment and health care operations. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to The Colonade, 100 Old York Road, Jenkintown, PA 19046. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

**Right to Confidential Communications.** You also have the right to request to receive private health information communications by alternative means or at alternative locations. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to The Colonade, 100 Old York Road, Jenkintown, PA 19046. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to Amend.** If you feel that the protected health information we have about you is incorrect or incomplete, you have the right to request that your protected health information be amended. Only the health care entity (e.g., doctor, hospital, clinic, etc.) that created your protected health information is responsible for amending it. For more information regarding the procedures for submitting such a request, contact «Practice\_Address1».

**Right to an Accounting of Disclosures.** You have a right to an accounting of disclosures of your protected health information, for purposes other than treatment, payment or health care operations by Aesthetic Plastic Surgery and Skin Care Center or any of the people or companies who perform treatment, payment or health care operations on our behalf. To request this list of disclosures we made of protected health information about you, you must submit a request in writing to The Colonade, 100 Old York Road, Jenkintown, PA 19046 Your request must state a time period which may not be longer than six (6) years prior to the date of your request and may not include dates before April 16, 2003. Your request should indicate the form in which you want the list (for example, on paper or electronically). Aesthetic Plastic Surgery and Skin Care Center MAY WANT TO ESTABLISH REQUIREMENTS FOR PAYMENT FOR LISTS, BECAUSE YOU CAN CHARGE FOR ACCOUNTINGS OF DISCLOSURES.]

**Right to a Paper Copy of this Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time.

- \* You may obtain a copy of this Notice at our website: [www.drcenter.com](http://www.drcenter.com)
- \* To obtain a paper copy of this Notice, contact Dr. Bruce E. Genter.

**To learn more about these procedures, or to make any of these requests, you should contact Dr. Bruce E. Genter, 215-572-7744.**

#### CHANGES TO THIS NOTICE

Aesthetic Plastic Surgery and Skin Care Center reserves the right to change this notice. We reserve the right to make the revised or changed Notice effective for protected health information we already have about you, as well as any information we create or receive in the future. We will post a copy of the current Notice on Aesthetic Plastic Surgery and Skin Care Center's website: [www.drcenter.com](http://www.drcenter.com). The Notice will contain, in the top right-hand corner, the effective date.

#### COMPLAINTS

If you believe your privacy rights have been violated and/or that Aesthetic Plastic Surgery and Skin Care Center has not followed this policy, you may file a complaint with Aesthetic Plastic Surgery and Skin Care Center's Dr. Bruce Genter, or with the Secretary of the Department of Health and Human Services. To file a complaint with Aesthetic Plastic Surgery and Skin Care Center, contact Tammi J Regan, Practice Director at 215-572-7744. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

#### OTHER USES OF PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information not covered by this notice or the laws that apply to Aesthetic Plastic Surgery and Skin Care Center will be made only with your written permission ("authorization"). If you provide us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the medical treatment or other services that we have provided to you.

#### QUESTIONS?

If you have any questions regarding this notice, please contact Tammi J Regan, Practice Director 215-572-7744.

**AESTHETIC PLASTIC SURGERY AND SKIN CARE CENTER  
PATIENT HIPAA 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.

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Signature

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Date

# Contact Authorization

All calls regarding your care, test results and appointments will be made to your home phone. If you would like us to contact you at alternate phone number, please indicate that number here:

#1: (    ) \_\_\_\_\_ #2: \_\_\_\_\_

\_\_\_\_ I hereby authorize this practice to contact me by phone and if I am not present, they **MAY** leave a message on my answering service.

\_\_\_\_ I prefer that this practice **NOT** leave a message if I am not present.

The following people, other than a duly designated guardian or conservator, are authorized to discuss my \_\_\_\_ medical condition and/or \_\_\_\_ billing information with a healthcare professional in this practice:

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Name	Relationship	Phone
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Name	Relationship	Phone
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\* Do you wish this contact authorization to be **indefinite**? \_\_\_\_yes \_\_\_\_no

**If you do not wish this authorization to be indefinite**, please indicate the month, day, and year this authorization will expire. \_\_\_\_\_

Signature \_\_\_\_\_