DERMACARE
COSMETIC SURGERY
Making your Appearance Reflect your Spirit

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ HOME NO. _____

CITY: _____ STATE: _____ ZIP: _____ CELL NO. _____

D.O.B. _____ AGE: _____ SEX: _____ WEIGHT: _____ HEIGHT: _____

EMPLOYMENT: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ WORK NO. _____

E-MAIL: _____

HOW DID YOU HEAR ABOUT US?

GOOGLE, FACEBOOK, REAL SELF, HEALTH & LIVING MAGAZINE, CLIPPER, THUNDERBOLT NEWSPAPER, FRIEND, OTHER; _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____ PHONE NO. _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ALLERGIES - (IF NONE, PLEASE CIRCLE NKDA)

_____

_____

_____

PRIMARY CARE PHYSICIAN: _____ PHONE NO. _____

DO YOU USE NICOTINE PRODUCTS? YES / NO **HOW OFTEN?** _____

MEDICATIONS – DOSE FREQUENCY AND REASON FOR USE:

	MEDICATION	DOSE & HOW OFTEN	REASON FOR USE
1.			
2.			
3.			
4.			
5.			

PREVIOUS SURGERIES/PROCEDURES/TREATMENTS

1.			
2.			
3.			
4.			
5.			

WHAT PROCEDURES, TREATMENTS OR PRODUCTS ARE YOU INTERESTED IN?

SURGICAL PROCEDURES:

[] BREAST AUGMENTATION [] BREAST LIFT / REDUCTION [] TUMMY TUCK [] TICKLE LIPO

[] ARM LIFT [] THIGH LIFT [] BRAZILIAN BUTT LIFT [] FACE/NECK LIFT [] BROW LIFT

[] BLEPH – EYELIDS [] HETTER PEEL [] OTHER: _____

AESTHETIC SERVICES:

[] CHEMICAL PEELS [] MICRODERMABRASION [] FACIALS [] DERMAPLANING

[] THERMI-RF SKIN TIGHTENING [] BLU-U LIGHT TREATMENT [] ECLIPSE MICRO-NEEDLING

[] GENESIS LASER [] FOTO FACIAL [] PEARL LASER [] LASER HAIR REMOVAL [] LASER VEIN REMOVAL

[] TRU-SCULPT TIGHTENING [] PHOTODYNAMIC THERAPY W/LEVULAN

LASER LIGHT THERAPY:

[] TEXTURE / PORES / WRINKLES / SCARS []OTHER: _____

[] FACIAL REDNESS _____

[] BROWN PIGMENT / SUN DAMAGE _____

[] ACTIVE ACNE

[] SPIDER VEINS

[] HAIR REMOVAL

[] SKIN TIGHTENING

INJECTABLES:

[] BOTOX - (FOREHEAD, AROUND EYES, BETWEEN EYEBROWS)

[] JUVEDERM – (NASOLABIAL FOLDS, LIPS)

[] VOLUMA – (CHEEKS)

SKIN CARE:

[] DRY / MATURE [] SENSITIVE

[] OILY / ACNE [] OTHER _____

[] COMBINATION _____

FINANCIAL POLICY

THANK YOU FOR CHOOSING DR. REZA A. ROD, M.D. AS YOUR PLASTIC AND RECONSTRUCTIVE PROVIDER. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY WHICH EACH PATIENT MUST READ AND SIGN PRIOR TO RECEIVING TREATMENT. IN ADDITION, A PATIENT HISTORY NEEDS TO BE COMPLETED BEFORE SEEING THE DOCTOR.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. FOR YOUR CONVENIANCE, WE ACCEPT CASH, CASHIERS CHECKS, AS WELL AS, VISA, MASTER CARD, DISCOVER, AMERICAN EXPRESS CREDIT CARDS. WE ALSO OFFER FINANCING WITH EXTENDED PAYMENT PLANS WITH PRIOR CREDIT APPOVAL.

USUAL AND CUSTOMARY RATES

OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT POSSIBLE FOR OUR PATIENTS AND WE CHARGE WHAT IS USUAL AND CUSTOMY FOR OUR AREA. THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

COLLECTION ACCOUNTS & RETURNED CHECKS

IN THE EVENT THAT YOUR ACCOUNT GOES TO COLLECTION STATUS OR YOUR CHECK PAYMENT DOES NOT CLEAR, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION FEES, INCLUDING BUT NOT LIMITED TO: COURT FEES, LAWYER FEES, COLLECTION AGENCY FEES AND OTHER EXPENSES INCURRED WHILE TRYING TO COLLECT ON YOUR ACCOUNT.

COSMETIC PATIENTS

IF YOU PAY FOR A COSMETIC PROCEDURE YOU MAY NOT SUBMIT IT TO YOUR INSURANCE COMPANY AFTER THE PROCEDURE HAS BEEN PERFORMED. IF YOU HAVE SUBMITTED A REQUEST FOR PRIOR AUTHORIZATION AND IT WAS DENIED AND YOU WANT TO PAY CASH FOR YOUR PROCEDURE, YOU MAY NOT APPEAL THE DECISION TO THE INSURANCE COMPANY AFTER THE PROCEDURE IS PERFORMED YOU WILL NOT BE REIMBURSED ANY PORTION OF THE COSMETIC PROCEDURE FEES YOU PREVIOUSLY PAID.

"I HAVE READ THE FIANCIAL POLICY AND UNDERSTAND AND AGREE TO ALL TERMS DESCRIBES ABOVE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO DR. REZA A. ROD, M.D., PLLC FOR ALL MEDICAL AND SURGICAL CHARGES INCURRED BY ME OR MY DEPENDENTS THAT ARE NOT COVERED BY MY INSURANCE CARRIER." I HAVE READ NOTICE OF THIS ORGANIZATION'S PRIVACY PRACTICES.

PATIENT SIGNATURE **DATE**

NOTICE OF PRIVACY PRACTICES

WE UNDERSTAND THAT INFORMATION ABOUT YOU AND YOUR HEALTH IS PERSONAL. WE ARE COMMITTED TO PROTECTING HEALTH INFORMATION ABOUT YOU. WE CREATE A RECORD OF THE CARE AND SERVICES YOU RECEIVE FROM US, WHICH WE NEED TO PROVIDE YOU WITH QUALITY CARE AND TO COMPLY WITH CERTAIN LEGAL REQUIREMENTS. THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY DR. REZA A. ROD, M.D., WHETHER MADE BY YOUR PHYSICIAN OR ANY EMPLOYEE OF DR. REZA A. ROD. THIS NOTICE WILL TELL YOU ABOUT THE WAYS IN WHICH WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU. WE ALSO DESCRIBE YOUR RIGHTS TO THE HEALTH INFORMATION WE KEEP ABOUT YOU, AND DESCRIBE CERTAIN OBLIGATIONS WE HAVE REGARDING THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION.

WE ARE REQUIRED BY LAW TO:

- ∞ MAKE SURE THAT HEALTH INFORMATION THAT IDENTIFIES YOU IS KEPT PRIVATE
- ∞ GIVE YOU THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU.
- ∞ FOLLOW THE TERMS OF THE NOTICE THAT IS CURRENTLY IN EFFECT.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

- ∞ FOR TREATMENTS
- ∞ FOR PAYMENTS
- ∞ FOR HEALTH CARE OPERATIONS
- ∞ AS REQUIRED BY LAW
- ∞ TO AVERT A SERIOUS THREAT TO HEALTH AND SAFETY
- ∞ AS REQUIRED BY MILATERY OR VETERANS AND WORKERS COMPENSATION
- ∞ PUBLIC HEALTH RISKS
- ∞ HEALTH OVERSIGHT ACTIVITIES
- ∞ LAWSUITS AND DIPUTES
- ∞ LAW ENFORCEMENT
- ∞ CORONERS, HEALTH EXAMINERS AND FUNERAL DIRECTORS
- ∞ NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES
- ∞ PROTECTIVE SERVICE FOR THE PRESIDENT AND OTHERS

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

- ∞ RIGHTS TO INSPECT AND COPY
- ∞ RIGHT TO AMEND
- ∞ RIGHT TO ACCOUNTING OF DISCLOSURES
- ∞ RIGHT TO REQUEST RESTRICTIONS
- ∞ RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS
- ∞ RIGHT TO A PAPER COPY OF THIS NOTICE

CHANGES TO THIS NOTICE:

WE RESERVE THE RIGHT TO CHANGE THIS NOTICE. WE WILL RETAIN A COPY OF THE CURRENT NOTICE IN OUR FACILITY.

COMPLAINTS:

IF YOU BELIEVE THAT YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED YOU MAY FILE A COMPLAINT WITH US. ALL COMPLAINTS MUST BE IN WRITING. PLEASE CONTACT THE OFFICE ADMINISTRSTOR AT THE LOCATION OR DEPARTMENT YOU WERE TREATED TO FILE A COMPLAINT.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE:

WE WILL REQUEST THAT YOU SIGN A SEPARATE FORM ACKNOWLEDGING YOU HAVE RECEIVED A COPY OF THIS NOTICE. THE ACKNOWLEDGEMENT WILL BECOME PART OF YOUR RECORDS.

I HEREBY CONSENT DR. REZA A. ROD, M.D. TO USE MY PROTECTED HEALTH INFORMATION (PHI) FOR THE PURPOSES OF PROVIDING TREATMENT, OBTAINING PAYMENT FOR HEALTH CARE SERVICES, OR FOR THE PURPOSE OF CARRYING OUT HEALTH CARE OPERATIONS. I ALSO CONSENT DR. REZA A. ROD, M.D. TO USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION FOR TREATMENT SERVICES PROVIDED BY ANOTHER HEALTH CARE PROVIDER OR ENTITY.

I FURTHER ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES, WHICH PROVIDES ME WITH A DETAILED DESCRIPTION OF THE USES AND DISCLOSURES ALLOWED BY THIS CONSENT, AS WELL AS OTHER RIGHTS I MAY HAVE REGARDING MY PROTECTED HEALTH INFORMATION.

PATIENT SIGNATURE **DATE**