Scottsdale
PLASTIC SURGEONS

Acknowledgement of Receipt

_____ I acknowledge Scottsdale Plastic Surgeons has provided me a copy of its Patient's Rights and Responsibilities, which include information regarding Advanced Directives and Patient Grievance

_____I acknowledge that Scottsdale Plastic Surgeons has provided me with a Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Scottsdale Plastic Surgeons may use and disclose my protected Health Information. I have reviewed it carefully. I understand that the Notice of Privacy Practices is subject to change.

Signature : _____ Date: _____
(Patient/Parent/Guardian)

Signature: _____ Date: _____
(Scottsdale Plastic Surgeons – Witness)

15757 North 78th Street
Scottsdale, AZ 85260
tel (480) 787-5815 fax (480) 787-5814
www.ScottsdalePS.com

Scottsdale Plastic Surgeons, PLC
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PATIENT INFORMATION FORM

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

DOB: _____ Age: _____ Gender: _____

Social Security Number: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our clinic?

☐ ScottsdalePS.com ☐ Patient Referral: _____ ☐ Insurance Referral: _____
☐ Facebook ☐ Friend: _____ ☐ Dr. Referral: _____
☐ Google ☐ Salon: _____ ☐ Seminar: _____
☐ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Name: _____ Policy #: _____ Group ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Name: _____ Policy #: _____ Group ID: _____

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Assignment and Release

I, test test, have insurance coverage and assign to Scottsdale Plastic Surgeons all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured / Guardian Date

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, **please list**:

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Have you or do you still have:	No	Yes	Description
2. Asthma	☐	☐	
3. Arthritis	☐	☐	
4. Bleeding Tendencies	☐	☐	
5. Cancer	☐	☐	
6. Chronic Lung Disease	☐	☐	
7. Convulsions or Fits	☐	☐	
8. Diabetes	☐	☐	
9. Emphysema	☐	☐	
10. Epilepsy or Seizures	☐	☐	
11. Gout	☐	☐	
12. Heart Disease	☐	☐	
13. Heart Trouble	☐	☐	
14. Hepatitis or Liver Trouble	☐	☐	
15. High Blood Pressure	☐	☐	
16. Kidney Disease	☐	☐	
17. Kidney Trouble	☐	☐	

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18.	Leukemia	☐	☐	
19.	Mental Illness	☐	☐	
20.	Have you ever been advised to or had psychiatric care?	☐	☐	
21.	Migraine Headaches	☐	☐	
22.	Obesity	☐	☐	
23.	Problem Scarring	☐	☐	
24.	Reapeted Infections	☐	☐	
25.	Severe Allergies	☐	☐	
26.	Stroke	☐	☐	
27.	Thyroid Trouble	☐	☐	
28.	Tuberculosis	☐	☐	

29. Others Not Listed: _____

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Current or past recreatioal drug use?
   ☐ No ☐ Yes, If so, explain: _____
3. Do you drink? ☐ No ☐ Yes, how much? _____
4. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Family History

	Have any blood relatives had any of the following?	No	Yes	Description
1.	Cancer	☐	☐	
2.	Bleeding Tendency	☐	☐	
3.	Leukemia	☐	☐	
4.	Heart Disease	☐	☐	
5.	High Blood Pressure	☐	☐	
6.	Repeated Infections	☐	☐	
7.	Chronic Lung Disease	☐	☐	
8.	Tuberculosis	☐	☐	
9.	Asthma	☐	☐	
10.	Severe Allergies	☐	☐	
11.	Kidney Disease	☐	☐	
12.	Arthritis	☐	☐	
13.	Mental Illness	☐	☐	

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14.	Convulsions or Fits	☐	☐	
15.	Migraine Headaches	☐	☐	
16.	Diabetes	☐	☐	
17.	Gout	☐	☐	
18.	Thyroid Trouble	☐	☐	
19.	Obesity	☐	☐	

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

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Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA Information and Consent Form

Patient Name:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, test test, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

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PLASTIC SURGEONS

PATIENT RIGHTS

- To be treated with dignity and respect.
- Receive access to equally medical treatment and accommodations regardless of sex, creed, race, national origin, religion or source of payment.
- Patients have the right to have their treatment of other patient information kept private. Only by law may records be released without patient permission.
- Patients have the right to access care easily and in a timely fashion.
- Be fully informed and have complete information regarding their diagnosis, evaluation, treatment, and prognosis, as well as the risks and side effects associated with treatment or care that is (or fails to be) furnished.
- Exercise their rights without being subjected to discrimination or reprisal & respect for property.
- Voice grievance regarding treatment or care that is (or fails to be) furnished.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse and harassment.
- Receive the care necessary to regain or maintain his/her maximum state of health and if necessary, cope with death.
- Be fully informed of the scope of services available at the Center, provisions for after-hours care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If a patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.
- Make informed decisions regarding his or her care.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his/her own actions including refusal of treatment or not following the instructions of the physician or the Center.
- Approve or refuse the release of medical records to any individual outside of the Center, or as required by law or third party payment contract.
- Express grievances/complaints or suggestions at any time.
- Access to and/or copies of his/her medical record.
- Be informed of the Center's policy regarding Advanced Directives/living wills.
- Be fully informed before any transfer to another Center or organization and ensure the receiving Center has accepted the patient transfer.
- Expect the Center to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.
- Patients have the right to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients have the right to the delivery of services in a culturally competent manner.
- Patients have the right to information about the organization, its providers, services, and role in the treatment process.
- Patients have the right to information about clinical guidelines used in providing and managing their care.

If a patient is adjudged incompetent under applicable state health and safety laws by a court or proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.

If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state laws may exercise the patient's rights to the extent allowed by state law.

PATIENT RESPONSIBILITIES

- To treat those giving them care with dignity and respect.
- To give providers information they need, in order to provide the best possible care.
- To ask their providers questions about their care.

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- To help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- To let their provider know when the treatment plan no longer works for them.
- To tell their providers about medication changes, including medications given to them by others.
- To keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- To let their provider know about their insurance coverage, and any changes to it.
- To let their providers know about problems with paying fees.
- Not to take actions that could harm others.
- To report fraud and abuse.
- To openly report concerns about quality of care.
- To let their providers know about any changes to their contact information (name, address, phone, etc.).
- To understand and help develop plans and goals to improve their health.

ADVANCE DIRECTIVE NOTIFICATION

In the state of Arizona, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Scottsdale Plastic Surgeons respects and upholds those rights.

However, unlike in an acute care hospital setting, Scottsdale Plastic Surgeons does not routinely perform "high risk" procedures. While no surgery is without risk, most procedures performed in this center are considered to be of minimal risk.

Yow will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery.

Therefore, it is our policy that, regardless of the contents of any Advanced Directives or instructions from a health care surrogate or attorney-in-fact, if an adverse event occurs during your treatment at this center, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advanced Directives, or health care Power of Attorney. Your agreement with this Center's policy will not revoke or invalidate any current health care directives or health care power of attorney.

More information on Advanced Directives is available upon request at our Center. Upon request you will be given the opportunity to discuss any of the above information with your surgeon. If you do not agree with this Center's policy, we will be pleased to assist you in rescheduling your procedure.

PATIENT COMPLAINT OR GRIEVANCE

To report a complaint or grievance, you can contact the Practice manager at (480) 787-5815 or by mail:

Scottsdale Plastic Surgeons
15757 N 78th Street, Suite A, Scottsdale, AZ 85260

Complaints and grievances may also be filed at:
AAAHC
5250 Old Orchard Rd. Ste 200
Skokie, IL 60077
847-853-6060

****PATIENT COPY****

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PLASTIC SURGEONS

Photograph and Video Consent

Patient Name:_____ **DOB:**

In connection with the medical services that I am now receiving or have received from my physicians, Dr. Paul Holden and/or Dr. Ryan Tsujimura, I consent to the taking of video images and/or photographs of me or parts of my body, and I authorize publication and disclosure of those photographs and/or video images under the following conditions:

1. The photographs and/or video images are taken only at the request of Dr. Holden/ Dr. Tsujimura.
2. The photographs and/or video images shall be taken by Dr. Holden/ Dr. Tsujimura or by a person approved by him.
3. The photographs and/or video images shall be used for my medical records.
4. The photographs and/or video images, including images of my face or other features that may identify me as an individual, may also be used and disclosed to others for the following purposes, provided, however, that it is specifically understood that in any such publication or use I shall **NOT** be identified by name:

   ☐ For medical education, research, and science, including but not limited to publication in professional journals, professional videos, or medical books;

   ☐ In photo books that are viewed by other patients or potential patients;

   ☐ In Dr. Holden's/ Dr. Tsujimura's office literature, speaking engagements or videos (i.e. consultation and instructional DVDs and booklets);

   ☐ On Dr. Holden's/ Dr. Tsujimura's practice website, social media or other internet based marketing;

   ☐ For public relations purposes, including but not limited to use in Arizona regional newspapers, magazines, brochures, and television appearances.

   ☐ All of the above

   ☐ None of the above

I understand that once the information described in this form has been published or otherwise disclosed for any of the purposes described above, it may no longer be protected by federal privacy regulations.

I understand that this authorization is **voluntary** and that I will not be denied health care if I do not sign this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I can receive a copy of this form after I sign it.

I understand that this consent and authorization will be effective so long as I am a patient of Dr. Holden/ Dr. Tsujimura. However, I understand **that I may revoke this authorization at any time by notifying my physician in writing.**

Signed: _____ **Date:** _____
(If signed by personal representative, include relationship to patient)

Witness: _____ **Date:** _____

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