SAGE PLASTIC SURGERY

International Craniofacial Institute®
CLEFT LIP & PALATE TREATMENT CENTER

Patient Information

Patient Name: ______________________ DOB: ______________ Male / Female

Marital Status: ____________ Occupation: ____________ Employer: ____________

PARENT NAMES/Guardian (*if child*): ______________________________

Relationship: ☐ *Spouse* ☐ *Parent/Guardian* ☐ *Grandparent* ☐ *Other:* ________

Address: ______________________________ Apt #: ____________

City: ____________________ State: ____________ Zip: ____________

Primary Contact: ____________ Phone #: ____________ Home Cell Work

Secondary Contact: ____________ Phone #: ____________ Home Cell Work

Email(s): ______________________________

Emergency Contact: ______________________________ Phone: ____________

Relationship: ☐ *Spouse* ☐ *Parent/Guardian* ☐ *Grandparent* ☐ *Other:* ________

Primary Ins: ____________ **ID#:** ____________ **Grp#:** ____________

Policyholder: ______________________________ DOB: ____________

Secondary Ins: ____________ **ID#:** ____________ **Grp #:** ____________

Policyholder: ______________________________ DOB: ____________

Pharmacy: ______________________________ Phone: ____________

Location: ______________________________

Pediatrician/PCP Name & Phone/Location: ______________________________

____

How were you referred to us? ______________________________

Reason for Consultation/Treatment Requested? ______________________________

____

SIGNATURE: ______________________________ DATE: ____________

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PATIENT NAME:______________________________________

HEALTH INFORMATION:

Height _______Weight _______Date of Last Mammogram: ______
Do you smoke/use Nicotine products? ❒Yes ❒No Do you drink alcohol? ❒Yes ❒No

MEDICAL CONDITIONS:

❒ Diabetes ❒Heart Disease/High Blood Pressure ❒Anemia ❒Depression ❒Blood Clots (DVT)
❒Bruise Easily ❒Arthritis ❒Tuberculosis ❒Blood Clots (DVT) ❒Birth Control ❒Menopause ❒Shingles
❒Hepatitis ❒HIV/AIDS ❒Cancer ❒Thyroid Disorder: under/overactive ❒Asthma ❒Cold Sores

Please list any other medical condition, illness or handicap you may have:____

Current Medications (including aspirin products): ____

ALLERGIES:

Do you have or have you ever had any allergies/sensitivities? ❒Yes ❒No
If yes, please list and give type of reaction:____

PREGNANCY HISTORY:

Have you ever been pregnant?: ❒Yes ❒No Number of children___________

PAST OPERATIONS/TREATMENTS:

Please include ALL surgeries including cosmetic procedures:

Year	Type of Operation/Physician
_______	______________________________________
_______	______________________________________
_______	______________________________________

Have you ever experienced malignant hyperthermia? ❒Yes ❒No

FAMILY HISTORY:

Have any BLOOD RELATIVES had:
(Please list relatives with condition)

Diabetes?	❒Yes	❒No	___________________________
Cancer?	❒Yes	❒No	___________________________
Heart Disease?	❒Yes	❒No	___________________________
Bleeding Disorders?	❒Yes	❒No	___________________________
Cleft/Craniofacial?	❒Yes	❒No	___________________________
Unknown/Adopted	❒Yes		Date of Adoption: _____________

(For Pediatric Patients Only) BIRTH & INFANT HEALTH HISTORY (For Pediatric Patients Only)

-Did you have any illness or problems during your pregnancy?__________________________________
-Was the delivery by C-section? ❒Yes ❒No Birth weight __lbs. ____oz. ❒ Premature; How Many Weeks?_________
-Has your child had any of the following? ❒ Heart Defects ❒ Pneumonia ❒ Meningitis ❒ Cancer ❒ Tonsils/Adenoids out
-Other diseases, conditions or handicaps ____
-Does your children have now, or had in the past, any of the following:

Frequent ear infections?	❒Yes	❒No
5 or more colds/throat infections in the past year?	❒Yes	❒No
Convulsions or seizures?	❒Yes	❒No
Trouble with hearing?	❒Yes	❒No
Dental Problems?	❒Yes	❒No
Trouble feeding or eating?	❒Yes	❒No
-Is your child current on all immunizations?	❒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 manager 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, ____________________________________ 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: _________________________

Patient Authorization for Personal Representative

Purpose of request: I authorize Sage Plastic Surgery/International Craniofacial Institute _ to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, they may exercise my right to inspect, copy and correct my protected health information. They may also consent or authorize the use or disclosure of my protected health information:

____

Name of Personal Representative Phone

____

Address, City, State, Zip

Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) at legal entity authorized to do so by court order or law.

SIGNATURE:____ DATE: _________________________

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Financial & Insurance Policy

PATIENT NAME: ______________________________

All patients must complete our Patient Information Form and inform our office of any changes in address or insurance. In order for us to treat and care for our patients, we must have complete and correct information.

Payment for services rendered is ***due at the time of service***. We accept cash, cashier's checks, MasterCard, Visa, Discover, and American Express. We will be happy to file your insurance if you are a member of an insurance plan in which we are contracted. If a personal check is accepted, there will be a $35.00 service charge for any returned checks.

The charges on your account with our office will reflect ***our*** doctors' fees only. Any hospital, x-ray, laboratory, anesthesia, pathology, etc will be billed by the provider performing the service.

We are committed to providing you with the best possible health care, and we are pleased to discuss our professional fees with you at any time. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies. Please ask if you have any questions about our fees, your responsibility or the financial policy.

We will gladly answer questions regarding your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in your contract. Some insurance companies arbitrarily select certain services they will not cover and these are a patient responsibility.
- If your insurance coverage is through a plan that we are ***not*** contracted with, regardless of your carrier's rate of reimbursement, you will be responsible for the **FULL** balance of your account. This includes any amount over "reasonable and customary".

We *do not* file office visit claims on insurance plans that we do not participate with and you will be responsible for that cost at the time of service. We *will* file all insurance covered surgery claims to your insurance carrier and we will make every reasonable effort to maximize their reimbursement for you. If your insurance coverage is through a plan that we are ***not*** contracted with, a surgery deposit may be required prior to the scheduled surgery date. During the claim process, we may ask you to aid us in the claims payment process.

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

It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, you are encouraged to contact us promptly for assistance in the management of your account.

This form must be signed prior to services being rendered. It will become a part of your permanent record with this office.

"I hereby assign, transfer and set over to the Sage Plastic Surgery/International Craniofacial Institute all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with my current insurance company."

SIGNATURE:____ DATE: ______________________

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Photography Consent

Patient Name: ______________________________

I, ______________________________, consent to the taking of photographs by Sage Plastic Surgery/ International Craniofacial Institute (Dr. Carlos Raul Barcelo, Dr. Huay-Zong Law, Dr. Chelsea Snider or designee) of me or parts of my body in connection with the plastic surgery procedure(s) intended or performed. **I understand that photographs may be taken before, during, and after my procedure(s) as an important and routine part of my medical care and treatment. I further understand that these photographs will be kept strictly confidential as part of the medical chart.**

SIGNATURE:______________________________ DATE: ____________________

Release of Photographs Consent

Additionally, I authorize the use of my photographs in the formats listed below. I waive any right to inspect or approve the finished product, advertising, or other copy that may be used in connection with the options below. I understand that I will **NEVER** be identified by name in any use of these photographs, but that in some circumstances the photographs may portray features which make my identity recognizable. I understand that whenever possible, an attempt will be made to mask my identity using cropping or blocking out of distinguishing features.

(Please initial YES or NO for each of the items below)

_____ YES _____ NO For our **office photo gallery** to help future patients understand and see outcomes from surgery with our physicians.

_____ YES _____ NO On our **website/affiliated websites and/or social media** for prospective patients to see and understand outcomes from surgery with our physicians.

_____ YES _____ NO For **scientific purposes**, including lectures, seminars and medical articles.

I release and discharge Sage Plastic Surgery/International Craniofacial Institute from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs and/or any claims of libel.

I certify that I have read the above Authorization and Release and fully understand its terms.

SIGNATURE:______________________________ DATE: ____________________

**This consent may be revoked at any time with a written consent.*