Dr. Som
AESTHETIC, PLASTIC & RECONSTRUCTIVE SURGERY

PATIENT INFORMATION

Last Name:	First Name:		MI:
Sex (please circle one): ❑ M ❑ F	Marital Status:	Date of Birth:	Age:
Address:	City:	State:	Zip Code:
Home Phone:	Mobile Phone:		
Email Address:	Social Security No:		
Occupation:	Language spoken:		
Employer's Name:	Office Phone:		
Primary Care Physician:	Office Phone:		
Referring Physician:	Office Phone:		
How Did you hear about us: [ ] Google [ ] Friend [ ] Website [ ] Yelp Other:			
PERSONAL INSURANCE INFORMATION – PRIMARY			
Subscriber's Name:	Relationship to Subscriber:		
Insurance:	I.D. Number:		
PERSONAL INSURANCE INFORMATION – SECONDARY			
Subscriber's Name:	Relationship to Subscriber:		
Insurance:	I.D. Number:		
EMERGENCY CONTACT			
Name:	Phone Number:		
Relationship to patient:			

I CERTIFY THE INFORMATION THAT I HAVE PROVIDED IS CORRECT. I UNDERSTAND THAT HONEST AND COMPLETE ANSWERS TO EACH QUESTION ABOVE ARE IMPORTANT TO MY MEDICAL CARE AND I HAVE ANSWERED THEM TO THE BEST OF MY ABILITY. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS TO INSURANCE COMPANIES OR THEIR AGENCIES (INCLUDING MEDICARE), FOR THE PURPOSE OF FILING AND PAYMENT OF MEDICAL CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY BALANCE NOT COVERED BY MY INSURANCE. SHOULD I FAIL TO PAY MY BILL I AM FULL V RESPONSIBLE FOR THE COLLECTION FEE THAT THE PHYSICIAN WILL INCUR. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDES CURRENT RATE. MAY BE CHARGED ON ALL BALANCES OWING TO THE PROVIDER THAT ARE PAST DUE. I HEREBY AUTHORIZE MY PHYSICIAN TO RELEASE MY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY TO EITHER MEDICAL CARE OF IN PROCESSING APPLICATION FOR FINANCIAL BENEFIT. I AUTHORIZE RELEASE OF ALL RECORDS ON REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I PERMIT A COPY OF THIS RELEASE TO THE USED IN THE PLACE OF THE ORIGINAL.

RELEASE OF INFORMATION:

In General, medical information concerning the patient's procedure is treated as confidential by Som K Plastics, its personnel and members of its medical staff. I authorize the Center to release any information for determining coverage to my insurer or other entity responsible to claims payment without my further written consent.

I consent to treatment at Som K Plastics as an outpatient depending on my medical needs. Treatment can include testing (for example, x-rays and tests), routine care and procedures (for example, intravenous fluids or injections), and evaluation (for example, interviews and physical exams). However, this general consent does not include consent for invasive procedures (for example, surgery) or consent for my participation in research. Both circumstances require a separate consent process.

I understand that I may receive treatment given by Som K Plastics employees (such as nurses and technicians) and by physicians and other professionals on Som K Plastics Medical Staff (my attending physician and consultants) who are not Som K Plastics employees.

I understand that I retain no property rights to any tissue samples or bodily fluids removed from my body (specimens) as part of treatment. I further understand that Som K Plastics has no obligation to preserve these specimens; that it will retain or dispose of specimens according to its usual procedures.

I understand that I have the right to ask any questions about a proposed treatment (including the identity of any person providing or observing treatment) at any time. Because medicine is not an exact science and the outcomes of treatment are dependent upon my medical condition, I understand that no guarantees can be made as to the outcome of my care.

ASSIGNMENT OF BENEFITS

I agree to assign any right I may have to receive payment from a health insurance plan or other payor(s) for services rendered by Som K Plastics and the physicians caring for me during my treatment. I understand that I am financially responsible for all balances that are not covered by my health insurance plan or payor, as appropriate, based on the terms of contracts or the law. For example, the payment of non-covered services, deductibles and co-payments are the patient's responsibility. I also understand that I am financially responsible for collection costs should my account become delinquent.

NOTICE REGARDING RELEASE OF HEALTH INFORMATION

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and as further explained in The Wound Center/Som K Plastics Notice of Privacy Practices, The Center may use and disclose medical information to physicians or other providers for the purposes of providing treatment, and to payors for the purposes of payment for medical treatment. I acknowledge the receipt of a copy of Som K Plastics HIPPA Notice of Privacy Practices.

PERSONAL VALUABLES

I understand that Som K Plastics is not responsible for lost personal belongings and valuables and that family members or friends should be asked to take home money, jewelry and clothing or I should request that these items be placed in a safe place (locker). I also understand that I should inform the staff if I have dentures, eyeglasses, contact lenses, prosthetics or other items that I need to retain close by for personal functioning

❑ I have received, read, and understand these instructions:

_____ _____ _____

Print Name **Patient Signature** **Witness Signature**

❑ **Translation was provided for me to understand these instructions by:** _____

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COMPREHENSIVE PATIENT HISTORY

Patient's Name: _____ DOB: _____Height:____Weight:_____Age: _____

What is the main reason for your visit today? (Please describe)

_____
_____
_____

CURRENT LIST OF MEDICATIONS

(Prescriptions and non-prescriptions, including aspirin, ibuprofen, Advil,Aleve, Ecotrin, Vitamins. Please include dosage and frequency).

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Allergies to Food or Medication (including type of reaction):

_____

MEDICAL HISTORY *(please indicate if you have or had any of the following by encircling YES or NO,followed by a brief explanation, including dates).*

Cardiac Disease (Type)	❑ YES	❑ NO	_____
Lung Disease (Type)	❑ YES	❑ NO	_____
Ear or Sinus Issues	❑ YES	❑ NO	_____
Liver Disease / Hepatitis	❑ YES	❑ NO	_____
Kidney Disease	❑ YES	❑ NO	_____
Diabetes	❑ YES	❑ NO	_____
Cancer	❑ YES	❑ NO	_____
Received Chemo or Radiation	❑ YES	❑ NO	_____
Seizure Disorders	❑ YES	❑ NO	_____
High Blood Pressure	❑ YES	❑ NO	_____
Bleeding Disorder / Tendency	❑ YES	❑ NO	_____
Orthopedic Prosthesis / Implant	❑ YES	❑ NO	_____
Cataracts	❑ YES	❑ NO	_____
COPD	❑ YES	❑ NO	_____
Claustrophobia	❑ YES	❑ NO	_____
Thyroid Disease	❑ YES	❑ NO	_____
Gastrointestinal Disorder	❑ YES	❑ NO	_____
Difficulty clearing ears during diving/flying	❑ YES	❑ NO	_____
Other Conditions (specify)	❑ YES	❑ NO	_____
Any planned Surgical / Dental / Eye procedures?	❑ YES	❑ NO	_____

(Women) Pregnant or plan on becoming pregnant? ❑ YES ❑NO Number of pregnancies:____Vaginal Deliveries: ____ C-Sections:_____

SURGICAL HISTORY (please list all operations that you have had and when they were done):

_____

FAMILY HISTORY (please list any family history of cancer, skin, disorders, second or third-degree relatives):

_____

SOCIAL HISTORY (Tobacco use, Alcohol use, Recreational drug use):

Tobacco Use:_____packs per day How many years:_____Previous use:_____

Signature: _____ **Date:** _____
[Signature of insured of authorized person, legal guardian if minor]

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TREATMENT CONSENT FORM

The informed consent process allows you to make an informed decision concerning your health. Your physician can provide you with necessary information and advice, BUT IT IS SOLELY YOUR DECISION WHETHER TO UNDERGO THESE PROCEDURES.

1. I hereby authorize practitioners (physicians, podiatrist, nurse practitioners, and /or physician assistants) of The Wound Center, Inc., and Som K Plastics, and whomever they may designate as their assistants, as well as the facility: Comprehensive Outpatient Surgery Center, LP, to perform wound care and treatments upon me, serially and as necessary, including any of the following:
    a. Evaluation, assessment, treatment and management
    b. Wound debridement as deemed necessary: excisional/non-excisional, selective/non-selective. This includes removing any non-viable/devitalized tissue, down to and including bone.
    c. Incision and drainage procedure and/or amputation
    d. Biopsy of open or closed lesion(s)
    e. Wound closure
    f. Grafts or flaps: allografts (including, but not limited to: placenta, collagen-based, or fish-based) epidermal skin autograft, split-thickness autograft, full-thickness autograft, and/or any flap procedure (including but not limited to: skin, subcutaneous tissue, vascular/nervous tissue, adipose, muscle, tendon, fascia, and /or bone)
    g. Application of negative pressure wound therapy devices
    h. Application/injection of local and/or topical anesthetics for diagnostic and or pain control needs
    i. Recommendations for admission to hospital.
2. The risks and possible complications of standard wound treatment include, but are not limited to: infection, delayed or non-healing wound, pain, failure of the procedure, need for further procedures, temporary and/or permanent dysfunction, loss of limb, loss of life.
3. I acknowledge that I have received no guarantee concerning the outcome of the procedure(s) to which I am consenting.
4. I acknowledge that due to the nature of my condition, there is a chance that serial procedures might be necessary and will be rendered based on my current clinical presentation.
5. I consent to the administration of local anesthetics as necessary both topically and injection.
6. I consent to my laboratory testing deemed necessary
7. I consent to disposal of any tissue or parts, which may be removed during treatment.
8. I consent to the taking of photography and/or videos during any aspect of the treatment visit. This can be used for the following: medical record, billing, educational purposes (including but not limited to training other practitioners, lecturers, and other presentations). I understand that the photos and/or video will be modified so that I cannot be identified in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
9. I certified that I have read and fully understand that the above consent, and that all blank spaces were completed or crossed off prior to my signing. By signing below, I consent The Wound Center to provide medical care and treatment to me as deemed necessary.

Signature_____ **Date** _____
[Signature of insured of authorized person, legal guardian if minor]

Witness_____ **Date** _____

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HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes: how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law; and your rights to access and control your Protected Health Information. "Protected health information" ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, your health plan may require that your relevant PHI be disclosed to the health plan to obtain approval for treatment.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, 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 requirements of Section 164.500

Other Permitted and Required Uses and Disclosures: Other uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights with Respect to Your PHI: You have the right to request a restriction of your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location**. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically. You have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.**

Complaint: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

PRIVACY PRACTICES ACKNOWLEDGEMENT

This sheet is a supplement to the materials provided. Please refer to these handouts for more complete information. I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❑ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ❑ Obtain payment from third-party payers.
- ❑ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this content.

Signature_____ **Date** _____

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OFFICE POLICIES

NOTICE OF PRIVACY PRACTICES:

I acknowledge I have been provided a copy of the "Notice of Privacy Practices" form and have thoroughly read through it. Due to the new **HIPAA Privacy Act**, in order to protect your privacy our office will not mail lab results. If you are in need of a thorough discussion and/or Interpretation of results, a consultation appointment must be scheduled

RESCHEDULING: Keep Follow-up Appointments and Reschedule Missed Appointments.

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him/her the chance to check my condition and my response to treatment. During follow-up appointments, my provider might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

FOLLOWING RECOMMENDATIONS:

I understand that after examining me, my provider may make certain recommendations based on what he/she feels is best for my health. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his/her recommendations so that he/ she may fully inform me of any risks associated with on what he/she feels is best for my health.

FEES:

All fees, and in case of insurance, copays and deductibles, are due at the time of your visit. No exceptions. We accept all major credit cards, as well as cash. Checks are generally not accepted. If the office decides to make a one-time exception and accept a check, and if your check is returned by your bank unpaid, there will be a fee of $35.00 due to be paid by you.

ELECTRONIC COMMUNICATIONS:

I authorize Som K Plastics physician(s), and staff to use electronic methods of communication with me, such as email, voicemail, etc. I understand email may not be a secure method of transmitting information**. If I do NOT agree to electronic communication, I will notify the staff in writing.**

OBTAINING MEDICAL RECORDS:

I authorize Som K Plastics physician(s) and/staff to obtain my prior medical records from other healthcare institutions/providers in order to obtain a complete medical history. This may include hospitals, physicians, nursing homes, emergency rooms, mental health specialists and all appropriate entities who have provided healthcare to me. I also Som K plastics physician(s) and/staff to release my medical records to any other physician or parties involved in my care.

AFTER-HOURS, EMERGENCIES, AND HOLIDAYS:

If at any time you experience a life-threatening emergency, please call 911. Our regular office hours vary from day to day and the physician might not be in the office. Otherwise, you may page the doctor on-call by calling the main office phone number and follow the instructions.

DISCHARGE FROM PRACTICE:

Som K Plastics reserves the right to discharge any patient from the practice that he/she feels is non-compliant, abusive (verbally or physically) towards the staff or physicians. Other potential reasons for discharge from the practice include, but not limited to: repeat no shows, cancellations, tardiness, medication abuse, inappropriate behavior or unpaid balances.

We ask 24-48 hours to process prescription requests and prescription refills.

I have read, understand, and agree to the above.

Signature_____ **Date** _____

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CLIENT EMAIL/PHONE/TEXTING INFORMED CONSENT

You may give permission to your provider to communicate with you by email, phone, and text message (also known as SMS). This form provides information about the risks of these forms of communication, guidelines for email/phone/text communication, and how we use email/phone/text communication. It also will be used to document your consent for communication with you by email, phone, and text message.

Risks for using Email/Texting

The transmission of client information by email, phone and/or texting has a number of risks that clients should consider prior to the use of email, phone and/or texting. These include, but are not limited to, the following risks:

a. Emails, phone calls/voicemails, and text messages can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails sent through their company systems.
e. Emails, phone calls, voicemails, and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Emails, voicemails, and texts can be used as evidence in court.
g. Emails, phone calls, voicemails, and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party

Conditions for the use of Email/Texts

The provider cannot guarantee but will use reasonable means to maintain the security and confidentiality of email, phone, voicemail, and text information sent and received. The provider is not liable for improper disclosure of confidential information that is not caused by the provider's intentional misconduct.

Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Any particular email and/or text will be read and responded to within 24-48 business hours. The provider will respond to text messages, voicemails, and emails Monday-Friday during the hours of 9AM-5PM, unless otherwise specified. Voicemails, text messages, and emails will not be answered outside of these hours or on the weekends/holidays.
b. Email and texting are not appropriate for urgent or emergency situations. If you experience a health emergency, please go to your nearest emergency room and/or call 911.
c. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
d. Email communication will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
f. The provider is not liable for breaches of confidentiality caused by the client or any third party.
g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.
h. Non-face-to-face evaluation and management of services provided by the provider to a client via telephone is subject to billing if initiated by an established client, or guardian of an established client.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of cell phones, email and/or texts between my provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that my provider may impose to communicate with me by email or text. By signing this form, I authorize the provider to send text messages to my cell phone regarding scheduling and treatment. I understand that standard text messaging rates will apply to any messages receive. I also understand that I or the provider may revoke this permission in writing at any time. I agree not to hold the provider liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my cell phone number and or cell provider changes I will inform my provider

❑ I accept and **DO** want to receive text messages
❑ I accept and **DO** want to receive Emails.
❑ **Cell Phone:** _____
❑ **Email Address:** _____

❑ I decline and **DO NOT** want to receive text messages at this time.
❑ I decline and **DO NOT** want to receive Emails at this time.

Client name: _____ **Client signature:** _____ **Date:** _____

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CREDIT CARD ON FILE BILLING AUTHORIZATION

Som K Plastics is offering a secure and convenient method of payment for the portion of services that your insurance does not cover, but for which you are responsible. This would include co-payments, co-insurance and annual deductibles.

Your credit card information will be kept confidential and secure, and payments to your card are processed only after the claim has been filed and processed by your insurance carrier.

I authorize Som K Plastics to capture my credit card information and to charge my credit card as payment for any balance put into the "patient responsibility" as a result of my insurance plan's deductible, co-insurance or co-payment.

I understand and agree that this payment will be processed after the claim is finalized and when we receive a copy of the Explanation of Benefits (EOB) from my insurance plan. Som K Plastics will also provide me with a receipt as proof of payment.

I certify that I am an authorized user of this credit card, and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Print Name: _____ DOB: _____

Cardholders Signature: _____ Date: _____

CREDIT CARD INFORMATION				
Card Type:	❑ Master Card	❑ Visa	❑ Discover	❑ Amex
Cardholder Name (as shown on card):				
Card Number:		Security Code:		Exp Date:
Billing address:			Zip code:	

CREDIT CARD ON FILE BILLING AUTHORIZATION FAQ

Q: What is a deductible?
A: An annual deductible is the dollar amount you must pay out of your own pocketing during your plan year for medical expenses before your insurance begins to pay. For example, if the policy has a $1,000 deductible, you must pay the first $1,000 of medical expenses before your insurance will begin to pay. Your insurance company must receive a claim to process in order to apply balances towards your deductible.

Q: Is my credit card secure?
A: Yes, we keep your credit card info securely within your HIPAA compliant Electronic Medical Record and Billing System in addition to an encrypted payment gateway.

Q: What if I need to discuss my bill?
A: We will always work with you to resolve any issues and will refund you if we have made a billing error. We will only charge the amount that we are instructed by your insurance carrier to collect as part of patient responsibility on your EOB.
If you disagree with how your insurance carrier processed the claim you will need to contact their customer service department directly.