The Plastic Surgery Institute

71949 Hwy 111, Ste 300, Rancho Mirage, CA 92270
Phone (760) 568-2211 Fax (760) 568-3318

Patient Information

Name: _____ DOB: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ SSN: _____

Address: _____City: _____ State: _____Zip: _____

Cell Phone: _____ Email: _____

Marital Status: _____ Occupation: _____

Emergency Contact:_____Phone:_____

Insurance:_____Policy:_____Group:_____

How Did You Find Us?

- ○ *Friend/ Family Member*
- ○ *Staff Member*
- ○ *Instagram*
- ○ *Google*
- ○ *Facebook*
- ○ *Internet Search*
- ○ *Yelp*
- ○ *TikTok*
- ○ *Magazine*

Please list referral name or how you found our office: _____

Reason for your Visit?

Nose & Face	Breast & Body	Med Spa
○ Primary Rhinoplasty	○ Breast Augmentation	○ Botox®
○ Revision Rhinoplasty	○ Breast Lift	○ Dermal Fillers
○ Facelift/ Neck Lift	○ Breast Reduction	○ Laser Treatment
○ Brow Lift	○ Abdominoplasty	○ Microneedling
○ Lip Lift	○ Brachioplasty (Arm Tuck)	○ Medical Grade Skin Care
○ Upper Lids	○ Liposuction	
○ Lower Lids	○ Mommy Makeover	○ Other_____

Please write which procedures you are interested in from list above: _____

What is your ideal timeline for having your procedure(s) completed: _____

Have you consulted with other physicians about the procedure(s) indicated above: ☐ No ☐ Yes

Is this procedure a revision from a previous surgery: ☐ No ☐ Yes

If yes, how many previous surgeries? _____

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure Y____ N____
Heart Attack Y____ N____
Angina/chest pain Y____ N____
Heart bypass surgery Y____ N____
Pacemaker Y____ N____

NEUROLOGICAL

Stroke Y____ N____
Seizures Y____ N____
Dizziness/ fainting Y____ N____
Neurological disorder Y____ N____
Parkinson's Disease Y____ N____
Migraines Y____ N____
Double Vision Y____ N____

PSYCHIATIC

Depression Y____ N____
Anxiety Y____ N____
Psychiatric Care Y____ N____

ENDOCRINE

Diabetes Y____ N____
Graves' Disease Y____ N____
Thyroid Disease Y____ N____
Taken Steroids Y____ N____
Poly Cystic Ovarian Syndrome Y____ N____

HEMATOLOGIC/ONCOLOGIC

Bleeding or clotting disorder Y____ N____
Easy Bruising Y____ N____
Anemia Y____ N____
Sickle Cell Disease Y____ N____
Blood clots in lungs/legs Y____ N____
Chemo or Radiation Therapy Y____ N____

URINARY/REPRODUCTIVE

Kidney Disease Y____ N____
Urinary Disease Y____ N____
Dialysis Y____ N____

If Female, could you be pregnant?

Number of pregnancies_____

Date of last mammogram_____

Last menstrual cycle _____

Heart Failure Y____ N____
Irregular Heartbeat Y____ N____
Heart Murmur Y____ N____
Do you exercise? Y____ N____

RESPIRATORY

Abnormal Chest X-ray Y____ N____
Asthma Y____ N____
Bronchitis Y____ N____
Emphysema Y____ N____
Use a C-PAP Machine?
Recent Chest Infection Y____ N____
Shortness of Breath Y____ N____
At night? On exertion? Y____ N____
Cough - With Sputum? Y____ N____
Sleep Apnea Y____ N____
Y____ N____

MUSCULOSKELETAL

Sciatica Y____ N____
Herniated disc Y____ N____
Arthritis Y____ N____
Rheumatoid Y____ N____
Neck, Back, Arm, Leg numbness/ nerve damage Y____ N____

GASTROINTESTINAL/INFECTIOUS

Hiatal Hernia Y____ N____
Jaundice Y____ N____
Heartburn and or Ulcers Y____ N____
Hepatitis Y____ N____
Cold Sores / HSV Y____ N____
HIV Y____ N____

SKIN

Skin cancer Y____ N____
Melanoma Y____ N____
Staph Infection Y____ N____

EYES

Cataract Y____ N____
Glaucoma Y____ N____
Corrective lens Y____ N____

Health Information

Is there a personal or family history of **genetic disorders** or **anesthetic complications**? ☐No ☐Yes
If yes, please explain_____

Do you have any implanted products or devices such as a pacemaker, insulin pump, pain control device or facial implants including chin and cheeks? If yes, please list:_____

Please list all prior operations or hospitalizations and any complications:

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____
5. _____ Date:_____

Medications & Allergies

Please list ALL medications including weight loss and hormone replacement therapy

Prescriptions, Over the Counter Medicines, Aspirin, Vitamins such as Fish Oil, Flax Seed Oil and St. John's Wort

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list ALL allergies including medication, Latex and adhesives. Describe reactions

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction:_____
4. _____ Reaction: _____

Social Health History

Tabacco Usage:

Are you currently a smoker or ever used tobacco products including vapes or chews? ☐No ☐Yes
If yes, for how long? _____ How often?____

Alcohol Consumption:

☐Never ☐Rare (1-2 drinks a week) ☐Moderate (7-10 drinks a week) ☐Heavy (more than 10 drinks a week)

Did you ever drink heavily in the past? ☐No ☐Yes

Are you feeling hopeless about the present/future? ☐No ☐Yes

Do you currently have thoughts of harming yourself? ☐No ☐Yes

I, the undersigned, certify that I (or my dependent) have insurance coverage with the company specified above and assign directly to The Plastic Surgery Institute all insurance benefits, if any, otherwise payable to me for services rendered, and I understand that he is not a member of my health insurance company. 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 insurance submissions.

Signature of Insured/Guardian Date

Photography Consent

I understand that photographs must be taken of me in order for any treatments or medical grade skin care products to commence. I understand that photographs are required and will be taken before, during and after my procedure as part of my medical care and to document the aesthetic process.
I further understand that these photographs will be kept strictly confidential in compliance with HIPAA laws.

Initial____

Refund Policy

I understand that *The Plastic Surgery Institute* has a zero-refund policy. We do not offer guarantees for results from any of the services that *The Plastic Surgery Institute* offers such as, but not limited to surgical procedures, Botox, dermal fillers, laser, microneedling, PRP, or skin care/ skin care products.

Initial____

Cancellation Policy

In addition, I am aware that a 24-hour cancellation policy exists. If I do not cancel my appointment within the time frame I agree to pay a missed appointment fee of $100.00.

Initial____

Release

I certify that the above information is correct to the best of my knowledge. I will not hold the staff of The Plastic Surgery Institute responsible for any errors or omissions that I may have made in the completion of this form and I acknowledge that I have received the Notice of Privacy Practices.

Initial____

Patient Signature Date

Reviewed By Date

Notice of Privacy Practices

To our patients –

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy -

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances –

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement officer.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To a federal official for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information –

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychological notes. You must submit your request in writing to the Surgery Center.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to The Surgery Center. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact The Plastic Surgery Institute (760-568-2211). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for used and disclosures that are not identified by this notice or permitted by applicable law.

Notice of Privacy Practices

I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices by The Plastic Surgery Institute.

Name of Patient (Please Print) _____

Signature of Patient_____Date_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical practice, that as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim in the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdiction limit of the small claims court against the physician, and the physician' partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joidner in this arbitration of any person or entity which would otherwise be a proper addition party in a court action, and upon such intervention and jodiner any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 333.1 and 333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in
one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a
civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim
in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly
provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services. _____Patient or Patient's Representatives Initials _____

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATOIN AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:The Plastic Surgery Institute DATE_____

Print Patient's Name_____

Patient's Signature _____ DATE_____

Signature of Translator (if applicable) _____ DATE_____

Telehealth/ Telemedicine Informed Consent

Telemedicine/ Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care.

Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Patient medical records · Medical images · Live two-way audio and video ·

Expected Benefits: Improved access to medical care, faster communication with necessary healthcare providers. More efficient medical evaluation and management. ·

Possible Risks: As with any medical procedure, there are potential risks associated with the use of telemedicine/ telehealth. These risks include, but may not be limited to: · In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s); Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information; ·In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine/ telehealth, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine/telehealth during my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine/ telehealth interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Alternatives have been explained to my satisfaction.
5. I understand that telemedicine/ telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my doctor of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine/ telehealth in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding telemedicine/ telehealth, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize The **Plastic Surgery Institute/ Mirage Surgery Center** to use telemedicine/ telehealth in the course of my diagnosis and treatment.

Patient's Signature_____ **Date**_____

___ **I have been offered a copy of this consent form**