



Important Information – Please Read Entirely

This new patient paperwork must be filled out and returned to our office **before** the doctor can see you. **All** forms must be signed. If you have any concerns regarding signing any of the forms you may call the office and we will be happy to answer any questions. You may return to paperwork to our office prior to the time of your appointment, or you may bring it in with you at the time of your appointment. We do not advise scanning the paperwork and emailing it to us as there is always a security risk attached to divulging personal information via email. We must have the paperwork filled out completely at the time of your appointment or your appointment will need to be rescheduled.

Please make sure to arrive at the appointed time shown on the letter accompanying the new patient paperwork and bring along a current medication list, driver's license or picture ID and your insurance card.

If you **cannot** keep your appointment it must be cancelled 24 hours prior to your appointment time, if this is not done it may be considered a failed appointment and you may be charged \$40.00. We realize that illness can strike at any time and allowances for that will be made, however, the sooner we are aware that you will not be keeping your appointment the better, as your appointment can then be made available to patients who are on a waiting list.

Insurance co-pay or cosmetic consultation fee is due at the time of service and is payable by cash, check, Visa, MasterCard or American Express. There will be a \$25.00 charge for returned checks. You are responsible for your co-pay, deductible and any non-covered services.

Thank You,

Northstate Plastic Surgery



Nearest relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Whom may we thank for referring you to us? _____

If not referred, how did you hear of us? _____

IN CASE OF EMERGENCY:

Whom may we contact in case of an emergency? _____ Phone: _____

What is your relationship to this person?

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for Northstate Plastic Surgery for any services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status on the above information.

Patient Signature: _____ Date: _____

Parent Signature (if patient is a minor): _____ Date: _____



HISTORY INTAKE FORM

Name: _____ Birth Date: _____ Sex: _____ Age: _____
Spouse/Significant Other: _____ Home Phone #: _____
Primary Care Physician: _____
Employed (Occupation): _____
(Please Circle) Left or Right Handed
Chief Complaint (List all symptoms/reasons for the procedure or surgery): _____

Medical History (Please check all that you have had) No Medical Problems

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Herniated Disc |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Impaired Hearing | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chronic Back Pain |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Impaired Vision | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures | <input type="checkbox"/> Transfusions | <input type="checkbox"/> Clotting Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Vascular Disease | | |
-

Surgical History (Please check all that you have had and THE YEAR THEY TOOK PLACE)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Bowel Surgery |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Carpal Tunnel Release | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> D & C |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Exploratory Surgery | <input type="checkbox"/> Foot Surgery | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Renal Surgery | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Prostate Surgery |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Vascular Surgery | <input type="checkbox"/> Other | |
-

Anesthesia:

General _____ Local _____ Any adverse reactions? Yes _____ No _____
If yes, explain _____

REVIEW OF SYSTEMS: Do you now or have you had within the past year:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Weight Change | <input type="checkbox"/> Swollen Feet/Ankles | <input type="checkbox"/> Seizures | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Joint Muscle Pain | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Chronic Diarrhea |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Swollen Lymph Nodes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Easy Bleeding |
| <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Depression | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Ears, Nose Throat Problem | | |
| <input type="checkbox"/> MRSA | | | |
-

Social History (Please check all that apply)

Tobacco use Y N How Much _____ Years of use _____ Quit _____
 Alcohol use Y N How Much _____ Years of use _____ Daily Y N
 Do you use recreational drugs of any sort? _____

Have you ever been diagnosed with Mental Illness Y N

Depression Anxiety Emotional instability Substance Abuse Bipolar PTSD
 Schizophrenia Other _____

Treatment received: _____



Drug Allergies:

- | | | | | |
|-------------------------------------|---|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Ace Inhibitors | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cephalosporins | <input type="checkbox"/> Cipro |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Compazine | <input type="checkbox"/> Demerol | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Elavil |
| <input type="checkbox"/> Flagyl | <input type="checkbox"/> Hormones | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Morphine | <input type="checkbox"/> NSAIDs |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Phenergan | <input type="checkbox"/> Reglan | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Tegretol |
| <input type="checkbox"/> Toradol | <input type="checkbox"/> Valium | <input type="checkbox"/> Vasotec | <input type="checkbox"/> Vicodin | <input type="checkbox"/> Other _____ |

Other Allergies:

- | | | | | |
|--|--------------------------------------|--|---------------------------------------|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> All Tapes | <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Elastic Tape | <input type="checkbox"/> Foam Tape |
| <input type="checkbox"/> Non Specific Tape | <input type="checkbox"/> Paper Tape | <input type="checkbox"/> Plastic Tape | <input type="checkbox"/> Silk Tape | <input type="checkbox"/> Animals |
| <input type="checkbox"/> Betadine | <input type="checkbox"/> Feathers | <input type="checkbox"/> Grasses | <input type="checkbox"/> House Dust | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Molds | <input type="checkbox"/> Plastic | <input type="checkbox"/> Pollen | <input type="checkbox"/> Seasonal |
| <input type="checkbox"/> Soap | <input type="checkbox"/> Other _____ | | | |

Family History

Have any blood relatives ever had the following:

- | | | | |
|--|--|-----------------------------------|---|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer | <input type="checkbox"/> AIDS or HIV |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Clotting Disorders |
- Complications with Anesthesia? Type of anesthesia: _____

Member	Alive	Deceased	Age	Health Status or Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____

Medications (Please list all prescriptions and over the counter medications)

NAME	DOSAGE	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Do you take St. Johns Wort? Yes No
 Do you take Echinacea? Yes No
 Do you take other herbal medicines? Yes No If Yes, Please list:

I verify that the above information is true and accurate to the best of my knowledge.

Signature of Patient, or Parent if Minor

Date



Name: _____

Date: _____

Service Menu

Please let us know if you would like more information on any of the following:

Injectables & Fillers

- Botox
- Juvederm
- Voluma
- Fat Injections
- Sculptra

Facial Procedures

- Facelift
- Cheek Augmentation
- Chin Augmentation
- Ear Surgery
- Eyelid Surgery
- Facial Implants
- Brow Lift
- Lip Augmentation

Body Contouring

- Arm Lift
- Buttock Augmentation
- Liposuction
- Mommy Makeover
- Lower Body Lift
- Tummy Tuck

Breast Enhancements

- Breast Augmentation
- Breast Implants
- Breast Lift
- Breast Reduction
- Breast Revision

Non-Invasive Treatments

- Vaginal
Rejuvenation/Tightening

Other Services

- Coolsculpting

Other: _____

How did you hear about us? _____



ELIGIBILITY CERTIFICATION

I _____, CERTIFY THAT I AM ELIGIBLE FOR HEALTH BENEFITS UNDER
Patient's Name

Name of Insurance Company

EMPLOYER: _____

SOCIAL SECURITY #/ID#: _____

I AM AWARE THAT IF THE ABOVE NAMED PLAN AND COVERAGE IS NOT TRUE AND ACTIVE, I SHALL BE RESPONSIBLE FOR ALL CHARGES RELATED TO SERVICES PROVIDED TO ME AND WILL PAY ALL CHARGES IN FULL.

I AM ALSO AWARE THAT ALTHOUGH MY INSURANCE COMPANY MAY HAVE AUTHORIZED A PROCEDURE IT DOES NOT GUARANTEE PAYMENT AND ULTIMATELY I AM RESPONSIBLE FOR THE SERVICES PROVIDED TO ME.

Signature of Patient or Responsible Party: _____

Printed Name of Signatory: _____

Date: _____

Emily C. Hartmann, M.D.

Kevin D. Myers, M.D.



MEDICAL RELEASE AND FINANCIAL POLICY

1. Release of Information: I hereby authorize the physicians of Northstate Plastic Surgery to furnish to my insurance company any and all information regarding my medical condition that is necessary to process my medical claims and/or obtain authorization for services. I also authorize the physicians of Northstate Plastic Surgery to release any information necessary to other testing or medical facilities in order to schedule or perform prescribed medical testing.
2. Assignment of Benefits: I hereby assign to the physicians of Northstate Plastic Surgery all payments to which I am entitled to for medical and/or surgical expenses related to the services rendered. This assignment will remain in effect until revoked by me in writing.
3. Refund of Payment: It is understood that any money received from my insurance company or companies over and above my indebtedness will be refunded to the appropriate insurance party. Any overpayment by me will be refunded to me, with the **exception of cosmetic surgeries. If I cancel my procedure at least two weeks in advance I will receive a full refund, if cancelled one week in advance I will receive a refund of half the amount paid, if cancelled later than one week in advance there will be no refund to me.**
4. Private Insurance: I agree to pay my co-payment or agreed percentage of services rendered according to my insurance policy at the time of service. Any remaining balances will be paid by me within one month of services rendered by the physicians of Northstate Plastic Surgery. I also take responsibility for any balance left over if the physicians of Northstate Plastic Surgery are not a contracted provider for my insurance.
5. Medicare Patients: I agree to pay the remaining balance after Medicare pays for the services rendered by the physicians of Northstate Plastic Surgery. I understand that such remaining balance is required by law to be passed on to Medicare patients.
6. **THERE WILL BE A \$40.00 MISSED APPOINTMENT FEE IF NOT CANCELLED WITHIN 24 HOURS, THE ONLY EXCEPTION WOULD BE IF THE APPOINTMENT WAS CANCELLED DUE TO ILLNES AND THE OFFICE WAS NOTIFIED THE DAY OF THE APPOINTMENT**
7. **THERE MAY BE A CHARGE FOR ANY FORMS THAT NEED TO BE FILLED OUT BY OUR OFFICE.**
8. Validity: A photocopy of this assignment is to be considered as an original.

Patient Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Relationship of Guardian to Patient: _____



PATIENTS' RIGHTS AND RESPONSIBILITIES

Patients' rights and responsibilities are written, acknowledged by all staff, and posted in a common area. Patients' rights shall include, but not be limited to:

1. Exercise these rights without regard to sex or cultural, economic, educational, or religious background, or the source of payment for care.
2. Patients are given equitable, unbiased, considerate, and respectful care.
3. Patients are provided appropriate privacy regarding medical records and during examinations, treatment, and consultation. Any medical information will not be released without the patient's written consent. The patient has the right to be advised as to the reason for the presence of any individual.
4. Receive as much information about any proposed treatment or procedure as the patient may need in order to give description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment, and the risks involved in each.
5. Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment.
6. Patients, prior to treatment, are informed of their financial responsibility regardless of source of payment.
7. Patients have the ability to have their complaints addressed, and to receive an appropriate response.
8. Reasonable continuity of care and to know in advance the time and location of appointment as well as the identity of persons providing care.
9. Be informed of continuing health care requirements following discharge.
10. Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
11. THIS OFFICE DOES NOT HONOR ADVANCED DIRECTIVES.

PATIENT RESPONSIBILITY

The patient and family have the responsibility to provide, to the best of their knowledge, accurate and complete information about:

- Present complaints and current/chronic illnesses.
- Past illnesses and hospitalizations.
- Past and present medications and relevant immunizations.
- Allergies including medications, foods, etc.
- All other information related to past and present health.

The patient and family are responsible for:

- Reporting unexpected changes in his or her condition to the physician.
- Understanding of the contemplated course of action and what is expected of them.
- Identification of specific concerns with compliance, special needs, and limitations.

COMPLIANCE WITH INSTRUCTIONS

The patient is responsible for:

- Following the treatment plan recommended by the primary physician who is responsible for his care, including instructions of nurses and other allied health personnel as they carry out the coordinated plan of care.
- Implementing the responsible physician's plan of care.
- Arranging for discharge/transfer from facility.
- Keeping and/or canceling appointments with the physicians or facility in a timely manner.
- Arranging and paying for transportation when discharged.

The patient is responsible for all outcomes if he/she refuses treatment or does not follow any treatment or instructions as prescribed by the physician.

I have read and understand this form.

Signature: _____

Date: _____



NOTICE OF PRIVACY PRACTICE

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.

Northstate Plastic Surgery Associates, Inc. is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, effective March 23, 2017.

Northstate Plastic Surgery Associates, Inc.
1260 East Avenue, Suite 100
Chico, CA 95926
(530) 345-5900
Privacy Official: Practice Manager

We will use your health information for treatment: For example: Information obtained by your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent health care provider with copies/email of various reports that should assist him or her in treating you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations. Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Specialized government functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Coroners/Funeral Directors: We may disclose health information to funeral directors/coroners consistent with applicable law to carry out their duties.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing and controlling disease, injury, or disability.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Your Health Information Rights: Although your record is the physical property of Northstate Plastic Surgery Associates, Inc., this information belongs to you. You have the rights to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522,

It is a requirement that the above requests be in writing.

We are not required to agree with all of your requests.

It is the policy of this medical practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California law.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

Should our information practices change, we will notify you on your next visit.

We will not use or disclose your health information without your written authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received written revocation of the authorization according to the procedures included in the authorization.

Complaints: Complaints about this notice or how this medical practice handles your health information should be directed to the Privacy Officer listed above. If you are not satisfied with the manner in which this office handles complaints, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg. 200 Independence Ave., S.W.
Room 509f HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Este aviso está disponible en español en la recepción.



ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that a copy of the current notice of Privacy Practices has been posted in the reception area and a copy will be given to me if requested.

Patient name: _____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

____ Parent or guardian of minor patient

____ Guardian or conservator of an incompetent patient

____ Beneficiary or representative of deceased patient

Please list any individual(s) that you consent that our practice may contact to discuss your health information, treatment, payment/billing questions and health care options.

1. _____ relationship: _____

2. _____ relationship: _____

3. _____ relationship: _____

4. _____ relationship: _____