**Welcome to Northstate Plastic Surgery**! Here are a few important things to know prior to your appointment:

Please bring this completed packet with you to your appointment. If you are unable to complete this packet prior to your appointment, please arrive 30 minutes early. If your paperwork is not completed prior to your appointment time, your appointment may be rescheduled.

Please make sure to arrive at the appointed time and bring a current medication list, driver's license or picture ID and your insurance card. It's always a good idea to bring any past medical records that relate to your visit.

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. There will be a $40.00 missed appointment fee if not cancelled within 24 hours. If you cancel your cosmetic consultation appointment with two weeks' notice your fee will be refunded.

Insurance co-pay is due at the time of service and is payable by cash, check, Visa, MasterCard or American Express. The cosmetic consultation fee is $100 and is due prior to your appointment, this fee will be applied to your surgery should you be a candidate.

Thank You,

Northstate Plastic Surgery

NORTHSTATE
PLASTIC SURGERY

# PATIENT INFORMATION FOR MEDICAL RECORDS

Patient's Name: ____________________________________________________________Date: ______________
First Middle Last

Home Phone:________________________________Cell Phone:_________________________________________

Date of Birth: _______________Age:____________ Email Address: _____________________________________

Soc Sec #: ____________________ R or L Handed (circle one) Marital Status: S M W D (circle one)

Home Address: ______________________________ City:____________________ State: _____ Zip: _________

Mailing Address: _____________________________ City:____________________ State: _____ Zip: _________

Primary Care Physician: ______________________ Pharmacy: _______________ Street/City: _____________

**Email Communication:** Patient Care Items: Yes _____ No _____ Specials/News: Yes _____ No _____

**Race:**
Please circle one: American Indian or Alaska Native - Asian - Native Hawaiian/Other Pacific Islander -

Black or African American - White - Hispanic - Other Race - Other Pacific Islander -

Unreported/Refused to Report

**Ethnicity:**
Please check one: Hispanic or Latino ___ Not Hispanic or Latino ___ Refused to Report ___

First Language__________________________________________________________________

**Employment Information:**

Your employer: __________________________________________ Occupation: ___________________________

Business Address: ______________________________________ City:______________State: _____ Zip:__________

Business Phone: ______________________ Is this a work injury? Yes _____ No _____ Date of Injury: ____________

Spouse's Name: ______________________________ Date of Birth: ________________ Soc Sec:_______________

Spouses Employer: ____________________________ Address: ____________________ Work Ph:_______________

**INSURANCE INFORMATION:**

Primary Insurance: ________________________________________Insurance ID: __________________________

Secondary Insurance:_____________________________________Insurance ID: __________________________

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? _________________________________

Do you have a designated Surrogate Decision Maker? Yes___ No___ If Yes, Name:____________________________

***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:________________________

PATIENT PHOTOGRAPHS

Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Northstate Plastic Surgery Associates. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Northstate Plastic Surgery Associates.

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the Northstate Plastic Surgery Associates staff.

We may ask for use of your photos for other Media postoperatively; you are under no obligation to permit us to use those.

Patient or Guardian Signature:______________________________________________________ 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

__Asthma
__Fainting Spells
__Cirrhosis
__Herniated Disc
__Pneumonia
__Impaired Hearing
__Hepatitis
__Chronic Back Pain
__Bronchitis
__Parkinson's Disease
__Ulcers
__Osteoporosis
__Emphysema
__Impaired Vision
__Hiatal Hernia
__Skin Disease
__Cardiac
__Spinal Cord Injury
__Bleeding Tendencies
__Chemotherapy
__Blood Clots
__Head Injury
__Anemia
__ Thyroid
__Heart Disease
__Migraine Headache
__Diabetes
__Dialysis
__Hypertension
__Seizures
__Transfusions
__Clotting Disorder
__Cancer
__Stroke
__Arthritis
__ Other
__Glaucoma
__Vascular Disease

_____________________________________________________________________________________________

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

__None
__Appendectomy
__Back Surgery
__Bowel Surgery
__C-Section
__Carpal Tunnel Release
__Gall Bladder
__D & C
__Eye Surgery
__Exploratory Surgery
__Foot Surgery
__Heart Surgery
__Hernia Repair
__Hysterectomy
__Joint Replacement
__Mastectomy
__Renal Surgery
__Tonsillectomy
__Tubal Ligation
__Prostate Surgery
__Vasectomy
__Vascular Surgery
__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:

__Weight Change
__Swollen Feet/Ankles
__Seizures
__Dry Eyes
__Skin Rash
__Joint Muscle Pain
__Chronic Cough
__Chronic Diarrhea
__Chest Pain
__Swollen Lymph Nodes
__Jaundice
__Easy Bleeding
__Rapid Heart Beat
__Depression
__Easy Bruising
__High Blood Pressure
__Hepatitis A, B, C
__Ears, Nose Throat Problem ________________________________________
__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:

| | | | | |
|---|---|---|---|---|
| __None | __Ace Inhibitors | __Aspirin | __Cephalosporins | __Cipro |
| __Codeine | __Compazine | __Demerol | __Dilantin | __Elavil |
| __Flagyl | __Hormones | __Ibuprofen | __Morphine | __NSAIDs |
| __Penicillin | __Phenergan | __Reglan | __Sulfa | __Tegretol |
| __Toradol | __Valium | __Vasotec | __Vicodin | __Other_______ |

_ Other Allergies:

| | | | | |
|---|---|---|---|---|
| __None | __All Tapes | __Adhesive Tape | __Elastic Tape | __Foam Tape |
| __Non Specific Tape | __Paper Tape | __Plastic Tape | __Silk Tape | __Animals |
| __Betadine | __Feathers | __Grasses | __House Dust | __Iodine |
| __Latex | __Molds | __Plastic | __Pollen | __Seasonal |
| __Soap | __Other ______________________ | | | |

Family History

Have any blood relatives ever had the following:

| | | | |
|---|---|---|---|
| __Breast Cancer | __High Blood Pressure | __Diabetes | __Stomach Ulcer |
| __Heart Disease | __Depression | __Stroke | __Rheumatic Fever |
| __Tuberculosis | __Glaucoma | __Cancer | __AIDS or HIV |
| __Arthritis | __Thyroid Disease | __Anemia | __Bleeding Disorders |
| __Asthma | __Kidney Disease | __Melanoma | __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: _________________

NORTHSTATE
PLASTIC SURGERY

## 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 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.

1260 East Avenue, Suite 100 • Chico, CA 95926 • 530·345-5900 *phone* • 530·345-5995 *fax*

# 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. 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.

4. 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.

5. Cosmetic Consultations: There will be a non-refundable $100 cosmetic consultation fee charged at the time of booking. If you are a candidate for surgery, this amount will be credited towards your surgical procedure.

6. Cancellation policy: 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 illness and the office was notified the day of the appointment. If you cancel your cosmetic consultation appointment with two weeks' notice your fee will be refunded.

7. Forms: There may be a charge for any forms that are filled out by our office.

8. There will be a $25 charge for returned checks.

9. 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. Refunds can take up to 30 days to be processed.**

10. 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 plant 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: ____________________