NORTHSTATE
PLASTIC SURGERY

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

Preferred 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: _____

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? _____

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:_____

NORTHSTATE
PLASTIC SURGERY

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 Yes or No)
____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: _____

NORTHSTATE
PLASTIC SURGERY

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? _____

NORTHSTATE
PLASTIC SURGERY

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*

NORTHSTATE
PLASTIC SURGERY

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/reschedule my procedure at least two weeks in advance I will receive a full refund, if cancelled/rescheduled one week in advance I will receive a refund of half the amount paid, if cancelled/rescheduled 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:_____

NORTHSTATE
PLASTIC SURGERY

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:_____

NORTHSTATE
PLASTIC SURGERY

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.

NORTHSTATE
PLASTIC SURGERY

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: _____