PACIFIC HEIGHTS PLASTIC SURGERY

JONATHAN L. KAPLAN, M.D., M.P.H., F.A.C.S.
AESTHETIC AND RECONSTRUCTIVE SURGERY

Name: (Last)_____(First)_____ (MI)_____ Date: _____

Address:_____City:_____Zip:_____

Marital status: S M WID DIV Birthdate:_____/_____/_____ Sex: M / F

NEW patient / RETURNING patient Allergies:_____ Smoking: Y N Alcohol: Y N

Medications:_____

Please put a check next to your preferred primary contact:

[ ] Email:_____ [ ] Work Phone #:_____

[ ] Cell Phone #:_____ [ ] Home Phone #_____

Occupation:_____ Employer:_____

Employer Address:_____

In Case of Emergency Contact: _____

Phone #_(_____)_____Relationship:_____

Primary Physician: _____

Phone #: (_____)_____Address:_____

Referred By:_____May we thank them? [ ] Yes [ ] No

Internet Source: [ ] Google [ ] Yahoo [ ] Yelp [ ] BuildMyBod
Today I would like to learn more about (Please write in the procedure(s) of interest):_____

_____

My time frame for surgery is (circle one):

As soon as possible 1 - 3 months 6 - 12 months I have not yet decided

My estimated budget for surgery is:

[ ] Estimate $ _____ to $_____ [ ] I would like to learn about financing options [ ] Undecided

Email Policy: Dr. Kaplan is happy to communicate with you via email when you have questions or concerns. If you initiate email correspondence rather than the alternative of talking to Dr. Kaplan by phone, you accept the risks of using unsecure email accounts, which could result in the intercepting of protected health information (PHI) by unaffiliated parties. By signing below, you are stating that you've been notified of the risks, benefits and alternatives of email correspondence.

Signature: _____

2100 WEBSTER STREET, SUITE 429 - SAN FRANCISCO, CA 94115 - TEL: (415) 923-3005 - FAX: (415) 520-2299

Arbitration Agreement

ARTICLE 1

It is understood that any dispute as to medical malpractice, that is, 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 or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional 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

a. Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "Provider" as used in this Agreement includes the undersigned doctor, nurse practitioner, nurse midwife, or other health care provider and his or her professional corporation or partnership, and any employees, agents, successors-in-interest, heirs, and assigns of the foregoing individuals or entities. The provider signing this Agreement signs it on behalf of all the foregoing individuals and entities, and intends to bind each of them to arbitration to the full extent permitted by law.

b. Treatment Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Provider and Patient will be subject to compulsory, binding arbitration.

c. Other Providers (If Applicable). Patient understands that he or she may at times receive treatment from one or more health care providers who take call for, render medical services by arrangement with, or otherwise substitute for the undersigned Provider. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such health care providers will also be subject to compulsory, binding arbitration.

d. Coverage of Prenatal Claims (If Applicable). Patient understands and agrees that, if Provider treats her during pregnancy, any dispute of the sort described in Article 1 as to medical treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

ARTICLE 3

a. Informal Resolution of Disputes. In the event Patient feels that an issue has arisen in connection with the medical care rendered by Provider, Patient will promptly notify Provider so that the parties may have an opportunity to resolve the matter informally.

b. Method of Initiating Arbitration. If the issue cannot be resolved informally, Patient may initiate arbitration by sending a written demand to the Provider briefly describing the nature of his or her claim. Patient and Provider shall each designate an arbitrator to act as their respective party arbitrators. If more than two parties participate in the arbitration, parties aligned with Patient shall select one party arbitrator, and parties aligned with Provider shall select the other party arbitrator. The two party arbitrators shall select a third person to serve as a neutral arbitrator, and the decision of the three arbitrators shall be final and binding upon the parties.

c. Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P. 1280-1296). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California which shall apply to the same extent as if the dispute were pending before a superior court of this State.

d. Interpretation of Agreement. If any part of this Agreement is held unenforceable, it shall be severed and shall not affect the enforceability of the remainder. This Agreement supersedes and replaces any previous arbitration agreement between Provider and Patient and applies to all care previously rendered by Provider to Patient.

ARTICLE 4

a. Rescission. Once signed, this Agreement governs all subsequent medical services rendered by Provider to Patient until or unless rescinded by written notice within 30 days of signature. Written notice may be given by a guardian or conservator of Patient if Patient is incapacitated or a minor.

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

Patient's Name *(Please Print)*: _____

Dated: _____ Signed: _____

Provider's Name *(Please Print)*: _____

Dated: _____ Signed: _____

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Compliance Assurance Notification

To our Valued Patients:

We want you to know we take the protection of your Personal Health Information (PHI) very seriously. We want you to know all of our employees; managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help up prevent any inappropriate use of PHI and we welcome your input regarding any service problems, so that we may remedy the situation promptly.
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Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain patients' consents for uses and disclosures of health information about the patient to carryout treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or healthcare operations, in order to provide health care that is in your best interest.

We also want you to know that we support full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entitles are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Thank you,
Jonathan Kaplan, M.D., M.P.H., F.A.C.S. and Staff

Print Name:_____Signature:_____Date:_____

2100 Webster Street, Suite 429 San Francisco, CA 94115 PH (415) 923-3005 FX (415) 520-2299

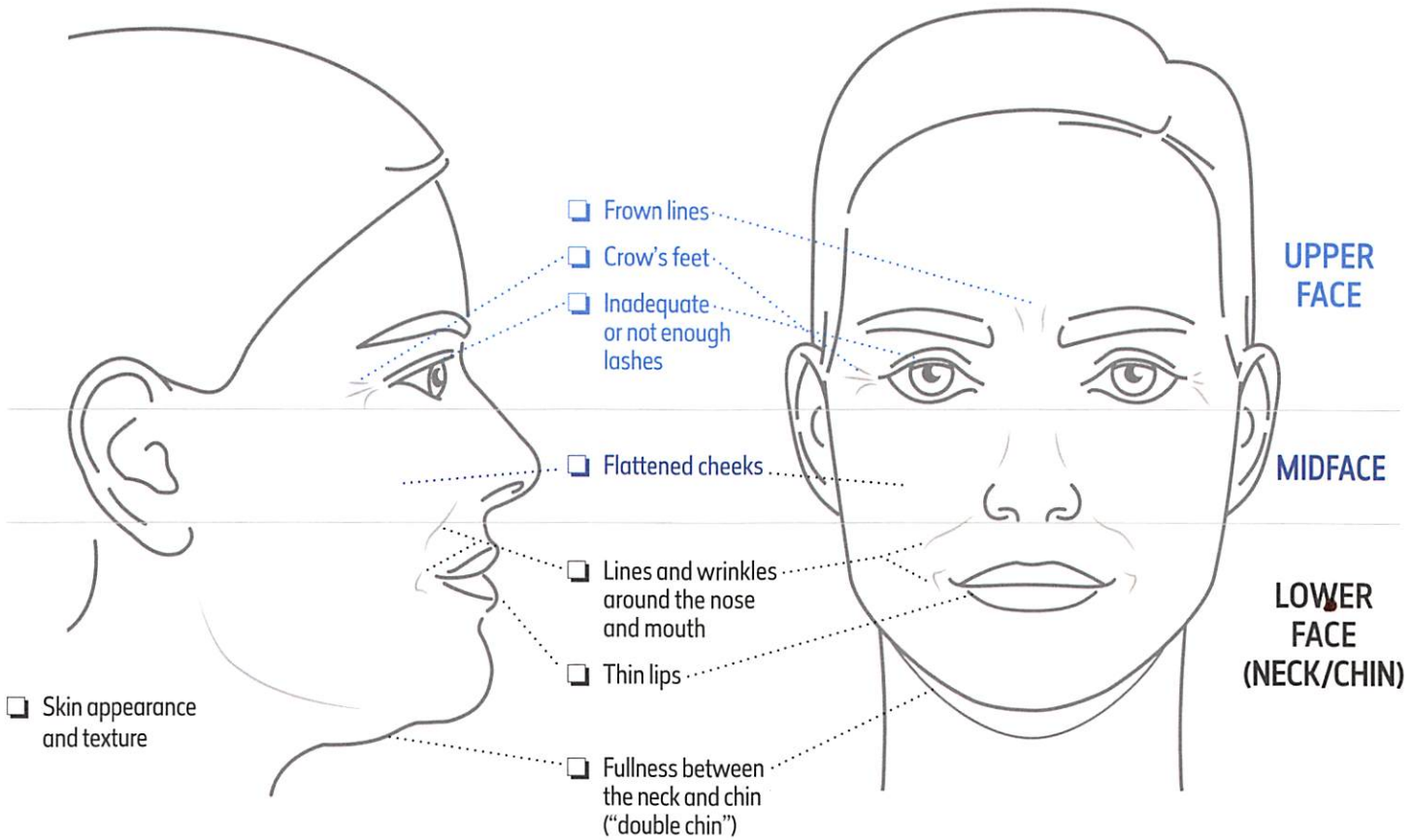
SELF-ASSESSMENT

NAME: _____ DATE OF BIRTH: _____ DATE: _____

What brings you in today? _____

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front office before your consultation.

Allergan.

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Financial Policies for Cosmetic Surgery/CoolSculpting

In keeping with the policies set forth by the American Society of Plastic and Reconstructive Surgeons, all fees are payable in advance. Cash, checks, or credit cards(Visa, MC, American Express) are accepted forms of payment. Financing is also available through CareCredit. Please note that when paying for surgery with a credit card, **up to an additional 3.5%** finance fee will be added to your total.

CONSULTATION:

The consultation fee is $50. You are charged at the time you schedule your consultation. The $50 goes towards any products or services purchased at the time of your consultation. You can reschedule your appointment once and if your appointment is missed or you need to reschedule a second time, you will be charged another $50 and the initial $50 you paid will not be credited towards any subsequent purchases.

APPOINTMENT CANCELLATION POLICY:

Our office strictly enforces a 48-hour cancellation policy and requires new patients to confirm an appointment with a valid credit card. If you are unable to keep an appointment you must call our office at least 48 hours in advance to avoid losing your $50 consultation fee. To reach us after-hours, please call the office and leave a message. We will retrieve your time- stamped message on the following business day and process your request.

SURGICAL SCHEDULING DEPOSIT:

When booking your surgery/CoolSculpting date, a $500 non-refundable deposit is required which is credited toward your surgical/CoolSculpting fees. If your surgery or CoolSculpting treatment date are within 2 weeks of the time that you book those procedures, the full payment is required at the time of booking.

The importance of adhering to the scheduled surgery date can not be overemphasized. Cancellations or postponed surgeries are serious and expensive, as arrangements for an anesthesiologist, nursing staff, operating room setup and recovery care are made at the time surgery is scheduled. CoolSculpting may require blocking out several hours of treatment time which is why payment prior to treatment is necessary.

SURGICAL/COOLSCULPTING FEES:

Preoperative visits, photos, routine postoperative care, suture removal, follow up examinations are included in your surgical/CoolSculpting fees. All surgical and operating

room fees or CoolSculpting fees are due 2 weeks prior to your surgery date. Our Patient Care Coordinator will discuss payment with you.

RESCHEDULING SURGERY:

Should you need to reschedule 14 to 8 days prior to surgery, there is an additional rescheduling fee of $750. Rescheduling 7 days or less prior to surgery the additional rescheduling fee is $1000. Our office must receive payment before any new changes to the surgery schedule are made.

CANCELING SURGERY:

Should you need to cancel a scheduled surgery 14 to 8 days prior to surgery/treatment, your operating room fee will at that time become non-refundable. Canceling 7 days or less 50% of your surgical fee will at that time become non-refundable. If your surgery is canceled 48 hours prior to your surgical date, Pacific Heights Plastic Surgery total fees will not be refundable. Again, the importance of adhering to the scheduled surgery date can not be overemphasized. CoolSculpting fees will not be refunded after payment. You are welcome to reschedule as needed without penalty.

REVISION FEES:

In the rare event that within the first six months of your surgery, refinement or further improvement is necessary, there will be no surgical fee; however an operating room and anesthesia fee will be charged. Dr. Jonathan Kaplan encourages complete post operative care and follow-up interaction to address any issues that might arise.

SEPARATE FEES:

The following fees are separate from Pacific Heights Plastic Surgery surgical fee and operating room charges:

- Anesthesiologist's Fee. You are quoted an estimated fee. Please bring a blank check for the anesthesiologist with you the day of your surgery.

- Any outside lab work (which includes pathology reports for skin lesions), overnight nursing, x-rays, recovery centers, all necessary routine prescription medications, extra postoperative supplies and extra liposuction garments.

Patient Signature:_____Date:_____

Patient Name:_____