# PACIFIC HEIGHTS PLASTIC SURGERY

DONALD M. BROWN, M.D., F.A.C.S.
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:_____

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:_____

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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: _____

[illegible] TEL: (415) 922-9005 FAX: (415) 771-6561

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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.

## 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,
Donald M. Brown, M.D., F.A.C.S., 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) 771-6561