

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: _____

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: _____

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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: _____

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Financial Policies for Cosmetic Surgery

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, an additional 2% finance fee will be added to your total.

CONSULTATION:

The consultation fee is \$100 and includes an in depth evaluation, examination, explanation of the surgery and your specific surgical recommendation. This fee is credited toward your surgical procedure if scheduled within six months and is due at the time of your first visit.

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 a late cancellation fee of \$50. 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 date, a \$500 non-refundable deposit is required which is credited toward your surgical fees. 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.

SURGICAL FEES;

Preoperative visits, routine postoperative care, suture removal, follow up examinations are included in your surgical fee. All surgical and operating room fees are due ten working days 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, 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.

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 a small operating room and anesthesia fee will be charged. Dr. Donald Brown and 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: _____