PATIENT REGISTRATION FORM

PLASTIC AND RECONSTRUCTIVE SURGERY

Aaron D. Smith, M.D.

Today's Date_____

Patient Name_____
Last First MI Nickname

Address_____
Street Apt/Ste City State Zip

Date of Birth_____ Age_____ Gender (circle one) F M Marital Status_____

SSN_____ Email_____

Do we have your permission to email you regarding your account (appointment reminders, invoices, etc..? (circle one) Y N

Would you like to receive email offers, specials, and updates (we don't solicit email addresses to third parties)? Y N

Phone_____
Home Mobile Work

May we leave a message? (circle) Yes No

Patient's (or custodial parent / guardian's) Employer_____

If a minor, parents and/or legal guardian's name_____

Primary reason for today's visit_____

Primary Care Provider_____ Referring Provider_____

If you were not referred by a Physician, whom can we thank for referring you?_____

Current insurance card(s) and photo identification are required for scanning. If you do not have them at your appointment, you may be asked to reschedule. Please complete the following:

Primary Insurance_____ Policy/ID#_____ Group#_____

Name of Policy Holder_____ SSN_____ Date of Birth_____ Gender F M

Relationship to Patient_____ Employer_____ Employer Phone_____

Secondary Insurance_____ Policy/ID#_____ Group#_____

Name of Policy Holder_____ SSN_____ Date of Birth_____ Gender F M

Relationship to Patient_____ Employer_____ Employer Phone_____

Emergency Contact-close friend or relative not living with you that we can contact in an emergency:

Name_____ Relationship_____ Phone_____
Last First

Spouse/Partner/Significant Other's Name _____

Name of person(s) we may speak with other than yourself regarding your medical care?_____

Phone_____ Relationship_____

MEDICAL HISTORY

Aaron D. Smith, M.D.

Patient Name _____ Age_____ Today's Date_____

Height_____ Weight_____

Reason for seeing a Plastic Surgeon?_____

Please circle any areas of interest: Botox Radiesse/Juvederm OBAGI Skin Care Products Latisse

Eyelid Surgery Facelift Breast Augmentation Breast Lift/Reduction Liposuction Tummy Tuck

What Medical Concerns are you currently being followed for? _____

_____

List all surgeries that you have had (include cosmetic surgery), major illnesses or Hospital admissions with dates

_____

_____

Current Medications that you are taking, including non-prescription drugs, vitamins, and herbals (include dosage)

_____

_____

List all drug allergies and reactions _____

Do you have any family history of cancer? (circle one) Yes No

If yes, who in your family had cancer and what kind?_____

Do you have any family history of bleeding disorders or bleeding tendencies? (circle one) Yes No

If yes, who in your family had a bleeding disorder and what kind?_____

Has anyone in your family had any difficulties with anesthesia? (muscle weakness, jaundice, breathing problems or unexpected fevers) Yes No

If yes, who in your family had difficulties and what kind?_____

Have you experienced any of the following? Please circle the appropriate box, and add notes as needed.

Recent Weight Loss	Yes	No		Shortness of Breath	Yes	No	
Fatigue	Yes	No		High Blood Pressure	Yes	No	
Skin Rashes	Yes	No		Previous Heart Attack	Yes	No	
Skin Cancer	Yes	No		Other Cardiac History	Yes	No	
Slow Healing	Yes	No		Hepatitis	Yes	No	
Change in Moles	Yes	No		Acid Reflux	Yes	No	
Bruise Easily	Yes	No		Bleeding Disorder	Yes	No	
Lightheaded/Dizziness	Yes	No		Anemia	Yes	No	
Depression	Yes	No		Arthritis	Yes	No	
Vision Problems	Yes	No		Back Injury	Yes	No	
Sleep Apnea	Yes	No		Cancer	Yes	No	
Diabetes	Yes	No		HIV	Yes	No	
Hyper/Hypothyroidism	Yes	No		Nipple Discharge	Yes	No	
Difficulty Breathing	Yes	No		Lumps in Breasts	Yes	No	
Asthma	Yes	No		Abnormal Mammogram	Yes	No	
Chest Pain	Yes	No		Previous Problems with Anesthesia	Yes	No	

Have you ever seen a cardiologist? Yes No Physician Name_____ Date of last EKG _____

Is there any possibility that you may be pregnant at this time? Yes No

Number of pregnancies_____ Number of children_____

Are you a (circle all that apply) Smoker Ex-Smoker Non-Smoker

If you are/were a smoker, how much are/were you smoking?_____ How long?_____ Quit how long ago?_____

How much alcohol do you drink?_____ Type?_____

I verify that the above information is true and accurate to the best of my knowledge.

Signature of patient or parent if minor Date

Aaron D. Smith, M.D. Financial Policy

We consider it a privilege that you have chosen us for your needs. We strongly believe that a clear understanding of our Patient Financial Policy is important to our professional relationship. Therefore, we strive to inform you of all the medical aspects of your needs and also would like to advise you on our financial policy.

- **Self Pay:** If you do not have medical insurance, or Dr. Smith is not contracted with your insurance company, payment is expected at the time of service unless other arrangements have been made with the office.

- **Commercial Insurance:** You must make sure that Aaron D. Smith, M.D. is an in-network provider for your insurance plan before your first visit and every time you change insurance plans. If you are not sure, please call your Plan Administrator for this information. The telephone number should be on the back of your insurance card. Current insurance cards must be presented to the office at each visit. It is your responsibility to provide our office with current insurance information. If current information is not obtained at the time of service, it will be your responsibility to pay until current information is provided to the clinic. Any change to personal information must be given to the office immediately. If surgery is scheduled, we will collect a deposit for your deductible, or co-insurance amounts prior to surgery.

- **Co-payments:** Co-payments are always collected at the time of service when you check in for your appointment. Failure to pay may lead to the cancellation or rescheduling of your appointment. We have a contract with your insurance company, which mandates collection of co-pays at the time of service. Failure to do so can result in Aaron Smith Plastic Surgery losing our contract with them.

- **Medicare:** We will bill Medicare and accept assignment, which means that we accept what Medicare approves. Medicare pays 80% of the approved amount after your yearly deductible is met. You or your secondary insurance is responsible for the remaining 20% of the approved amount. Medicare may automatically forward the claim to your secondary insurance. If they do not, we will bill your secondary insurance after Medicare pays. You need to know that there are some services Medicare does not pay for and these are spelled out in your Medicare handbook. You need to know your benefits, as you may be responsible for these charges.

- **Medicaid:** If you have Medicare, or any other insurance policy, and Medicaid is your secondary, you will be responsible for the portion remaining after Medicare pays. **We do not accept Medicaid**. If Medicaid is your primary, you are considered a self pay patient.

- **Surgery:** Your account needs to be in good standing, with a zero balance, prior to any surgical date. If your account is not in good standing, your surgery may be cancelled or rescheduled.

- **Statements:** When your insurance company has paid their portion of the charge, a statement will be generated and mailed to you. Any balance due is your responsibility and is due upon receipt of the statement from our office.

- **Returned Checks:** I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.

- **Privacy Policy:** I have been made aware of the privacy policy of Aaron Smith Plastic Surgery and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

My signature below indicates that I have read and agree to the above information and I, the undersigned/patient, am ultimately responsible for the fees. I authorize Aaron Smith Plastic Surgery to release my insurance carrier and its agents any information needed to determine the benefits payable under their coverage. I further authorize my insurance company and its carriers to reveal any information requested regarding claims for medical benefits to Aaron Smith Plastic Surgery. I authorize Aaron Smith Plastic Surgery to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit. A copy of this authorization may be used for the original. I request that payment of authorized medical benefits be made on my behalf to Aaron Smith Plastic Surgery for services furnished to me by Dr. Aaron Smith and his staff. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages. Your attending physician may have an ownership interest in one or more Ambulatory Surgery Centers.

_____ _____

Patient's Name (please print) Patient's Signature Date

Aaron D. Smith, M.D.

5901 Corporate Drive
Colorado Springs, CO 80919
719-355-1956
www.aaronsmithplasticsurgery.com

PHOTOGRAPHY CONSENT

Use of Photographs for Medical Education, Science, or Research

I consent to Aaron Smith Plastic Surgery using the photographs, videotapes, or films (collectively, the "Materials") for treatment purposes, internal health care operations, such as to improve quality of care to patients, to educate students, resident physicians, and other professionals, and for patient-related education for use in brochures and/or the Internet.

I agree that the Materials shall be the sole and exclusive property of Aaron Smith Plastic Surgery, free and clear of any claim on my part, and that I shall receive no royalties or other compensation or consideration for the Materials.

I release Aaron Smith Plastic Surgery and its personnel from any and all liabilities, which may arise from the use of disclosure of Materials and information under this authorization.

I understand that my name will never be provided; however, the Materials may reveal my identity if full or partial face photographs or other comparable images are obtained. I authorize Aaron Smith Plastic Surgery to use and disclose Materials, which may reveal my identity for scientific and educational related purposes. The disclosure of the Materials and information is authorized to medical, scientific or educational audiences via methods including, but not limited to, continuing medical education conferences, lectures, presentations, and publications in professional journals an/or books, magazines, patient-related educational brochures, and/or the Internet.

I understand that I may revoke this authorization at any time except to the extent that Aaron Smith Plastic Surgery has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: Aaron Smith Plastic Surgery, Attention: Medical Records Department, 5901 Corporate Drive, Colorado Springs, CO 80919. I understand that the revocation of this authorization will not apply to Materials and information that have already been disclosed in accordance with the terms of this authorization. I understand that this authorization will remain in effect unless specifically revoked by me.

I understand that Aaron Smith Plastic Surgery will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that if Materials and information are disclosed to a third party, the Materials and information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or entity that receives the Materials and information.

Signature of Patient | Print Name | Date

Signature of Witness | Print Name | Date

Aaron D. Smith, M.D.
5901 Corporate Drive
Colorado Springs, CO 80919
719-355-1956
www.aaronsmithplasticsurgery.com

Acknowledgement of Receipt of Notice

Aaron Smith Plastic Surgery

Jill Pintens, Privacy Officer 719-355-1956

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate your relationship to the patient:

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient

Patient Name: _____

Notes:

Aaron D. Smith, M.D.

5901 Corporate Drive

Colorado Springs, CO 80919

719-355-1956

www.aaronsmithplasticsurgery.com

NOTICE OF PRIVACY PRACTICES

Aaron Smith Plastic Surgery, 5901 Corporate Drive, Colorado Springs, CO 80919

Jill Pintens, Privacy Officer, 719-355-1956

Effective Date: January 01, 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. 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.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your first or last name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, recommend that you participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. 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.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.

18. 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.

19. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, we will provide your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and Colorado state law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is .If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

   If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.[For practices with websites add: We will also post the current notice on our website.]

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

State of Colorado Department of Health and Human Services
www.hhs.gov.ocr

The complaint form may be found at:www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.
You will not be penalized in any way for filing a complaint.