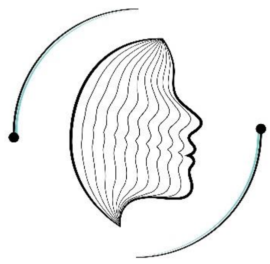

PATIENT REGISTRATION

First Name: __________________ Last Name: ____________________ Date of Birth: _____________
Address: _________________________ City: __________________ State: _______ Zip: ____________
Preferred Phone: (_____) ________________ Email Address: _________________________________
Driver's License: (please give a copy to front desk) Sex: ○ Female ○ Male ○ Decline to State
Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed
Emergency Contact: ___________________________________ Phone: (_____) ________________
Relationship: ___________________
How were you referred us? ○ Website ○ Friend ○ Family ○ Doctor ○ Other
Name of referral: _______________________

INSURANCE GUARANTOR INFORMATION

(Insurance patients only)

Name of Insurance Subscriber: ___________________________ Date of Birth: _______________ Relation to Patient: ____________________________ Phone Number: (______) ______________
Driver License #: ____________________________ SSN: __________________________________

PRIMARY INSURANCE INFORMATION

Insurance Company: ________________________ Phone Number: (_____) __________________
Policy #:______________ Group Number: ________________ Effective Date: _______________
Specialist Co-Pay Amount: ______________
Insurance Billing Address: ____

Authorization for Assignment of Benefits: By my signature below, I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment and payment (including to my insurance company).

Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. IF I AM UNINSURED, that I am fully responsible for all charges/ services provided at my appointment and payment is due at the time of service.

Authorization and Consent for Medical Care/Treatment: By my signature below, I hereby authorize United Plastic Surgery to furnish the necessary medical treatment or procedures including but not limited to laboratory procedures, surgical procedures and supplies as ordered by the attending physicians, his assistants, or designees. I further recognize that the physicians who practice at United Plastic Surgery may not be employees or agents of United Plastic Surgery, but independent physicians. United Plastic Surgery contracts with these physicians for services normally provided and questions relating to care that my physician has given or ordered should be addressed to him/her.

Lifetime Medicare B Signature Authorization: By my signature below authorize my holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of United and information needed for this or a related Medicare claim permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for the deductible and co-insurance.

Patient Signature: ____________________________________ Date: __________________________

United Plastic Surgery Confidential Communication Request:

As required by the Health Information Portability and Accountability Act (HIPPA) of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some methods of contact must be provided, and as appropriate, information, information as to how communication will be handled.

I (Print Name), ______________________________ herby request the use of the following confidential channels for the communication of information related to my personal health, treatment, or any matters relating to the care I am receiving at United Plastic Surgery. This request supersedes any prior requests for confidential channel communications I may have made.

Please select all that apply:

PHONE:

[ ] DO [ ] DO NOT I want you to contact me by telephone

[ ] DO [ ] DO NOT Leave messages on my answering machine

[ ] DO [ ] DO NOT Leave messages with any other person

Please indicate name(s), if any, of the individual(s) approved to take the above messages:

____

EMAIL:

○ DO ○ DO NOT Contact me via email.

MAIL:

○ DO ○ DO NOT Contact me via mail.

DIAGNOSIS & TREATMENT:

○ DO ○ DO NOT Want you to discuss my diagnosis, treatment, or any health related matters with my family members or anyone on my behalf.

Patient Signature: ____________________________________ Date: ______________________

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United Plastic Surgery Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate**: 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 of 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 1: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort contract, or otherwise, and shall bind all parties whose claims may rise out of or in any way relate to treatment or services provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses, and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to the Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S C. §§ 1-4). The parties shall bear their own costs, fees, and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4**: Retroactive Effect**: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.
Article 6: **Severability Provision**: In the event of any provision(s) of this Agreement is declared void and/or unenforceable, such provisions(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

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

_______________________________________ ___________________________________

Physician's or Authorized Representative Signature Patient's Signature Date

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United Plastic Surgery Financial Policy:

United Plastic Surgery is committed to providing you with top quality care. As a part of your care, we believe it is important to you to be informed about our financial policy as outlined below.

Missed Appointments:

At United Plastic Surgery, we have reserved your appointment especially for you. We would appreciate your understanding and cooperation with regard to cancellation. If you find that you must cancel, please do so at least 48 hours prior to your scheduled time. If appointments are not cancelled within the designated time, your credit card and/or account will be charged $150.

Insurance Coverage: (Insurance Patients Only)

If you are a new patient, please provide us with your insurance card for both your primary and secondary insurance carriers as well as a copy of your pharmacy, insurance card (if applicable) at the time of your appointment. If you are an existing patient, and you have any changes to your insurance, please provide updated copies at your next scheduled appointment or contact our billing office with our updated information. You will be asked annually for a new copy of your card. If you change insurances, please inform us of the change and provide us with a copy of your new card before your next visit. In addition to the billing information on your card, it is necessary to have access to the most current information regarding pre-certification and authorizations for any services needed within our practice. You as the patient are responsible for any and all deductibles, co- insurance, and any non-covered services deemed by your health insurance plan. Due to the complexity of care being provided within our practice, some treatments and procedures may not be considered medically necessary by your insurance carrier as a covered benefit even though we have found them to be clinically indicated.

Secondary Insurance: as a courtesy to our patients, the secondary policy will be billed for any remaining balances after payment processing and claim review of the primary insurance. Due to the allowed claim processing time for your primary insurance carrier, please allow up to 60 days after your date of service for secondary insurance processing to occur.

Co-Payments: Any and all co-payments are due at the time of service. A co-pay is a portion of a fee paid for all lab/injection visits, chemotherapy infusion visits, and office visits with a Physician, a Nurse, and/or Physician Assistant. Co-payments are a contractual fee with the health plans required to be paid by you as the patient. Co-payments and deductible fees cannot be waived or discounted.

Returned Check Policy:

If a check is returned to us for non-payment of insufficient funds, we will assess a $25.00 fee to your United account and you will be billed accordingly.

All Patients:

My signature below represents my acknowledgment of the financial policy as outlined above. I further understand that I will be held financially responsible for any and all charges denied by my health plan and/or if I present with no insurance benefits.

Print Name: ___________________________________ Date of Birth: ______________________
Patient Signature: ________________________________ Date: ______________________________

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving treatment. Absent of an emergency, United Plastic Surgery reserves the right to charge a fee of $150.00 for all missed appointments ("no shows") and appointments which are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

Print Name: ___________________________________

Signature: _____________________________________ Date: _______________________

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HIPPA Patient Consent Form:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996. (HIPPA).

The patient understands that:

➢ Protected health information may be disclosed or used for treatment, payment, to determine research eligibility, review of clinical data associated with participation in a research trial, or health care operations.
➢ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
➢ The Practice reserves the right to change the Notice of Privacy Practices.
➢ The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
➢ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
➢ The Practice may condition receipt of treatment upon the execution of this Consent.

Print Name: ______________________________ Date: ________________________

Patient Signature: __________________________ Staff Signature: ________________

Photography Consent-CHART USE ONLY

I (Print Name), ___________________________, consent to the taking of photographs by the staff of United Plastic Surgery of me or parts of my body in connection with the plastic surgery procedure(s) intended or performed. I understand that photographs may be taken before, during, and after my procedure(s) as a routine part of my medical care. I understand that I will never be identified by name in any use of these photographs, but that in some circumstances the photographs may portray features which make my identity recognizable.

I release and discharge United Plastic Surgery from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs. I certify that I have read the above Authorization and Release and fully understand its terms.

Print Name: ________________________________ Date: __________________________

Patient Signature: _______________________________ **Staff Signature**: ____________________

This consent may be revoked at any time with a written consent.

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CONSENT TO PHOTOGRAPHY, VIDEO, SOCIAL MEDIA, RECORDING AND/OR PUBLISHING

I consent to the taking of photographs, videos or audio recordings of me or parts of my body by John Larson M.D., his designee, and/or United Plastic Surgery, United Medical Doctors, and/or John Larson Plastic Surgery, Inc. hereinafter “You” or “Your”.

Print Name: ___________________________________

DESCRIPTION OF USAGE:

___X__ (Website) ___X__ (Affiliated Websites) ___X__ (News Segment) ___X__ (Print)
___X__ (Brochure) ___X__ (Social Media) ___X__ (Television) ___X__ (Radio)

In addition, you agree to be identified by name in the above reference: _____ (YES) _____ (NO)

I grant to John Larson M.D., his designee, and/or United Plastic Surgery, United Medical Doctors and/or John Larson Plastic Surgery, Inc., and/or Your affiliates, successors, or other persons acting under Your permission and authority, the irrevocable, perpetual, unrestricted, royalty free right, license and permission to copyright in Your own name, and to use, re-use, publish, reproduce and distribute, such audio and/or video recordings, pictures, composites, or other reproductions thereof, distorted or modified in form or character, without restriction as to changes or alterations, whether in conjunction with the subject’s true or fictitious name or in conjunction with other photographs or printed matter, made through a medium, including website publishing, for illustration, education, promotion, art, editorial, advertising, trade, or any purpose whatsoever, in such manner as you deem appropriate for such purposes. I understand that if such picture or image, or recording is published on the web, it may be downloaded by any computer user. You agree not to use the photograph/recording/image in any derogatory manner.
I waive the right to inspect or approve the finished product(s) and/or advertising copy or other matter used in connection with the product or the use for which it may be applied. I further waive any claims to royalties or monetary compensation connected with such recordings, creations or photographs, or the publication or distribution thereof.
My signature below confirms that I have the legal right to grant this license to you. I hereby release, discharge, and agree to hold You and/or Your affiliates, successors, or those acting under Your authority or permission, harmless from any liability connected with the photography, recording or creation or the use, re-use or publication of such images or recordings, including blurring, distortion, alteration, cropping, or the use in composite form, intentional or otherwise, that may occur or be produced in the processing of such products. This consent shall be binding upon me and the subject of this photography, or recording (if different), my heirs, agents, legal representatives, and assigns.

ACCEPTED AND AGREED

Print Name: ________________________________ Date: ___________________________

Patient Signature: ___________________________ Staff Signature: _________________

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