Dr. Q Plastic Surgery
70017 Highway 111 Suite 1
Rancho Mirage, CA 92270
(P) 760-324-2660 (F) 760-324-2677

Patient Information Form

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: CA Zip: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: female SSN: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our practice?

☐ Patient Referral: _____ ☐ Practice Website
☐ Friend: _____ ☐ Yelp
☐ Dr. Referral: _____ ☐ Google
☐ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Name: _____ Policy #: _____ Group ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Name: _____ Policy #: _____ Group ID: _____

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Assignment and Release

I, _____, have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured / Guardian Date

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

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Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Have you or do you still have:	No	Yes	Description
2. Asthma	☐	☐	
3. Emphysema	☐	☐	
4. High Blood Pressure	☐	☐	
5. Heart Trouble	☐	☐	
6. Hepatitis or Liver Trouble	☐	☐	
7. Kidney Trouble	☐	☐	
8. Diabetes	☐	☐	
9. Epilepsy or Seizures	☐	☐	
10. Stroke	☐	☐	
11. Problem Scarring	☐	☐	
12. Have you been advised to or had psychiatric care?	☐	☐	

13. Others Not Listed: _____

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Family History

Have any blood relatives had any of the following?	No	Yes	Description
1. Cancer	☐	☐	
2. Bleeding Tendency	☐	☐	
3. Leukemia	☐	☐	
4. Heart Disease	☐	☐	
5. High Blood Pressure	☐	☐	
6. Repeated Infections	☐	☐	

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7.	Chronic Lung Disease	☐	☐	
8.	Tuberculosis	☐	☐	
9.	Asthma	☐	☐	
10.	Severe Allergies	☐	☐	
11.	Kidney Disease	☐	☐	
12.	Arthritis	☐	☐	
13.	Mental Illness	☐	☐	
14.	Convulsions or Fits	☐	☐	
15.	Migraine Headaches	☐	☐	
16.	Diabetes	☐	☐	
17.	Gout	☐	☐	
18.	Thyroid Trouble	☐	☐	
19.	Obesity	☐	☐	

Section V: Medications

Are you taking ***ANY*** medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

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Please initial at least <u>one</u> of the following:

_____ I hereby authorize Dr. Suzanne Quardt and her allied health personnel to utilize my photographs for educational purposes in scientific journals, teaching seminars and/or textbook publications.

_____ I hereby authorize Dr. Suzanne Quardt and her allied health personnel to utilize my photographs as examples of surgical outcomes on her internet website. I understand that with the exception of full-face photographs, every effort will be made to eliminate or minimize identifying features.

_____ For office use only, I hereby authorize Dr. Suzanne Quardt and her allied health personnel to utilize my photographs for medical documentation of progress.

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

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Consent to Communicate

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info; Before and After photos should you request at any time. ***Initial:***_____				
☐ Email Dr Q's newsletter and other in office special promotions?				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – ***if so, list cell carrier:***				
☐ Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA Information and Consent Form

Patient Name _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, [illegible] do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

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ARBITRATION AGREEMENT

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.

All claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician 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.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

_____Patient Initials

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General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Retroactive Effect: If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration 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 MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patients Representative's Signature Date

By: _____
Print Patient's Name

By: _____ _____
Physician's or Authorized Representative's Signature Date

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FINANCIAL POLICIES AND RESPONSIBILITIES

I certify that the insurance information is correct and true, and that I am eligible for health plan coverage and benefits for non-cosmetic procedures. I understand that if the information is NOT true or is I am NOT eligible under the terms of my Medical and Hospital Subscriber Insurance Agreement then I am liable for all charges for services rendered. Also, if the information is NOT true, I agree to pay in full for all services within thirty (30) days of receiving the bill from Suzanne M. Quardt, M.D., Inc.

Your insurance company was your choice. Not all services may be covered under your particular insurance plan. All services NOT covered are your responsibility. Payments for services rendered, unpaid deductibles and copayments are due at the time of service.

There will be a $25 charge to patients that do not show for their appointment and for appointments cancelled less than 48 hours of the scheduled appointment.

There is a $50 charge for each check returned to us for insufficient funds.

I directly assign all medical and surgical benefits to Suzanne M. Quardt, M.D., Inc. and understand that I am personally financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize Suzanne M. Quardt, M.D., Inc. to release all information necessary to secure payment of benefits. I agree that a photocopy of this agreement is valid as the original.

Due to high volume of forms we are asked to fax and complete, there is a $5 charge per page for each page copied and/or faxed per patient's request.

There will be a charge of $50 for each Disability Form and other similar forms we are asked to complete.

_____ Patient Name

_____ Patient Signature

_____ Witness Signature

_____ Date