Alyson Wells, M.D.
Valley Plastic Surgery
Plastic, Reconstructive, and Cosmetic Surgery

PATIENT REGISTRATION

PATIENT'S NAME: _____

MAILING ADDRESS: _____

CITY, STATE, ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ AGE: _____ EMAIL: _____

EMPLOYMENT

EMPLOYED BY: _____

OCCUPATION: _____ MAY WE CALL YOU AT WORK: _____

ADDRESS AND PHONE: _____

MARITAL STATUS

PLEASE CIRCLE ONE: Single Married Separated Divorced Widow/Widower

SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER: _____

IN CASE OF EMERGENCY WE WILL CONTACT

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

How did you hear about Dr. Wells and Valley Plastic Surgery: Referred by a friend _____ Web/Internet _____

Referred by a doctor: _____ Emergency Room: _____ Advertisement/Publication: _____

Name of friend, referring doctor, or advertisement/publication: _____

HEALTH HISTORY FORM

What is the reason for your visit today? _____

Name, address, and phone number of your primary care physician: _____

_____

Past or Current Medical Problems (please circle all that apply):

High blood pressure Heart disease/heart attacks Heart murmur High cholesterol Diabetes Asthma

Seizures Lung disease Liver disease Breast cancer Depression Anxiety disorder

Other major illnesses: _____

Medications: _____

Do you take any diet pills/medications or have you in the past? If so, which ones? _____

Do you take any natural or herbal supplements? If so, which ones? _____

Allergies to medications: _____

Allergic to latex?: _____

Have you or a family member ever had complications from anesthesia? If yes, please explain: _____

_____

Please list any previous surgeries: _____

_____

Do you take aspirin on a regular basis? Yes No Do you take ibuprofen on a regular basis? Yes No

Have you taken steroid medications by mouth in the last 12 months? Yes No

Do you currently smoke cigarettes? Yes No If yes, how many packs per day? _____

Have you ever smoked cigarettes in the past? Yes No If yes, how many packs per day? _____

For how long did you smoke? _____ When did you quit smoking? _____

Are you pregnant? Yes No

The health history information above is true, correct, and complete to the best of my belief.

_____ _____

Patient (or guardian/parent) signature **Date**

INSURANCE INFORMATION

Insurance company: _____ Policy Holder: _____

Policy Holder's date of birth: _____ Identification Number: _____

Group Number: _____

Responsible Party: _____Patient _____Spouse _____Parent

I certify that the information regarding my insurance coverage is correct and complete. I authorize release of my medical records to the insurance company or responsible party for billing purposes. I authorize the insurance company or responsible party to pay directly to Valley Plastic Surgery. For and in consideration of services rendered, the undersigned jointly and severally obligates themselves for the payment of all services rendered by Dr. Wells and her staff. The undersigned hereby acknowledges that I/we are financially responsible for any health insurance deductible, co-insurance, or failure for any reason of any insurance carrier to pay Dr. Wells' charges, which I/we are due and rendered. In the event the patient's account is referred for collection, the undersigned agrees to pay and be responsible for all such medical charges together with all court costs, private process fees, collection costs, and attorney's fees in the amount of 1/3 of the balance, which sum the undersigned expressly agrees is reasonable. This assignment will remain in effect unless revoked by me in writing. A photocopy of this is to be considered valid as the original.

_____ _____

Signature Date

FINANCIAL POLICY

The fee for an initial cosmetic consultation is $100.00, payable at the time of service. This fee is inclusive of a second consultation within 60 days.

An estimate of the surgical fee will be provided at the time of consultation. The estimate does not include expenses which the patient may incur for a pre-operative "History and Physical" examination, blood tests, and prescription medications. A 20% deposit is required when the surgery date is scheduled in order to hold the date.

Final payment for all cosmetic procedures is due at least 2 weeks prior to the scheduled date of the procedure. Fees are fully refunded for cancellations made no later than 2 weeks prior to the date of surgery. If you cancel 8-13 days prior to the date of your surgery, you will be refunded 50% of your fee. There are no refunds or cancellations within 0-7 days of the scheduled surgery. If a patient is not cleared for surgery (on pre-operative evaluation by the responsible primary care doctor), the fee for surgery will be refunded 100%.

The patient is solely responsible for the entire fee, regardless of the source of payment. In the case of insurance-covered procedures, the patient is responsible for any co-payments and/or deductibles. In certain instances, a surgery may include a procedure covered by insurance and one which is not. In this case, there may be two consultations and two anesthesia charges which make up the total charges. If the insurance company pays these consultation and anesthesia charges, the patient will be responsible for any co-payments.

All post-operative visits related to the original procedure are included in the surgical fee for one year. Further consultation for unrelated issues or problems will be billed separately.

There will be a reduced surgeon's fee assessed for cosmetic re-operations and revisions performed within 12 months of the initial surgery. The patient will be responsible for the cost of the operating facility, anesthesia (if needed), and supplies.

Please initial_____

A fee of $30.00 will be assessed for any check returned to the practice unpaid. Exceptions to this policy may be considered on a case by case basis and will be at the sole discretion of the Practice Administrator.

Signature: _____ Date: _____

PHOTOGRAPHY CONSENT

I hereby authorize Dr. Alyson Wells and/or her staff to take photographs at the time of office visit and consultation, before surgery, and after any surgery, if performed. I understand that these photographs and may be released to my insurance carrier (if related to a possible insurance-covered procedure). They may be used for educational purposes if, and only if, my name and identification number are not connected to the photographs, thereby preserving my anonymity.

Signature: _____ **Date: _____**

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. We are required by law to protect the privacy of your protected health information. Please review the following carefully.

Protecting your privacy
Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper on the Internet. At Valley Plastic Surgery (hereafter referred to as "the Practice"), privacy is one of our highest priorities.

Keeping your information
Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims, and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information
In the course of doing business, we collect and use various types of information, such as name, address, and insurance/claims information. We use this information to provide service to you and to process your claims.

Keeping information accurate
Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate, or not current, please write or call us. We will take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How—and why—information is shared
This general consent for release of medical records that you sign authorizes Valley Plastic Surgery and Dr. Alyson Wells to disclose the information in your medical record for treatment, payment, and health care operations. We limit who receives information and what type of information is shared.

- Sharing information within the Practice. We share information within our company to deliver you the health care services and the related information/education needed by you.
- Sharing information for the purpose of arranging payment for your care. Your information may be shared with your insurer or other third-payer who is responsible for paying all or part of the cost of your care.
- Sharing information with companies that work for us. To help us offer you our services, we may share information with companies that work for us, such as billing and claims processing companies and practice management companies. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- Sharing information for health care operations. We may use and disclose information that is necessary for our operations e.g. internal quality assessments, contacting other health care providers about treatment alternatives. We may also disclose information to doctors, nurses, technicians, or other practice personnel who are involved in your medical care and treatment. Different areas of the practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions and lab work. We may also disclose medical information about you to people outside the practice who may be involved in your medical care after you leave our office, such as family members or others we may rely upon or ask to assist us in caring for you. We may use information about you to provide you with appointment reminders such as voicemail messages, postcards, or letters.

Please provide the name and phone number of a family member or friend that is permitted to receive messages/mail from our office pertaining to you in the event that we cannot get in touch with you:

Name and Relationship_____ Phone_____

- Other. Patient-specific, personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.
- You may be asked to sign a specific authorization for release of medical records, which will Authorize us to make a specific disclosure that is not covered by this authorization. The specific information, to whom it will be disclosed, and the purpose for which it will be used will be documented for your review before signing.
- You may revoke any consent or authorization provided to us by giving us a written notice of revocation.
- Please review your rights regarding your health information:
    - You have the right to inspect and copy your health information.
    - If you feel that the health information we have about you is incomplete or inaccurate, you have the right to request an amendment to your medical records. The request must be made in writing with the reason that supports your request.
    - You have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical records disclosures made by Valley Plastic Surgery, except for disclosures made for treatment, payment, and health care operations.
    - You have the right to receive a paper copy of this notice, if your request it.

- We are required by law to maintain the privacy of your protected health information and if you believe that your rights have been violated, you may complain to the Secretary of the US Department of Health and Human Services. You may also complain to Valley Plastic Surgery in person, over the phone, or in writing.
- We reserve the right to change our privacy policies and to make new policies effective for all protected health information that we maintain.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described about, we do not share information with other parties, including government agencies.

The Practice does not share any patient/client information with third-party marketers who offer their products and services to our patients.

I have read and understand the "Notice of Privacy Practices"

_____ _____

Signature Date

Alyson Wells, M.D.
Plastic, Reconstructive, and Cosmetic Surgery
Phone: 410.628.8200 Fax: 410.628.8203

VOICE MAIL CONSENT FORM

I, _____, consent to information regarding appointments, treatments, and billing being left on my voice mail.

Phone numbers approved for voice mail contact:

Home Phone _____

Cell Phone _____

Work Phone _____

Contact person _____ _____
Name Phone

Yes, I approve

_____ _____
Signature Date

No, I do not approve

_____ _____
Signature Date