Wally Hosn, M.D.

Plastic and Reconstructive Surgery

Registration

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**.

Patient Information

Patient's Name *(Last, First Middle Initial)* Social Security #	Sex: M F	Birth Date ___/___/____ Age _____	Marital Status: Single **[ ]** Married [**]** Widowed [ ] Divorced [ ]
Residence address City State Zip			Home Phone
Drivers License Number State: Number:		Email	Cell Phone
Name of Employer Address		Occupation	Business Phone
Name of Spouse/Parent		Would it be alright to contact you : Yes No If yes, which number would be best: Home Cell Business Email	
Reason for Visit:	Referred by: (include address and phone if available)		
Person to contact in case of emergency:	Relationship to patient	Phone	

Billing Information *(cosmetic patients do not need to fill out the insurance information)*

Credit Card Number: Type [ ] Mastercard [ ] Visa [ ]American Express [ ]Discover Other:		Name on the card: Expiration Date:	
Primary insurance company Address			Is insurance through your employer? Y N
Subscriber Name	Subscriber birth date	Policy #	Group #
Secondary insurance name Address		Policy #	Group #

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Wally Hosn, M.D. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

_____ _____

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Wally Hosn, M.D. for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Wally Hosn, M.D.

Name: _____ Date: _____

Previous Surgery, year and type of procedure: _____
_____

PERSONAL PAST HISTORY: Have you ever had:

Abnormal Bleeding:	Y N	Asthma:	Y N	Hypertension:	Y N
Abnormal Clotting:	Y N	Diabetes:	Y N	Sleep Apnea:	Y N
Acid Regurgitation:	Y N	Fainting Spell:	Y N	Snoring:	Y N
Anemia:	Y N	Heart Attack:	Y N	Thyroid Problems:	Y N
Angina:	Y N	Hepatitis:	Y N	Weight Change past 12 M:	Y N
Other Serious Illness:	Y N				

Please describe questions with a "Yes" answer: _____
_____
Have you ever received a transfusion? Y N If yes, what year? _____
Have you ever been tested for HIV? Y N If yes, what year? _____ Test results: o positive o negative
Do you wear: Contact Lenses: Y N Eye Glasses: Y N Hearing Aid: Y N Dentures: Y N

Indicate the type(s) of anesthesia received in the past, list any complications / reactions you experienced:
□ Local Anesthesia – (complications / reactions): _____
□ General Anesthesia – (complications / reactions): _____
□ Spinal / Epidural – (complications / reactions): _____

What is your height: _____ What is your weight: _____

MEDICATIONS: List dose or number of pills per day:

Prescription Drugs	Non-Prescription (Vitamins; Herbs)
_____	_____
_____	_____
_____	_____
_____	_____

Regular Aspirin use : Y N Dosage & Frequency: _____
NSA (Advil, Motrin, Ibuprofen) : Y N Dosage & Frequency: _____
Cortisone Injections Past Year : Y N Dosage & Frequency: _____

Drug Allergy: Y N List drug(s) and type of reaction: _____
_____
Latex Allergy: Y N Tape Allergy: Y N

SOCIAL:
Responsible adult available to assist during recovery period Y N Relationship: _____
Smoke: Y N Amount: _____ Coffee / Tea / Cola: Y N Amount: _____
Alcohol: Y N Amount: _____ Daily Exercise : Y N Amount: _____

FAMILY HISTORY: List any medical problems that run in the family:
_____

Date last seen by Primary Care Physician: _____
Primary Care Physician (Name) _____ (Telephone) _____
(Address) _____

WOMEN PATIENTS ONLY:
Number of pregnancies___Number of children___Last menstrual period_____ Did you breast feed Y N

Wally Hosn, M.D.

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and Health Care Operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Wally Hosn, M.D.

Notice of Privacy Practices Acknowledgement

Wally Hosn M.D.
1250 Peach St Ste. D
San Luis Obispo CA 93401
(805)541-0330

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name _____

Relationship to Patient _____

Signature _____

Date _____

Office use only_____

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ initials_____ reason_____

Wally Hosn, M.D.

Photography Consent

Patient Name: _____ D.O.B.: _____

It is standard procedure for Dr. Hosn and/or his staff to take pre and postoperative photographs of his patients. The undersigned hereby authorizes Wally Hosn, M.D. and/or the staff of the Aesthetic Plastic Surgery Center to be photographed while under the care of Wally Hosn, M.D.

- I agree to have both pre and postoperative photos taken for my record and for patient education purposes. My name will not be used on any such photographs. I understand the photos are the property of Wally Hosn, M.D.

- I hereby grant permission any and all purposes including, but not limited to: care, advertising, promotional, educational and medical office books, scientific presentations and teaching courses and in all media, including electronic, digital and print media and further consent to the release of such photographs, videotapes or case histories for the purpose of informing the medical profession or the general public about plastic surgery methods.

- I hereby consent to the above, without expectation of remuneration to me now or in the future, and that such use is subject only to the following limitations:
    - Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances that the photographs may portray features that shall make my identity recognizable.
    - I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

- I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty years from the date written below.

_____ _____

Patient or Legal Guardian Date

_____ _____

Witness Relationship