Newport Plastic Surgery, Inc.

Welcome to the Plastic & Reconstructive Surgery office of ***Parviz H. Goshtasby, MD.***
Please complete this form. All information is confidential.
Thank you.

New Patient Intake Form

PERSONAL INFORMATION

Name: _____ *Birth date:* ___/___/___

Date: _____ *Age:* _____

Current height: _____ *Weight:* _____

Reason for today's visit (Please be as specific as possible): _____

_____

How did you hear about us?: _____

Social Security #: _____ *Sex:* *Male / Female*

Home phone #: _____ *Cell #:* _____ *Work #:* _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

E-mail address: _____

Employer: _____ *Occupation:* _____

Insurance plan: _____

Marital status (circle one): Single / Married / Separated / Divorced / Widowed / Cohabitating / Other

Spouse/ Significant Other's Name: _____

Employer: _____ *Occupation:* _____

Birth date: ____ / ____ / ____ *Contact #:* _____

Family physician's Name: _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

Telephone: _____ *Date of last physical exam:* _____

Emergency Contact Person's Name: _____

Relationship: _____ *Contact #:* _____

MEDICAL INFORMATION

We are here to help you. Please answer as truthfully and completely as possible. Do you have (please circle):

Heart disease	*Autoimmune disorder*	*Asthma*
Drug dependency	*Anemia*	*Lung disease*
Blood disorder	*Serious accident history*	*Birth control*
Latex allergy	*Bulimia or anorexia*	*Chronic illness*
Mental illness	*Blood clotting disorder*	*Depression*
High blood pressure	*Cancer*	*Diabetes*
Sleep apnea	*CPAP machine*	*Environmental allergies*

If you circled any of the above, please explain in detail: _____

Other medical problems not listed above: _____

_____

List all previous surgeries (including cosmetic procedures): _____

Type: _____ *Date:* _____ *Dr.* _____

Type: _____ *Date:* _____ *Dr.* _____

Type: _____ *Date:* _____ *Dr.* _____

Type: _____ *Date:* _____ *Dr.* _____

Please list ALL medications, herbal supplements, and vitamins you are taking: _____

_____

_____

_____

Please list any allergies to medication with your reaction: _____

_____

GYNECOLOGIC INFORMATION

Number of pregnancies: _____ *Number of children:* _____ *Ages of children:* _____

Weight gain with each pregnancy: _____

Did or do you breastfeed?: _____ *How long?:* _____

Any history of breast cancer?: _____ *Do you do monthly breast self-exams?* _____

Last mammogram date: _____ *Result:* _____

LIFESTYLE INFORMATION

Do you smoke cigarettes?: Yes / No Other:

Packs per day: Number of years: Did you quit and when?:

Number of alcoholic drinks per week: Any recreational drugs:

Do you take Aspirin or Ibuprofen on a regular basis?: Yes / No

Are you on a diet pill or diet program now?: Yes / No Which one?:

Do you exercise?: Yes / No Activity: How often?:

Do you wear contact lens? Yes / No Glasses?: Yes / No

Who is your ophthalmologist?:

What are your hobbies and interests?:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Dr.Goshtasby's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

I understand that Dr. Goshtasby will provide medical care to the best of his abilities as a triple board-certified plastic surgeon, but it is ultimately my responsibility to understand and follow his recommendations for maximal treatment and recovery. As a result, appointment visits are meant to be kept and adhered to in a timely fashion. Our office policy requires a $50.00 fee for all missed appointments and/or cancellations under 48-hour notice. Thank you.

Signature *Date*

Newport Plastic Surgery Inc.

The Plastic & Reconstructive Surgery office of ***Parviz H. Goshtasby MD, FACS.***

HIPAA Consent Form

Patient Name: _____

Birth date: _____ *Contact #:* _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Dr. Goshtasby's office originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- *a basis for planning my care and treatment*
- *a means of communication among the many health professionals who contribute to my care*
- *a source of information for applying my diagnosis and surgical information to my bill*
- *a means by which a third-party payer can verify that services billed were actually provided*
- *and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals*

I understand that I have the right to review the Notice of Information Practices prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Dr. Goshtasby has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Patient Signature: _____

Witness Signature: _____

Date: _____

Newport Plastic Surgery, Inc.

The Plastic & Reconstructive Surgery office of ***Parviz H. Goshtasby, MD, FACS.***

Patient Name: _____ *SS#* _____

Birth date: _____ *Contact #:* _____

Assignment Of Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your medical benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims:

- *Although we are willing to complete insurance information forms and submit a claim on your behalf, we do NOT accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does NOT eliminate your financial obligation for your treatment.*
- *We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance carrier. This instructs your insurance company to make payment directly to our office.*
- *We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. Please note that Dr. Goshtasby is an independent medical practitioner who is not employed or paid by Hoag.*
- *Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within a 60-day grace period, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company directly for the balance paid. Please note that if you default on your obligations to pay your bill on time, your claim will be subject to a 5% per month late fee. If full payment has not been made after a 3-month overdue period, then our office policy requires the files be sent to a collections agency and an additional 25% collection services fee will be applied to your outstanding balance.*
- *Our office does not guarantee that your insurance company will pay for treatment you receive from us, especially as Dr. Goshtasby is NOT a participating provider for your plan. We will perform routine insurance billing procedures as an Out-Of-Network provider. However, if your claim is denied, you will be responsible for paying the full amount due at that time.*
- *Our office will NOT enter into a dispute with your insurance carrier over any claim, although we will provide necessary documentation that is requested in order to sort out any confusion or questions that may arise. At no point has Dr.Goshtasby nor his office agreed to accept any reduced rates given by your insurance carrier as payment in full, and it is ultimately YOUR responsibility to resolve any type of dispute over payments made or not made with your insurance company.*

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MEDICAL BENEFITS DIRECTLY TO DR. GOSHTASBY.

I FURTHER AUTHORIZE YOU TO DEBIT MY CREDIT CARD IF YOU HAVE NOT RECEIVED PAYMENT FROM MY INSURANCE COMPANY WITHIN 60 DAYS OF RECEIVING TREATMENT.

_____	_____	_____	_____
Signature of Patient/Responsible Party	*Credit Card #*	*Expiration Date*	*V-Code*

_____	_____	_____
Signature of Witness	*Name of Witness*	*Date*

Newport Plastic Surgery, Inc.

The Plastic & Reconstructive Surgery office of ***Parviz H. Goshtasby MD, FACS.***

Authorization for Release of Patient Information & Photographs

Patient Name: _____

Birth date: _____ *Contact #:* _____

I hereby consent to the taking of photographs by Dr. Goshtasby or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Goshtasby. I further authorize Dr. Goshtasby to release to the American Society of Plastic Surgeons ("ASPS") such photographs.

I also grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in publications, examination, testing, credentialing, and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize release of any health information and that my refusal will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Goshtasby.

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 further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. Goshtasby, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim 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.

Patient Signature: _____

Witness Signature: _____

Date: _____

Newport Plastic Surgery, Inc.

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Surgical Procedure Consent Form

Patient Name: _____

Birth date: _____ *Contact #:* _____

I authorize the performance of the following procedure: _____

_____

for the diagnosis of : _____

under the direction of Dr. Goshtasby.

I acknowledge that the proposed procedure, the potential risks and benefits, and the possible complications of such procedure have been explained to me as well as the implications of not undergoing this procedure. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. I also understand that complications sometimes occur that may require additional procedures and expenses, and no guarantee or assurance has been given as to the results that may be obtained from this procedure.

Patient Signature: _____

Witness Signature: _____

Date: _____

PATIENT RESPONSIBILITIES

AS A PARTNER IN YOUR HEALTHCARE, YOU HAVE THE FOLLOWING RESPONSIBILIES

1. Please provide ***accurate and complete*** information concerning your present complaints, past medical history, and other matters, relating to your health.
2. Please be sure that you ***clearly comprehend*** the course of your medical treatment and what is expected of you.
3. By ***following the treatment plan*** established by your physician including the instructions of nurses and other health professionals as they carry out the physician's orders, including return visits, this will be beneficial to you in maintaining your good health.
4. Please ensure that the ***financial obligations*** of your care are fulfilled in a timely matter.
5. If you need information or inquiring about ***Advance directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will)***, please call the Member Services Department of your Health Plan.
6. **We ask that you treat all providers, office personnel and other patients respectfully and courteously in order to Maintain Professional Relationship.**
7. You need to ***communicate openly*** with your physician so that you can develop a patient-physician relationship based on trust and cooperation.
8. You need to ***seek and obtain*** services as consistently as possible from your primary care physician and to call if your condition worsens.
9. You need to ***take charge*** of your health and make positive choices: by not smoking and getting appropriate exercise, ect. And to seek appropriate care when needed.
10. You need to consider the ***possible consequences*** if you refuse to follow the physician's orders or comply with the recommended treatment. In some cases, this could mean the transfer or termination from the physician.
11. **Please keep your scheduled appointments or give 48 hour notice of delay or cancellation. If no notice is given there will be a fee.**
12. You need to ***read*** all plan and education materials carefully as soon as you enroll so that you are aware of your benefits and their limitations. If you are unsure, please as questions when necessary.
13. You need to ***help*** your physician to maintain accurate and current medical records by being open and honest when you provide the necessary information and can ask questions when necessary.
14. Please ***constructively express*** your opinions, concerns and complaints to the appropriate personnel within your Health Plan.
15. You need to notify your pharmacy when you change primary care physicians.
16. Please be sure to ***call*** your physicians office ***after a reasonable period of time*** when you have any type of ***laboratory test, x-rays, mri's, ct's, or pathology results*** pending.
17. Please give ***72 hours*** prior to a prescription renewal or there could be a delay in medication renewal.

I have been informed of my responsibilities and I understand them fully.

PATIENT SIGNATURE _____ DATE _____

PRINT NAME _____ DATE _____

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 rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **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 service 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 or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, 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 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 of a demand for a neutral arbitrator by either party. 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. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

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 this 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 provisions 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. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **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 arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If 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

_____
Patient's or Patient Representative's Initials

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: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.
(2-12)