PATIENT REGISTRATION FORM

Last Name: **First Name:**

Home Address:

City: State: Zip:

Mailing Address:

City: State: Zip:

Home Phone: **Cell Phone:**

Work Phone: **Other:**

Email address:

Social Security #: **Birthdate:** **Age:**

Employer: **Occupation:**

Marital Status: M S D W

Family member contact: **Phone:**

What procedure are you interested in? _____

Were you personally referred by someone? _____

If not, how did you hear about Dr. Lowenstein? **(circle all that apply)**

Word of mouth Google SBplasticsurgeon.com LocateaDoc

Yellowpages.com Citysearch Breastimplants411 Yahoo

LoveYourLook other:

INSURANCE INFORMATION Insured's name:

Insurance Company: Insured's SS#:

Policy #: Group #:

Insurance Co Mailing address:

I authorize the release of any medical information necessary to process this claim and I authorize payment of surgical and medical benefits to Dr. Lowenstein when applicable. I accept responsibility for fees for medical services rendered which are determined by insurance not to be covered.

Signature_____**Date:**_____

Health Questionnaire **PATIENT NAME:** _____

When was your last **physical examination**? ____/____/____

How is your **general health**? _____

Who is your **primary physician**? _____

What **medical conditions** are you presently being treated for?

_____

_____

_____

Please list your **previous surgeries and any complications including anesthesia reactions:**

Surgery	Date	Complications

Please list any reasons for **hospital admissions:**

_____

_____

_____

_____

Do any illnesses run in your **family medical history?** (include anesthesia and bleeding problems)

_____

_____

_____

Has any of your relatives had **breast cancer**? YES / no
if so, who? _____

When was your last **mammogram**?
____/____/____

Please list all **medications to which you have allergies or intolerances:**

Medication Allergy	Reaction

Please list all **medications you are currently taking:**

_____

_____

_____

_____

What is your **height**? _____ What is your **weight**? _____

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician- patient relationship with this practice. Dr. Lowenstein will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as patient.

Health Questionnaire **PATIENT NAME: _____**

Please circle the appropriate answer

EYE	y	no
Visual Loss	Y	N
Dry eyes	Y	N
Itchy or irritated eyes	Y	N
Blurred or double vision	Y	N
Crossed or lazy eyes	Y	N
Cornea problems	Y	N
Thyroid eye disease	Y	N
Wear glasses or contacts	Y	N
Previous eyelid surgery	Y	N
NOSE		
Difficulty breathing through nose	Y	N
Previous nose injury	Y	N
Nasal Allergies	Y	N
Nose bleeds	Y	N
Sinus conditions	Y	N
Previous nose or sinus surgery	Y	N
FACE		
Radiation to face or neck	Y	N
Facial paralysis or weakness	Y	N
Acne or facial skin problems	Y	N
Previous facial surgery	Y	N
PSYCHIATRIC		
Any recent crisis in your life?	Y	N
Have you ever:		
been treated for depression?	Y	N
been treated for anxiety?	Y	N
received psychiatric treatment?	Y	N
been hospitalized for psychiatric treatment?	Y	N
LIFESTYLE		
Do you drink alcohol?	Y	N
If yes how much per week:		
Do you take recreational drugs?	Y	N
If yes what kinds:		

HEART/LUNGS	ye	no
Heart attack	Y	N
Congenital heart disease	Y	N
Heart murmur	Y	N
Palpitations / irregular heart beat	Y	N
High blood pressure	Y	N
Stroke	Y	N
Shortness of breath	Y	N
Chronic lung disease	Y	N
Cough	Y	N
Asthma	Y	N
BREAST		
Breast pain or discomfort	Y	N
Breast cysts or lumps	Y	N
Previous breast biopsies	Y	N
Breast cancer	Y	N
OTHER		
Liver disease(hepatitis, cirrhosis)	Y	N
Kidney or bladder problems	Y	N
Bleeding disorders	Y	N
Easy bleeding or bruising	Y	N
History of blood clots	Y	N
Blood transfusions	Y	N
Autoimmune disease	Y	N
Unusual scarring	Y	N
Thyroid disease	Y	N
Stomach or digestive disease	Y	N
Spine or back problems	Y	N
Diabetes	Y	N
History of cold sores or Herpes Simplex	Y	N
LIFESTYLE		
DO YOU SMOKE/ NICOTINE USE?	Y	N
HAVE YOU EVER SMOKED?	Y	N
MIGHT YOU BE PREGNANT?	Y	N

Signature: Date:

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MONTECITO PLASTIC SURGERY
ADAM LOWENSTEIN, MD, FACS
CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

Photo Consent

In connection with the plastic surgical services which I am receiving, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. These photographs may be taken only with the consent of Dr. Lowenstein under conditions approved by him.
2. The photographs shall be used for medical records. If, in the judgment of Dr. Lowenstein, medical research, education, or science will be benefited by their use, such photographs and information relating to my case may be published and republished in medical journals or books or used for any other purpose in the interest of medical education, knowledge or research. It is specifically understood that I will not be identified by name.
3. I understand that these photographs may be shown on a confidential basis to other patients in the practice who are considering the same type of surgery.

Financial Agreement

1. **RELEASE OF INFORMATION:** Montecito Plastic Surgery may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Dr. Adam D. Lowenstein for reimbursement for services rendered, and (2) any health care provider for continued patient care. Montecito Plastic Surgery may also disclosed on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal Law, statute or regulation. A copy of this authorization may be used in place of the original.
2. **CREDIT CARD POLICY** If you pay with credit card and services are provided, should there be a challenge to the charge you initiated, you wave your HIPAA right of confidentiality to allow Montecio Plastic Surgery to respond to your complaint.
3. **OTHER INSURANCE:** The undersigned agrees that I am individually obligated to pay in full two weeks prior to all services rendered to me by Dr. Adam D. Lowenstein if I belong to a plan that does not contract with Montecito Plastic Surgery. I understand proper documents will be provided following the procedure so I can submit the claim to my insurance, or I have the option to utilize billing services with an additional 8% charge due two weeks prior to services.
4. **NON-COVERED SERVICES:** I understand Montecito Plastic Surgery contracts with Medicare and Sansum Health Clinic only relate to services "covered" by these health service plans. Accordingly, the undersigned accepts full financial responsibility due two weeks prior to all items or services rendered, which are determined by the health service plan not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Montecito Plastic Surgery to obtain necessary health care service plan authorizations.

Signature _____ Date _____

Witness _____

1722 STATE STREET, SUITE 101 • SANTA BARBARA, CA 93101 • T (805) 969-9004 F (805) 969-7224
WWW.SBPLASTICSURGEON.COM

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MONTECITO PLASTIC SURGERY
ADAM LOWENSTEIN, MD, FACS
CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

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 PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests 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, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards. The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.
The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

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 prior authorization.
You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the 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 by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.
We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.
This notice if effective as of September 23, 32013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.
Feel free to contact the Practice Compliance Officer Susanne Engberg (805)969-9004 for more information, in person or in writing.

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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of Montecito Plastic Surgery. I hereby acknowledge receipt of Montecito Plastic Surgery's Notice of Privacy Practices.

Patient Name: _____
(please print)

Signature: _____ Date: _____

OR

I am a parent or legal guardian of _____ . I hereby acknowledge receipt of
(Patient Name)

_____ 's Notice of Privacy Practices with respect to the patient.
(Patient Name)

Name : _____ Relationship to Patient: ☐ Parent ☐ Legal Guardian
(Please Print)

Signature: _____ Date: _____