PLASTIC SURGERY NORTHWEST

Demographics

First Name	Last Name	MI	AGE	DOB
Other Names Used (past or present)		Preferred Language		SSN
Reason for visit? (List cause injury if applicable.)		Primary Care Provider		
Marital Status	Race		Ethnicity	
Spouses First Name	Last Name	MI	DOB	SSN
Address	City		State	Zip
Occupation	Employer		Email	
Check Contact Preference	☐ Home Phone	☐ Work Phone	☐ Cell Phone Text Message ok? Yes No	
Emergency Contact	Relationship to Patient	Primary Phone	Secondary Phone	
How did you hear about us? (Website, Magazine, RealSelf, Google, Friend, Other)				
Primary Health Insurance				
ID #		Group #		
Referral Required?			Copay	
Claim Number (L&I or auto insurance)			Date of Injury	
Insured Name	DOB	SSN	Employer	
Secondary Health Insurance				
ID #		Group #		
Insured Name	DOB	SSN	Employer	

Financial Information

Please bring your insurance card(s) with you to every appointment. It is the patient/guarantor's responsibility to know and understand their insurance benefits, covered services, and financial responsibilities. Changes in insurance carrier may affect your coverage. Please notify our office immediately of any changes to avoid delays. Failure to pay your bill may result in your account information being sent to a 3rd party company for resolution.

Plastic Surgery Northwest accepts the following forms of payment: *All major credit/debit cards, CareCredit, cash, and check.*

PLASTIC SURGERY NORTHWEST

Our billing staff members are available from 8:00AM – 5:00PM Monday through Friday and can be reached by calling 509-838-1010, option #3.

Health History

Height	**Weight**

Do you have or have you had any of the following (circle for each):

Breast Cancer	No	Yes	Vision problems	No	Yes	DVT/Pulmonary Embolus	No	Yes
Ovarian Cancer	No	Yes	Hearing problems	No	Yes	Family History of Blood Clots	No	Yes
Other Cancer	No	Yes	Pain in joints/muscles	No	Yes	Genetic Hypercoagulability	No	Yes
Chronic_pain/narcotics	No	Yes	GERD/reflux	No	Yes	Inflammatory Bowel Disease	No	Yes
Depression	No	Yes	Problems swallowing	No	Yes	Varicose Veins	No	Yes
Anxiety	No	Yes	Constipation	No	Yes	Current Central Line or Port	No	Yes
Heart Attack / Pain	No	Yes	Kidney Problems	No	Yes	Hormone Based Contraceptive	No	Yes
EKG Abnormalities	No	Yes	Problems urinating	No	Yes	Hormone Replacement Therapy	No	Yes
High Blood Pressure	No	Yes	Thyroid problems	No	Yes	History of three or more lost Pregnancies	No	Yes
Stroke	No	Yes	Diabetes	No	Yes			
Seizures	No	Yes	Autoimmune Disorder	No	Yes			
COPD	No	Yes	Weight Changes	No	Yes	Other:		
Asthma	No	Yes	Cold sores	No	Yes			
Shortness of Breath	No	Yes	Problems with scarring	No	Yes			

Physician Use Only:

Surgeries: (list any surgical procedures you have had and the month/year of surgery)

Family History: Please list any major medical problems of your immediate family <u>including any issues with anesthesia.</u>

Nicotine Use: (including gum, patches, vape, chew, etc)	**Do you Consume:**	**If yes to either: what type, how much, how often?**
Yes/No Former (please indicate date quit): If Yes, what type: If Yes, how much:	**Alcohol:** Yes/No **Drugs:** Yes/No	

Have you ever been pregnant?	Yes	No	**Who do you currently live with?**
Have you ever, or do you plan on breast feeding?	Yes	No	
Is there any chance you are currently pregnant?	Yes	No	

Preferred Pharmacy: **Location:**	**Allergies:** (Medications, Latex, or other)

Medications: List the name of all medications/supplements you are presently taking or have taken within the last month, including steroid use (**use back if needed.**)

PLASTIC SURGERY
NORTHWEST

Release of Information

I authorize Plastic Surgery Northwest, LLC to use and/or disclose the named individual's protected health information, including any and all documents containing information regarding any amendment of such information in the medical records as described below for the purpose of continuity of care for the period of _____ to _____.

Records to be disclosed:

- Comprehensive overview of chart from date:_____ to _____.
- Images
- Other (specify type (required) – e.g. discharge summary, operative reports, billing records, lab reports.)

_____

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it will not affect any actions taken prior to my revocation. If I do not revoke this authorization, it will expire 10 years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable confidentiality rules. If I have questions about the use or disclosure of my health information, I can contact Plastic Surgery Northwest at 509-838-1010.

You may specify that Plastic Surgery Northwest withhold specific information. Please list the information that you would like withheld below.

_____

*Please initial the below referenced information you wish to authorize.

_____I hereby give my consent for Plastic Surgery Northwest Physicians or staff to leave information regarding my treatment, results, appointment information, or recommendations on my voicemail at the phone numbers I have provided.

_____I hereby give my permission for Plastic Surgery Northwest Physicians or staff to phone me at my work or may text.

_____I hereby give my permission for Plastic Surgery Northwest Physicians or staff to discuss my billing, appointment, and caretaking information with the person/persons listed below:

Name_____Relationship to Patient_____

Minors: A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care, (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older.)

I certify that I have read the about Authorization and Release and fully understand its terms.

_____ _____

Patient Signature *Date*

PLASTIC SURGERY
NORTHWEST

PHOTO AND VIDEO CONSENT AND AUTHORIZATION

Agreement for capture, disclosure and use of still photos, moving video and computer images.

I,_____, authorize the capture, disclosure and use, as noted below, of photographs, video and **accompanying protected health information** related to my healthcare services at Plastic Surgery Northwest ("Media"). I understand that my photo will be taken and placed in my permanent medical record.

Media may also be used or disclosed for:

Y	N	
☐	☐	Photo albums for the education of Plastic Surgery Northwest patients
☐	☐	Publication in print or visual media, including medical journals, textbooks, educational videos, or presentations
☐	☐	Publication on the Plastic Surgery Northwest website, social media platforms, or in other advertising media representing and/or marketing Plastic Surgery Northwest and its services and physicians

Published Media may include my image, voice, age, sex, medical condition, treatment, and outcome, but this consent does not authorize the release of written or printed medical records. However, please withhold the following specific information:

Please list any identifying marks (including tattoos, birthmarks etc.) that you would like removed from the images. No corrections will be made that will alter the appearance of actual surgical results.

All Media will become the property of Plastic Surgery Northwest and may be retained for the purposes and uses approved in this consent. I understand that Plastic Surgery Northwest may receive compensation for its use and/or disclosure of Media in marketing materials such as websites, media outreach, brochures, television, and/or any other media outlets or for other marketing purposes. I understand and agree that I will not receive any compensation for use of Media, and I waive any right for myself, my spousal community or my heirs and assigns to receive any compensation. I agree to hold harmless Plastic Surgery Northwest and its associated physicians and any and all employees from all claims and liabilities whatsoever in law and in equity arising from disclosure and use of Media as authorized in this consent.

I understand that I may refuse to authorize the disclosure and use of any Media and that my refusal to consent will prevent its disclosure and use except solely in connection with healthcare services at Plastic Surgery Northwest, but such refusal will not affect the healthcare services that I receive from Plastic Surgery Northwest. I understand that I have the right to revoke this authorization in writing at any time, but I further understand that revocation will not apply to or cause the retraction of previously published, disclosed or used Media.

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

By signing below, I acknowledge and certify that I have read, understood, and agreed to the terms of this consent, and that I have received a copy of the signed consent.

_____

Patient Name Date of Birth

_____

Patient / Guardian Signature Date

PLASTIC SURGERY
NORTHWEST

TELEHEALTH AUTHORIZATION AND RELEASE

I hereby consent to communicating by cell, e-mail and online with Dr. _____ and his/her staff and personnel (hereinafter referred to collectively as "my Doctor") so as to conduct virtual consultations, telemedicine/telehealth, and any other purpose deemed by my Doctor to be appropriate while I am receiving medical and aesthetic services.

As announced by the US Department of Health & Human Services ("HHS") on March 17, 2020, I understand my Doctor is now authorized to use non-public facing audio and/or video communication technology to provide telehealth, whether or not related to COVID-19, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, but my Doctor is not authorized to use public facing technology, such as Facebook Live, Twitch or TikTok. I accept that even authorized non-public facing third-party applications potentially introduce privacy risks, but my Doctor will enable all available encryption and privacy modes when using these applications.

I also agree that my Doctor may communicate with me by the following additional methods:

Cell # (calls and texts) ( ) _____ E-mail _____

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. Unless and until I revoke this authorization, it will exist in perpetuity from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

I release and discharge my Doctor and all parties acting under my Doctor's license and authority from any telehealth medical privacy claims I might otherwise have had prior to HHS's March 17, 2020 notification. I certify that I have read this Authorization and Release and fully understand its terms.

_____ _____
Patient Signature *Witness/Physician/Staff*

_____ _____
Patient Name *Date*

I have read the above Authorization and Release. I am the parent, guardian or conservator of the patient, a minor. I am authorized to sign this consent on the patient's behalf.

_____ _____
Parent/Guardian/Conservator Signature *Date*

_____
Parent/Guardian/Conservator Name