Sierra Nevada Cosmetic and Laser Surgery
540 W. Plumb Lane, Suite 110
Reno, NV 89509
PH: (775)525-1712
Fax: (775) 499-5676

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cosmetic + laser surgery

Patient Information Form

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

DOB & Age: _____

Gender: _____ SSN: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our office?

☐ Patient Referral: _____ ☐ Dr. Referral: _____ ☐ Friend: _____

☐ Google ☐ Facebook ☐ Realself.com ☐ Other:

What procedures or treatments are you interested in? _____

_____

Pharmacy: _____

Address: _____

_____

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Emergency Contact

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Name: _____ Policy #: _____ Group ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Name: _____ Policy #: _____ Group ID: _____

Assignment and Release

I, _____, have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured Patient / Guardian Date

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Section I: Surgery History

1. Have you ever had surgery? ☐ No ☐ Yes Please give us surgery year and description:

_____

_____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes ☐ N/A Height: _____ Weight: _____

	Have you or do you still have:	No	Yes	Description
2.	Bleeding Tendencies	☐	☐	
3.	Cancer	☐	☐	
4.	Diabetes	☐	☐	
5.	Heart Disease	☐	☐	
6.	Hepatitis or Liver Disease	☐	☐	
7.	High Blood Pressure	☐	☐	
8.	Immunodeficiency	☐	☐	
9.	Kidney Disease	☐	☐	
10.	Lung Disease	☐	☐	
11.	Mental Illness	☐	☐	
12.	Migraine Headaches	☐	☐	
13.	Problem Scarring	☐	☐	
14.	Stroke or Seizures	☐	☐	
15.	Thyroid Disease	☐	☐	

16. Others Not Listed: _____

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Section III: Allergies and Sensitivities

Are you allergic to any medications, anesthesia or anything non-medication? ☐ No ☐ Yes, type of allergic reaction:

_____

_____

Section IV: Social History

Tobacco Use: ☐ No ☐ Yes, how much? ☐ Previous use, when quit? _____

Alcohol Use: ☐ No ☐ Yes, how much? ☐ Previous use, when quit? _____

Recreational Drug Use: ☐ No ☐ Yes, how much? ☐ Previous use, when quit? _____

Section V: Family History

☐ Adopted

	Have any blood relatives had any of the following?	No	Yes	Relationship and Description
1.	Bleeding Tendency	☐	☐	
2.	Cancer	☐	☐	
3.	Diabetes	☐	☐	
4.	Heart Disease	☐	☐	
5.	High Blood Pressure	☐	☐	
6.	Immunodeficiency	☐	☐	
7.	Kidney Disease	☐	☐	
8.	Lung Disease	☐	☐	
9.	Mental Illness	☐	☐	
10.	Migraine Headaches	☐	☐	
11.	Stroke or Seizures	☐	☐	
12.	Others not listed:			

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Section VI: Medications and Vitamins/Herbal Supplements

Are you taking any medications? ☐ No ☐ Yes, please list:

Are you taking any vitamins or herbal supplements? ☐ No ☐ Yes, please list:

Section VII: Cosmetic Procedures

Have you ever had any cosmetic procedures? ☐ No

☐ Yes, injectables, please list:

☐ Yes, surgery, laser, or other procedures, please list:

Section VIII: History of Sun Exposure

Do you have a significant history of sun exposure (e.g. tanning bed use, outdoor hobbies, occupation, etc.)?
☐ No ☐ Yes, please list:

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

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Consent to Communicate

Patient Name:_____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message – if so, list cell carrier:			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA Information and Consent Form

Patient Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, <PersonalInfo.FirstName> <PersonalInfo.LastName>, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

Consent to Photograph or Film

I, , give consent that Sierra Nevada Cosmetic and Laser Surgery can photograph or film me but only to the extent necessary and so long as the images are used solely for purposes of (a) identifying me as a patient or for purposes of documenting my health status, diagnosis and treatment while a patient; (b) conducting education and training, quality assurance and performance improvement functions for and on behalf of Sierra Nevada Cosmetic and Laser Surgery and its professional staff; and (c) publishing the results of my treatment on Sierra Nevada Cosmetic and Laser Surgery's website which, in this particular case, required me to sign the HIPAA authorization form.

The purpose of this form is to obtain my prior written consent so that Sierra Nevada Cosmetic and Laser Surgery may photograph or film me for one or more of the following purposes listed below for which I do hereby consent.

(Initial all purposes that apply):

_____ Use or disclosure of image for marketing or advertising purposes and patient education

_____ Use or disclosure of image for medical specialty board in formulating its examination of applicant physicians

_____ Use or disclosure of image in a professional presentation or journal publication

Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of surgery, except there will be no expiration for the purpose of medical or scientific research or use in specialty board examinations.

I also agree to sign the HIPAA authorization form which permits Sierra Nevada Cosmetic and Laser Surgery to use or disclosure these images but only to the extent permitted by HIPAA and other applicable laws and regulations.

Computer Imaging Disclaimer

Computer imaging may be used to better educate you about your upcoming surgery. Although an approximation of intended results is to be displayed, I realize that there are differences in graphic artistic ability and surgical technique. I realize that computer imaging does not constitute and should not be construed to be an exact representation of post-surgical results. I understand that it is impossible to guarantee intended results. I understand that the alteration of any images is purely for the purpose of education, illustration and discussion.

_____ _____

Patient (or Patient's Legal Representative) Signature Date

_____ _____

Witness Signature Date

Sierra Nevada Cosmetic and Laser Surgery

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Patient Name:_____

Please read each question carefully and circle the answer that is true for you. Also write in answers where indicated.

1. Are you worried about how you look? Yes No
   - If yes: Do you think about your appearance problems a lot and wish you could think less about them? Yes No
   - If yes, please list the body areas that you don't like:

     _____

     _____

If you answered "NO" to either question above, you are finished with this questionnaire. Otherwise, please continue.

2. Is your <u>main concern</u> with how you look that you aren't thin enough? Yes No
3. How has this problem with how you look affected your life?
   - Has it often upset you? Yes No
   - Has it got in the way of doing things with friends, dating or social activities? Yes No
     If yes: describe how?

     _____

     _____
   - Has it caused you problems with work or school? Yes No
     If yes: describe how?

     _____

     _____
   - Are there things that you avoid because of how you look? Yes No
     If yes: what are they?

     _____

     _____
4. On an average day, how much time do you usually spend thinking about how you look?
   Add up all the time you spend in a total day Circle your answer

   Less than 1 hour 1-3 hours in a day more than 3 hours in a day

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Sierra Nevada Cosmetic + Laser Surgery on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Sierra Nevada Cosmetic + Laser Surgery to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Sierra Nevada Cosmetic + Laser Surgery. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party | Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party | Relationship to Patient

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Cancellation/No Show Policy

1. *Cancellation of A Doctor's Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we may, at our discretion, need to reschedule the appointment.

3. *Account balances*

We will require that patients with a balance not owed by insurance, pay their account balance in full, prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to an office representative with whom they can review their account and concerns.

_____

Print Patient Name

_____ ____/____/____

Signature Patient/Guardian **Date**

_____ ____/____/____

Signature of Witness **Date**

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RECORD RELEASE REQUEST:

Date: _____

To: _____
Doctor/Practice Name

Address: _____

_____

Phone: _____ Fax: _____

Patient Name: _____
Please Print First and Last Name

Date of Birth: _____

I authorize the release of medical records relevant to medical treatment, or copies of such, and request that they be transferred to:

Sierra Nevada Cosmetic + Laser Surgery
Kyle T. Yamamoto, M.D.
Address and Phone listed below
Fax: (775) 499-5676

Signature: _____
Patient or Legal Guardian