PATIENT INFORMATION

Name_____ MI_____ DOB_____ Age_____

Parent/Guardian if patient is a minor _____

S.S #_____ Male_____ Female_____ Single_____ Married_____

Address_____ City_____ State_____ Zip_____

May we send correspondence by mail to the above address? (circle) YES / NO

Home Ph#_____ Cell #_____ Work # _____

May we leave a message on the above phone numbers? (circle) YES / NO

Email _____

Would you like to communicate by email & receive our e-newsletter or promotional emails? (circle) YES / NO

CARETAKER/EMERGENCY CONTACT INFORMATION

Name_____

Relationship to you: (circle) Spouse / Friend / Parent / Grandparent / Child

Address_____ City_____ State_____ Zip_____

Phone#_____ Cell #_____ Work # _____

***Do you allow The Vu Center to disclose medical information regarding your treatment?** (circle) **YES / NO initial_____**

Referred By _____ Phone _____
PCP _____ Phone _____

PLEASE READ AND SIGN BELOW:
AUTHORIZATION FOR RELEASE OF INFORMATION:
I herby authorize The Vu Center for Plastic and Hand Surgery, PC to release any information requested by my caretaker/emergency contact, insurance company (reconstructive procedures), or to release information to any hospital, laboratory or physician I may be referred to by this office. I also acknowledge that I have received a copy of the privacy practices.

I hereby consent and authorize examination and treatment by Dr. Kim-Chi Vu and such assistant or staff as may be assigned by her.

"To the best of my knowledge I have provided above and on the following page, regarding my medications, past medical history, allergies, and smoking history is accurate, complete and honest. I understand that failure to disclose this information may be detrimental to my condition and treatment and accept responsibility for any omissions."

A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ **Date** _____

Relationship: (circle one) Self Parent Guardian

PATIENT HISTORY

Patient Name: _____ **Date of Birth**:_____
Date of Visit: _____ **Reason for Visit**: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS, IF SO WHAT?

_____

ARE YOU TAKING ANY MEDICATION? *PLEASE LIST MEDICATION NAMES AND DOSAGES*

1. _____ **3.** _____
2. _____ **4.** _____

CURRENT HEIGHT: _____ **WEIGHT:** _____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	Yes	No		Yes	No
Anxiety/depression	___	___	HIV/AIDS	___	___
Bleeding disorder/clots	___	___	Hypertension	___	___
Cancer	___	___	Kidney disease	___	___
Diabetes	___	___	Liver disease	___	___
GI bleeding	___	___	Lung disease/Asthma/COPD	___	___
Hepatitis	___	___	Seizures	___	___
Sleep apnea	___	___	Stroke	___	___
Heart disease/attack	___	___			

If you have any **heart conditions**, who is your cardiologist? _____
Any recent **EKG** performed? Date and location: _____
Any other medical conditions? _____
If female: date of last menstrual period_____ Any possibility of pregnancy?_____

HAVE YOU HAD ANY SURGERY IN THE PAST? *PLEASE LIST SURGERY TYPE AND DATE*

1. _____ **3.** _____
2. _____ **4.** _____

ANY PROBLEMS WITH ANESTHESIA IN THE PAST? Yes or No
If yes, explain: _____

DO ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE FOLLOWING?
PLEASE INDICATE WHICH FAMILY MEMBER & IF MATERNAL OR PATERNAL RELATIVE

1. Bleeding disorder/clots_____ **4.** Heart disease_____
2. Cancer_____ **5.** Hypertension_____
3. Diabetes_____ **6.** Kidney disease_____
Any other medical conditions? _____

SOCIAL HISTORY

Smoke? How much?_____ Type of work you do:_____
Alcohol? How much? _____ Hobbies: _____
Recreational drug use? _____ Married or single? _____
(marijuana, methamphetamines, etc.)

DO YOU HAVE ANY RECENT SYMPTOMS OF THE FOLLOWING?

1. Fever/chills	yes/no	8. Heartburn	yes/no
2. Rashes/sores	yes/no	9. GI bleeding	yes/no
3. Nasal congestion/sore throat	yes/no	10. Body/joint pain	yes/no
4. Chest pain	yes/no	11. Headache	yes/no
5. Cough/shortness of breath	yes/no	12. Dizziness/fainting	yes/no
6. Swollen lymph nodes	yes/no	13. Anxiety/depression	yes/no
7. Nausea/vomiting	yes/no		

THE VU CENTER
PLASTIC & HAND SURGERY

PHOTO CONSENT FORM

FOR MEDICAL RECORD:

Patient understands that photographs will be taken before, during, and after Patient's procedure(s) as a routine part of medical care. Patient understands that these photographs will become part of the medical record which will remain the property of The Vu Center for Plastic and Hand Surgery, P.C. ("The Vu Center") and will be kept strictly confidential as Protected Health Information. Patient authorizes The Vu Center, The Vu Center's physicians and their representatives to take photographs of Patient to be used and disclosed in relation to Patient's medical care, including but not limited to the following circumstances: treatment; billing and payment; insurance purposes; appointments and test results; requests by any governmental body or agency; requests by medical providers; to report abuse; to comply with any state or federal law, regulation or rule; to avoid harm; and/or pursuant to authorized written requests. By signing below, Patient understands that Patient may revoke this consent at any time, in writing (not by e-mail, text message, or other electronic forms of communication), but that such revocation will have no effect on any actions taken prior to the date that revocation is received by The Vu Center.

Patient Signature: _____ Date: _____

CONSENT TO ADDITIONAL USES OF PHOTOGRAPHS

In addition to the MEDICAL RECORD, Patient agrees and authorizes The Vu Center and its physicians to use and disclose photographs of Patient to be used and disclosed in relation to the following:

Note: The Vu Center does not disclose any Patient's name. Patient can request to have their face removed from photographs if applicable.

PHOTO ALBUM

Photographs of Patient may be used and disclosed by The Vu Center and its physicians for the purpose of patient education and information, including but not limited to their use during patient consultations in a "photo album" to inform patients about plastic surgery procedures and methods, provided Patient will not be identified by name or date of birth. By initialing this paragraph and signing below, Patient agrees to waive any and all claims and rights relating to the use of these photographs as described herein, including but not limited to any claims for remuneration. Patient further agrees to release and discharge The Vu Center, their physicians and employees, and any facility in which Patient's medical procedure(s) were performed, from any and all claims or actions that Patient has or may have relating to their use as described herein. Patient understands that Patient may revoke this consent at any time, in writing (not by e-mail, text message, or other electronic forms of communication), but that such revocation will have no effect on any actions taken prior to the date that revocation is received by The Vu Center. **Initial _____**

WEBSITE

Photographs of Patient may be used and disclosed by The Vu Center on its internet website to educate and inform the public about plastic surgery procedures and methods, provided Patient will not be identified by name or date of birth. By initialing this paragraph and signing below, Patient agrees to waive any and all claims and rights relating to the use of these photographs as described herein, including but not limited to any claims for remuneration. Patient further agrees to release and discharge The Vu Center, their physicians and employees, and any facility in which Patient's medical procedure(s) were performed, from any and all claims or actions that Patient has or may have relating to their use as described herein. Patient understands that Patient may revoke this consent at any time, in writing (not by e-mail, text message, or other electronic forms of communication), but that such revocation will have no effect on any actions taken prior to the date that revocation is received by The Vu Center. **Initial _____**

MEDICAL EDUCATION

Photographs of Patient may be used and disclosed by The Vu Center and its physicians for the purpose of medical education and training, including but not limited to their publication in medical websites, medical journals and medical textbooks, provided Patient will not be identified by name or date of birth. By initialing this paragraph and signing below, Patient agrees to waive any and all claims and rights relating to the use of these photographs as described herein, including but not limited to any claims for remuneration. Patient further agrees to release and discharge The Vu Center, their physicians and employees, and any facility in which Patient's medical procedure(s) were performed, from any and all claims or actions that Patient has or may have relating to their use as described herein. Patient understands that Patient may revoke this consent at any time, in writing (not by e-mail, text message, or other electronic forms of communication), but that such revocation will have no effect on any actions taken prior to the date that revocation is received by The Vu Center. **Initial _____**

ALL MEDIA

Photographs of Patient may be used and disclosed by The Vu Center in any print or broadcast media, including but not limited to any and all print media, internet media, broadcast media, pamphlets, and presentations, in order to inform the public about plastic surgery procedures and methods. By initialing this paragraph and signing below, Patient agrees to waive any and all claims and rights relating to the use of these photographs as described herein, including but not limited to any claims for remuneration. Patient further agrees to release and discharge The Vu Center, their physicians and employees, and any facility in which Patient's medical procedure(s) were performed, from any and all claims or actions that Patient has or may have relating to their use as described herein. Patient understands that Patient may revoke this consent at any time, in writing (not by e-mail, text message, or other electronic forms of communication), but that such revocation will have no effect on any actions taken prior to the date that revocation is received by The Vu Center. **Initial _____**

SIGN BELOW TO CERTIFY THAT YOU HAVE READ THE ABOVE CONSENT TO *ADDITIONAL* USES OF PHOTOGRAPHS AND FULLY UNDERSTAND AND AGREE TO ITS TERMS

Patient Signature: <Patient Signature> Date: <Current Date>

PLEASE SIGN ELECTRONICALLY AT THE TIME OF YOUR APPOINTMENT TO CERTIFY THAT YOU HAVE READ THE ABOVE CONSENT TO ADDITIONAL USES OF PHOTOGRAPHS AND FULLY UNDERSTAND AND AGREE TO ITS TERMS

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can access this information. PLEASE REVIEW CAREFULLY. **PLEASE KEEP FOR YOUR RECORDS.**

The Vu Center for Plastic and Hand Surgery, P.C. ("The Vu Center") knows that the information we collect about you and your health is private. The Vu Center is required by Federal and State law to protect this information. The information in this notice tells you how we may use or disclose information about you. Not all situations are described. We are required to give you notice of our privacy practices regarding the information we collect and keep about you.

The Vu Center may use and disclose information without your written authorization under the following circumstances:

- Treatment- We may use or disclose information with health care providers who are involved in your treatment or care. Information may be shared to carry out a plan for your diagnosis and treatment.
- Payment- We may disclose information to receive payment or to pay for health care services you receive. Information may be provided to your health plan for billing purposes.
- Appointments and Test Results- We may send you reminders for your medical care and results of medical testing we may order in the course of your treatment.
- State or Federal Requests- We may use and disclose information when required by federal or state law, or by a court order.
- Abuse- Information required by law to report suspected abuse may be disclosed to appropriate government agencies.
- Government Programs- Information for public benefits under government programs, such as Supplemental Security Income (SSI).
- To Avoid Harm- Information to law enforcement agencies to avoid serious threat to the health and safety of persons or the public.
- Family- We may disclose information to your family or others who are involved in your medical care. YOU HAVE THE RIGHT TO OBJECT TO THE SHARING OF INFORMATION IN THIS SITUATION.
- Responsibility – Your healthcare is your own. We encourage you to ask questions and take responsibility for your health and healing.
- Release of Information – If you request that we submit The Vu Center's records to a third party, other than another physician's office, we require that you sign a release.
- Request for Restriction on Use and Disclosure – If you have a restriction you wish The Vu Center to be aware of, we will provide you with a form to sign. Please see a staff member.

Other uses and disclosures require your written authorization. At your request, you will be given a Request for Restriction of Use and Disclosure of Health Information form to complete. You may cancel this authorization at any time in writing.

COSMETIC PAYMENT POLICY

Thank you for allowing us to provide the services you desire in cosmetic and reconstructive surgery. As part of cosmetic surgery, our policy is that payment in full is due prior to commencement of surgery. The following guidelines have been set to allow you to fully understand our policy. We are committed to you to assist you in any way to make your surgery as comfortable as possible. Please read the following and initial each statement to acknowledge that you have read our guidelines. Please do not hesitate to ask us if you have any questions, as we hope to make your surgery as favorable as possible so that we may continue to provide the services that you may desire. Thank you.

- *All cosmetic consultations are $50.00, nonrefundable. If you need to cancel your consultation, you must do so 24 hours prior to your appointment. If you cancel or miss your appointment without giving the office 24 hour notice, you will be billed a nonrefundable fee of $75. Initial ___*

- *You will be provided with a written estimate of fees at your consultation. The quote will include the surgeon's fee, the operating room fee, and the anesthesia fee. This estimate is subject to change, since we do not have control over the fees for the operating room and anesthesia. Once you have decided to proceed with surgery, confirmation of fees from the facility and anesthesiologist will be confirmed. Fees for additional items which may include, but are not limited to, hospital stay, implants, garments, cosmetic insurances, pain pump, are not included in the fee quote and may be billed separately. Pre/post lab work, surgical recovery and autologous blood, if needed, are not included in this quote. Initial ___*

- *After scheduling your surgery date, you will be scheduled for a preoperative visit prior to surgery. At that time, we ask that you pay the remaining balance on your account.* ***We accept all major credit cards except American Express.*** *We also accept CareCredit, Cash, Check and Money Order. There will be a $50.00 charge for all returned checks.* ***Initial ___***

- *If an EKG, lab work, or pathology report is found to be medically necessary before or after your surgery, it will be billed separately by the hospital or laboratory. Pre/Post lab work, surgical recovery - autologous blood, if needed, are not included in the fee quote. Initial ___*

- *We are not responsible for the operating room/facility fee, and anesthesia fee, but it is included in the estimated quote. We will be more than willing to disburse the funds on your behalf. Initial ___*

- *Prescription medications vary from patient to patient and are a separate expense; therefore, they are not included in the quote. Your health insurance will typically pick up these expenses with your routine co-pay. Initial ___*

- *If revisionary procedures are deemed necessary, a surgeon's fee may apply depending on each individual case; however, the cost of the operating room, facility, supplies and anesthesia would be your responsibility. Initial ___*

- *CANCELLATION POLICY: All of our patients who cancel appointments or surgeries do so for legitimate, honest reasons such as a death in the family, illness of a child, loss of job, etc. Nonetheless, The Vu Center physician's and surgeon's time is valuable. Thus, we must uphold our policy evenly and across-the-board without judging whether one patient's reason for cancellation is more valid than another's. Initial ___*

- *There will be a $500.00 nonrefundable scheduling fee due at the time you decide to schedule your surgery, which will be applied to The Vu Center's surgeon fee. If you need to reschedule, there will be an additional nonrefundable fee of $250.00. If you cancel your surgery within ten (10) business days before your surgery you will be charged 25% of the price quotation. If your surgery is cancelled before (10) business days, we will refund your money minus the original $500 deposit fee. This deposit will be held for you for one year at which time you may use only towards another surgery. Please understand that such changes affect not only your surgeon, the surgical facility, the anesthesiologist, but other patients as well. Initial ___*

- *We do have Financing Programs available to assist you with paying for your surgery. If you wish to learn more, we will gladly provide you with the proper information. We accept certain plans with Care Credit. These options of payment are only accepted when paying full price for surgeries. Initial ___*
- *We occasionally have specials on our cosmetic surgeries and treatments. If there is a surgery you are interested in that is currently on special, you may only pay with credit card, check or cash. We will not accept payments from third party financing companies for surgeries on special. We also do not accept American Express. Initial ___*

- *Payment for Botox, injectable fillers, or products are paid in full on the day of your treatment or visit. Initial ___*

- *Skin care products purchased are nonrefundable, unless there is a legitimate contamination or tampering of the product. Initial ___*

- *Procedures purchased as package treatment programs are at a discounted rate, and must be paid in full at the time of your first treatment. Should you decide to cancel your treatments at any time during your treatment package program, then each treatment session performed will be charged at the individual treatments full price and any remaining balance will be refunded back to you. Initial ___*

- *You will be directly billed for any outstanding balances for all services provided. If you do not pay the patient balance within 30 days after receiving the initial statement, we will contact you to establish a payment plan. Initial ___*

- *After 60 days, if we have not received payment from you and you have not contacted us about payments, your bill will be submitted to a collection agency or small claims court, depending on the amount due. Initial ___*

- *All outstanding balances will have a reoccurring administrative fee of $7.50 per month. You are able to dispute the charges after the entire principal balance is paid in full, but it is on a case by case basis. Please speak to your billing representative for further questions. Initial ___*

- *There will also be a $25.00 collection fee if your account gets transferred to a collection agency. Initial ___*

- *If we feel our patient is not physically or mentally ready or prepared to undergo a surgical procedure we reserve the right to cancel the surgery or refuse to schedule. Initial ___*

The Vu Center for Plastic and Hand Surgery, PC does not bill any insurance for these procedure and/or services.

I, _____(patient name), have read the above COSMETIC PAYMENT POLICY and guidelines. By signing electronically for this COSMETIC PAYMENT POLICY, I understand and will comply with my financial responsibilities for cosmetic procedures. I understand that no cosmetic procedure, under any circumstances, will be billed to my insurance by The Vu Center for Plastic and Hand Surgery, PC or The Vu Center's physicians.

By signing this waiver, I also acknowledge that The Vu Center for Plastic and Hand Surgery, PC has advised me not to submit a bill on my own to my insurance in any way. I agree to be personally responsible for paying the financial charges for any cosmetic services, treatments or procedures I have.

Patient Signature:_____ Date:_____

PLEASE SIGN ELECTRONICALLY AT THE TIME OF YOUR APPOINTMENT TO CERTIFY THAT YOU HAVE READ THE ABOVE CONSENT TO ADDITIONAL USES OF PHOTOGRAPHS AND FULLY UNDERSTAND AND AGREE TO ITS TERMS