Nguyen Plastic Surgery

Cosmetic, Reconstructive, Hand and Laser Surgery
2500 Nesconset Highway, Suite 4D
Stony Brook Medical Park
Stony Brook, NY 11790

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PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date: _____

Patient: _____
last name first name middle initial

Address: _____
street city state zip

Sex: __ Female __ Male Marital Status: __ single __ married __widowed __divorced

Height: _____ Weight: _____ Birth Date: ___ / ___ / ___ Age: ____

SS# _____ - _____ - _____ Occupation:_____ Employer: _____

Home Phone: (___) ___ - _____ Cell: (___) ___ - _____ Bus. Phone: (___) ___ - _____ ext: _____

Email address: _____

SPOUSE INFORMATION

Spouse's Full Name: _____

Spouse's Occupation: _____ Employer: _____ Bus. Phone: (___) ___ - _____

IF PATIENT IS A MINOR

Mother's Name: _____

Occupation: _____

Bus. Phone: (___) ___ - _____

Birth Date: ___ / ___/ ___ SS# _____ - _____ - _____

Father's Name: _____

Occupation: _____

Bus. Phone: (___) ___ - _____

Birth Date: ___ / ___/ ___ SS# _____ - _____ - _____

PHARMACY

NAME:_____ PHONE: ( ) _____-_____

Address: _____
street city state zip

OTHER INFORMATION

In cases of Emergency, please contact (full name):_____

Relationship:_____ Phone: (___) _____ - _____

Name of referring Physician:_____

Referred to this office by: __ Newsday __Yellow Pages __Friend __MD __Website __ Other_____

INSURANCE INFORMATION

Responsible Party: _____
last name first name middle initial

Address: _____
street city state zip

Relationship to Patient: _____

SS# _____ - _____ - _____ Home Phone: (___) ___ - _____ Bus. Phone: (___) ___ - _____

Primary Company:_____

Address: _____
street city state zip

Phone: (___) ___ - _____ ID #:_____ Group #: _____

Subscriber: _____ Relationship to Patient: _____

Secondary Company:_____

Address: _____
street city state zip

Phone: (___) ___ - _____ ID #:_____ Group #: _____

Subscriber: _____ Relationship to Patient: _____

Additional Company:_____

Address: _____
street city state zip

Phone: (___) ___ - _____ ID #:_____ Group #: _____

Subscriber: _____ Relationship to Patient: _____

MEDICAL HISTORY

Patient Name: _____

Reason for today's visit: _____

_____

Age: _____ Sex: ___ Female ___ Male Height: _____ Weight: _____

Do you have any medical problems such as:

1.	bleeding disorders	__ yes __ no	9.	recent or current infection	__ yes __ no
2.	surgery	__ yes __ no	10.	angina/ myocardial infarction/ CHF	__ yes __ no
3.	alcohol/ drug abuse	__ yes __ no	11.	high blood pressure	__ yes __ no
4.	smoking	__ yes __ no	12.	kidney disease/ GU disease	__ yes __ no
5.	COPD (pulmonary)	__ yes __ no	13.	liver/ G.I. disorder	__ yes __ no
6.	asthma	__ yes __ no	14.	neurologic illness	__ yes __ no
7.	diabetes mellitus	__ yes __ no	15.	psychiatric illness	__ yes __ no
8.	loose teeth/ dentures	__ yes __ no	16.	history of serious illness	__ yes __ no

IF YES, explain: _____

_____

MEDICATIONS - Are you currently taking any medications? (prescribed &/or over the counter) __ yes __ no

IF YES, list ALL medications: _____

_____

ALLERGIES - Are you allergic to any drugs? __ yes __ no

IF YES, list ALL drug allergies: _____

_____

SMOKING __ yes __ no IF YES: __ Present __ Past How many packs per day? _____

If PAST, please indicate how long ago: _____

ALCOHOL Do you drink alcohol? __ yes __ no

If YES, how often and how much? _____

OBSTETRICAL Do you have any children? __ yes __ no

If YES, how many? _____

FEMALE PATIENT date of last menstrual period: _____ date of last mammogram: _____

Interpretation: Normal _____ Other _____

PAST MEDICAL HISTORY

SURGERY

Have you ever had surgery? __ yes __ no

If YES, explain and give dates: _____

_____

_____

MEDICAL

Do you have any medical problems? _____

_____

_____

Family Medical History - please list any applicable condition(s):

Father _____ Mother _____

Brothers _____ Sisters _____

Other _____

Primary Care Physician: _____ Phone: (___) ___ - _____

Address: _____

Other - Is there any other information and/or special needs we should know about?

_____

_____

_____

ACCIDENT INFORMATION

Accident Related to: __ Work __ Auto __ Other _____

Date of accident: _____ Where accident occured _____

Were you hospitalized? __ yes __ no IF YES, give dates: from _____ to _____

Please list injuries: _____

Please give a brief description of accident: _____

_____

_____

Are you presently working? __ yes __ no

FOR NO_FAULT

Name of Person whose no-fault insurance is covering accident:

_____
last name first name middle initial

Address: _____
street city state zip

Insured's phone number: (___) _____ - _____

Insurance Company Name: _____ Phone: (___) _____ - _____

Address: _____
street city state zip

ID #: _____ Claim #: _____

Adjuster Name: _____

FOR WORKMAN'S COMPENSATION

Employer's Name: _____ Phone: (___) _____ - _____

Address: _____
street city state zip

Policy #: _____

Contact Person: _____

RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. It is a courtesy extended by this office to send your bill to the insurance carrier on your behalf. Having insurance is not a substitute for, nor a guarantee of payment.
Many companies have fixed allowances or percentages based on ***your contract with them***, not our office. It is your responsibility to pay the deductible, co-incurance and any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but ***you*** are responsible for your bill. If the balance is not paid, the claim will be forwarded to collections and you will be responsible to pay the collection fee as well as a 2% interest charge per month. All returned checks will be assessed a service fee of $30.

At times, this office may need to file a complaint on your behalf with the New York State Insurance Superintendent. I authorize Nguyen Plastic Surgery to file a complaint on my behalf. I also authorize my insurance carrier to mail checks, whether in my name, or in the physician's name, to her office addess and give Nguyen Plastic Surgery authorization to deposit any checks payable to me.

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

The Non-Medicare Patient:
I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Nguyen Plastic Surgery. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

The Medicare Patient:
I request that payment of authorized Medicare benefits be made to me or on my behalf to Nguyen Plastic Surgery for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that Physician services are billed separately and that I may receive a bill from the Physician's office. I understand that I am financially responsible for co-pays and all charges whether or not covered by insurance.

I agree to be financially responsible for all charges. I have read this information and understand it.

Has your address changed since your last visit to our office? **__ yes __ no**
Has your phone number changed since your last visit to our office? **__ yes __ no**
Has your insurance coverage changed since your last visit to our office? **__ yes __ no**

Changes: _____

_____

Patient signature:_____ Date: _____
(Parent if Minor)

Witness signature:_____ Date: _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with your HIPAA Compliance Officer. You have the right to review your privacy notice, to request restrictions and revoke consent in writing after you have reviewed your privacy notice.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misue of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment for health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

_____

_____

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