



Patient

New Patient Registration

Insurance Information Subscribers Information

Last Name: _____

Last Name: _____

First Name: _____

First Name: _____

Address: _____

Address: _____

City/State/Zip: _____

City/State/Zip: _____

SS#: _____

SS#: _____

Employer: _____

Employer: _____

Phone (H): _____

Phone (H): _____

(W): _____

(W): _____

(C): _____

(C): _____

E-mail: _____

Relationship: Spouse Child Other _____

Date of Birth: _____

Date of Birth: _____

Sex: Male Female

Secondary Insurance: _____

.....
Name of Spouse: _____

In Case of Emergency: _____

Phone: _____

Phone: _____

Primary Care Physician: _____

Referring Physician: _____

Insurance Information: Please Submit Insurance Cards for Copying

CONSENT FOR TREATMENT: The undersigned authorizes the above named Health Care Provider to provide treatment including X-Rays, blood withdrawal, local anesthesia, intravenous solutions and the performance of other procedures which the Provider considers necessary and proper in the treatment of the above named patient.

RELEASE OF RECORDS: I hereby authorize the Provider to furnish insurance companies with any information concerning my treatment which may be requested, including photocopies from my patient records as necessary for completion of my claim or as may be required by law. I further authorize Provider to furnish information from my records pertaining to the treatment as requested by other Doctors or medical care facilities for continued care and treatment.

PAYMENT AGREEMENT: I, the undersigned, understand that I am responsible for all charges for treatment received regardless of insurance coverage; I understand that the Provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. Provider reserves the right to decline further services to the patient for non-payment. Patient accounts are due at the time treatment is given unless other arrangements are made in advance. A charge of \$27.50 will be charged on all RETURNED CHECKS.

I, the undersigned, assign benefits payable for physician services to the physician or organization furnishing the services and authorize the physician's group/organization to submit a claim to my health insurance carrier on my behalf.

Signature of patient (or parent, if minor)

Date:

Family member/responsible party

Date:

PATIENT HEALTH QUESTIONNAIRE

Head and Neck

- Altered sense of smell
- Nasal obstruction
- Snoring
- Nasal discharge
- Nosebleeds
- Sinusitis
- Facial pain
- Local skin lesions that have changed recently
- Lumps or swelling around the head or the neck

Yes

No

Eyes

- Double vision/blurred vision
- Dry eyes
- Itchy/watery eyes
- Glaucoma
- Flashing lights
- Floater
- Retinal problems
- Are your eyes matted/dry in the a.m.?

Yes

No

Respiratory System

- Chronic cough
- Wheezing, asthma
- History of TB or lung cancer
- Allergies

Yes

No

Neurologic

- Headaches
- Transient loss of vision
- Seizures
- Strokes
- Head injury
- Anxiety or depression

Yes

No

Cardiovascular System

- Heart Murmur
- Chest pain
- Swelling of the ankles
- Shortness of breath on exertion
- Heart surgery or angioplasty
- High blood pressure

Yes

No

Endocrine

- Diabetes
- Over or underactive thyroid

Yes

No

Urogenital

- Frequent urination
- Prostate problems
- Kidney Disease

Yes

No

Gastrointestinal

- Heartburn or Ulcers
- Jaundice, Liver Disease, Hepatitis

Yes

No

PATIENT HEALTH QUESTIONNAIRE

General

	Yes	No
Skin Cancer	_____	_____
Skin Diseases	_____	_____
Bleeding Disorder	_____	_____
Previous blood transfusion	_____	_____
Blood clots	_____	_____
Have you ever been on "Acutane"?	_____	_____
Have you ever had cold sores?	_____	_____

Have you ever considered facial cosmetic surgery, such as (please check):

- Rhinoplasty (Nose)
- Eyelids
- Face or Neck Lift
- Scalp reduction
- Laser Skin Resurfacing/Wrinkles
- Chemical Peel/Dermabrasion
- Protruding ears
- Chin Implant
- Scar revision
- Retin A/Glycolic Acid/Vitamin C
- Removal of moles

Would you like to discuss this with Dr. Clevens? Yes No

Please list all operations you have had (including prior plastic surgery): _____

Please list all pills and medications you take regularly (including over-the-counter medications and vitamin supplements): _____

Do you smoke? Yes No If so, how much? _____

Do you drink alcohol? Yes No If so, how much? _____

Do you use recreational drugs? Yes No If so, how much? _____

Please list all allergies (medications, inhalants, foods, contact allergies): _____

Please describe any other problem which may not have been covered above and which you would like the doctor to know: _____

How did you hear about Dr. Clevens? (Please check)

- Friend Television Newspaper Yellow Pages Radio
- Physician Referral Seminar Mailing Other

THANK YOU

Bermax II, LLC d/b/a
Clevens Center for Facial Cosmetic Surgery
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY
BE USED AND DISCLOSED AND HOW YOU CAN GET
ACCESS TO THIS INFORMATION
Please review it carefully

If you have any questions about this notice, please contact our Privacy Official at 321-951-3223.

WHO WILL FOLLOW THIS NOTICE:

Clevens Center for Facial Cosmetic Surgery and all members of its workforce.

This notice describes our privacy practices.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that any health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment, We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

As Required By Law We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person, any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Health Oversight Activities We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Public Health Risks We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release health information if asked to do so by law enforcement officials:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at our facility; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to our privacy officer and must be contained on one page of paper legibly handwritten or typed. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, in addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures You have the right to request a list accounting for any disclosures of your health information we have made. To request this list of disclosures, you must submit your request in writing to our privacy official, the request must state a time period which may not be longer than six years. Requests for an accounting of disclosures for Treatment, Payment or Operations can only be made if maintained in electronic health records and the time period may not be longer than three years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not be exceed a total of 60 days from the date you made the request.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to our privacy official. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse or disclosure of specified surgery to your spouse.

Right to Request Confidential Communications You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. To request confidential communications, you must make your request in writing to our privacy official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request if from our privacy official.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our privacy official. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing, at any time. If you revoke your permission we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Rev:01/01/2010



Bermax II, LLC d/b/a Clevens Center for Facial Cosmetic Surgery

Acknowledgement of receipt of Notice of Privacy Practices

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a **Notice of Privacy Practice** that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and will provide me a copy of any revised notice.

I understand that Ross A. Clevens, MD, FACS, is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me.

I further understand that Ross A. Clevens, MD, FACS, reserves the right to change their notice and practices and prior to implementation.

I wish to have the following restrictions to the use or disclosure of my health information:

MY MEDICAL CARE MAY BE DISCUSSED WITH: _____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

- () Consent received by _____ on _____.
- () Consent refused by patient, and treatment refused as permitted.
- () Consent added to the patient's medical record on _____.

Privacy Notice Date: 1/1/2010