Singhal Plastic Surgery, P.C.

MEDICAL HISTORY & REVIEW OF SYSTEMS

Patient Name:_____ **DOB:** _____

Reason for today's visit/ Consultation for:_____

Medications - Please include prescriptions, OTC medications, supplements, contraceptives & hormones, and or GLP-1 receptor agonist medications for weight loss, injections (ie: Wegovy. Ozempic, Semaglutide, and Mounjaro). List dose and time of day taken -

_____

_____

_____

_____

Allergies (include medications and environmental allergies. List type of reaction):

Tape: Y/N Iodine: Y/N Latex: Y/N No known drug allergies

Other allergies:_____

Past Medical History (circle yes if you have currently or ever had in the past any of the following):

Bleeding disorder Y/N	Blood clots Y/N	High Blood Pressure Y/N
Heart disease/heart murmur Y/N	COPD/Asthma Y/N	Acid reflux/heartburn Y/N
Sleep apnea Y/N	Stroke/TIA Y/N	Seizure disorder Y/N
Hepatitis/Liver disease Y/N	HIV/AIDS Y/N	MRSA infection Y/N
Cancer Y/N	Diabetes Y/N	Thyroid disorder Y/N
Kidney disease Y/N	Keloid scarring Y/N	Poor or delayed healing Y/N
Blood transfusion Y/N	Adverse reaction to anesthesia Y/N	Mammogram Y/N

Any other not listed here:_____

_____

Surgeries and Hospitalizations - list <u>all</u> surgeries and hospitalizations, including non-cosmetic & cosmetic procedures & year of surgery):

_____

_____

_____

_____

History of Immediate Family Members (circle yes or no; if yes, indicate which family member):

	Circle	Family Member		Circle	Family Member
Bleeding Disorders	Y / N		Blood Clots	Y / N	
Complications with anesthesia	Y / N		Cancer (including melanoma)	Y / N	
High Blood Pressure	Y / N		Coronary artery disease/ heart attack	Y / N	
Diabetes	Y / N		Stroke/Aneurysm	Y / N	

Any other not listed here:_____

_____

Social History:

Marital status: Single Married Lives with significant other /Partner Separated Divorced Widowed

Live with: _____Pets: _____

Employment status: employed unemployed retired student

Preventive Care: **Exercise:** Type/ how often _____ Immunizations: Up to date/ NOT up to date

Tobacco: have you ever used tobacco (including vaping/chewing) Y/N
How much/how often?_____Quit? Y/N if yes, when?_____

Alcohol: Y/N Type: _____ Number of drinks per week _____

Caffeine: Y/N Type: _____ Number of drinks per week _____

Recreational drug use: Y/N Type and frequency (including marijuana)_____

Review of Systems (circle any of the following symptoms you have experienced in the past 3 months):

Fever	Unintentional weight gain/loss	Fatigue	Night sweats
Headaches	Nasal congestion/Runny Nose	Blurred vision	
Hearing Loss	Ear infection	Sore throat	
Cough	Shortness of breath	Wheezing	Chest Pain
Heart Palpitations	Swelling legs	Heart Murmur	Abdominal Pain
Diarrhea	Constipation	Nausea	Vomiting
Heartburn/GERD	Renal disease	Pain with urination	Blood in urine
Joint pain	Back pain	Muscle pain	Scoliosis
Numbness/tingling	Seizures	Weakness	Easy bruising
Easy bleeding	Depression	Anxiety	Rashes/Lesions

Females only: last menstrual period____/____/____ Are you currently Pregnant Y/N

Previous pregnancies: Full Term___Premature__ Stillbirth/Miscarriage____ Abortion___Total___

Physical Conditioning: Check the activity you are most able to perform comfortably:

- ☐ Washing car, walking at a pace of 1 mile/18 minutes
- ☐ Shoveling snow, Mowing lawn, Walking at a pace of 1 mile/12-15 minutes
- ☐ Jogging

Patient/guardian signature: _____ Date: _____

Reviewed with patient by: _____ Date: _____

SINGHAL PLASTIC SURGERY P.C.

9081 NE 81st Terrace, Kansas City, MO 64158
PHONE: (816) 429-7576 Fax (816) 429-6753

TODAY'S DATE: _____

PATIENT'S NAME

_____
(Last) (First) (Middle) (Nickname)

DATE OF BIRTH_____ SEX: M ( ) F ( ) PATIENT'S SOCIAL SECURITY # _____

GUARDIAN NAME (if applicable)_____ RELATIONSHIP _____

ADDRESS_____ CITY_____ STATE_____ ZIP _____

HOME TELEPHONE (_____)_____ CELLULAR PHONE(_____) _____

EMAIL ADDRESS:_____

I ACCEPT TEXT APPOINTMENT REMINDERS TO MY CELL PHONE FROM SPS: YES NO (circle one)

NAME OF NEXT OF KIN OR OTHER LOCAL CONTACT_____
TELEPHONE NUMBER_____

PATIENT'S EMPLOYER_____ PHONE (_____) _____

WHO REFERRED YOU TO OUR OFFICE? _____

ADDRESS _____

PHONE (_____) _____

PRIMARY CARE PHYSICIAN_____

ADDRESS_____

PHONE (_____) _____

PHARMACY INFORMATION_____

ADDRESS_____

PHONE (_____) _____

PRIMARY/SECONDARY INSURANCE CO. _____

A copy of your driver's license and insurance card(s) will be taken at check-in and on a yearly basis. These will be kept on file, and in the event labs are needed, we will provide this copy to the lab so your insurance may be billed for charges

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Financial Policy

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable health care. Please review the following information and let our staff know if you have any questions. Please then sign as indicated below.

All Fees due prior to procedure - When scheduling a procedure at Singhal Plastic Surgery, payment for SPS is due in full two weeks prior to your procedure date. There will be separate charges for facility and anesthesia, which will be given at your consultation and is due, in full, to the surgery center & anesthesia providers prior to your scheduled surgery date.

_____ (Initials) **I have read and understand the above.**

Deposits Due – Upon scheduling your surgery with Singhal Plastic Surgery you will be asked to pay a deposit of $500, which will be applied to the surgeon's fees.

Surgery Cancellation Financial Responsibility - Any patient having cosmetic surgery is responsible for the surgical fees quoted as well as additional fees for anesthesia, OR facility and possible laboratory, x-ray, and pathology fees. All payments must be received at SPS at least 2 weeks before the scheduled surgery. If the surgery is cancelled by the patient, in less than 2 weeks of the scheduled surgery or any time following the pre-op appointment, there is a non-refundable booking and scheduling fee of $1000.00, which is a part of the overall administrative cost. If the surgery is cancelled by the patient, in less than 48 hours of the scheduled surgery, the fee will be $2500.00 which will be deducted from the surgeons fees paid. Refund checks may take up to 6 – 8 weeks to process.

_____(Initials) **I have read and understand the above.**

Surgical Revision Policy - The revision surgery at Singhal Plastic Surgery may be offered to me at my request and at no point in time, would I be forced to submit to this surgery. I understand that the willingness of this practice to offer revision would not be an admission of guilt, deviation from standards of practice or malpractice. The willingness of this practice to offer revision would be an attempt to act upon your expectations. Many a times, the results obtained from the initial surgery are hard to improve upon due to multiple factors, similar to the factors that were responsible for the outcome from the initial surgery. I also understand that revision & secondary procedures carry an increased risk.

I understand that revision surgery may result in a *basic cost* similar to the initial surgery based on the time and supplies required for the initial surgery. Singhal Plastic Surgery is unable to defer the cost of anesthesia and surgery center fees. I may be asked to pay a nominal revision fee of $1000. These fees will be agreed upon and paid in full prior to any procedure.

By accepting the revision, I also agree to follow up with the care-providers at Singhal Plastic Surgery as recommended.

_____(Initials) **I have read and understand the above.**

I understand and unconditionally and irrevocably accept the financial responsibilities as outlined above.

_____

Print Patient Name

_____ _____

Patient Signature **Date**

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Patient Medical Consent Form

Singhal Plastic Surgery, P.C.

Consent to Medical Treatment / Authorization to Release Information

I (for) undersigned patient do hereby voluntarily consent to such physician care involving routine diagnostic procedures and medical treatment by, his/her assistants or designees. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this visit. I further authorize Singhal Plastic Surgery, P.C. to release to the insurers herein specified, or to any agency concerned with the payment of the patient's medical charges, any and all information (including copies of records) relating to the patient's care.

Responsibility of Patient

I hereby guarantee full and prompt payment to Singhal Plastic Surgery, P.C. of all charges made as a result of services rendered during this visit.

Accidental Exposure of the Healthcare Worker

I understand that, as permissible by law, if any healthcare worker is exposed to the patient's blood or other bodily fluid, that the office may perform test(s) on the patient's blood or other bodily fluid to determine the presence of human immunodeficiency virus (HIV, the virus associated with AIDS). I consent to the testing for other communicable diseases, including but not limited to hepatitis and syphilis, in the event of an accidental exposure to a healthcare worker. I understand that such testing is necessary to protect those who will be caring for the patient.

_____ (Initials) **I have read and understand the above.**

_____

Print Patient Name

_____ _____

Patient Signature **Date**

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HIPAA Notice of Privacy Practices

Singhal Plastic Surgery, P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Also, while using your credit card for payment your relevant Protected Health Information may be disclosed to the credit card company if charges are disputed.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, peer reviews, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published, and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices. I have read and understand the above.

_____ _____

Patient Signature **Date**