ANSON • EDWARDS • HIGGINS
PLASTIC SURGERY ASSOCIATES

Areas of Concern

Patient's Name _____ _____ _____
Last First Date

What are your main concerns for today's visit?

_____
_____
_____
_____
_____
_____

Please check the problem area that concern you. Include anything you wish to discuss, even if it is not the main reason for your visit.

Face/Eyes/Neck
☐Aging Face
☐Aging Brow/Forehead
☐Botox
☐Facial Fillers (Juvederm, Voluma, Restylane, Sculptra, ETC)
☐Wrinkles/Fine Lines
☐Skin Texture
☐Skin Pigment
☐Dark Circles
☐Laser Treatment
☐Eyelash Growth (Latisse)

☐Excess Sweating (Botox)
☐Hand Treatments

Breast/Chest
☐Breast Size
☐Breast Asymmetry Correction
☐Breast Lift
☐Breast Reduction
☐Breast Implant Revision
☐Pectoral Implants (Men)
☐Nipple/Areola Concerns
☐Gynecosmastia

Excess Skin
☐Abdomen

☐Thighs
☐Arms

Liposuction
☐Abdomen
☐Bra Rolls
☐Hips/Flanks
☐Inner Thighs
☐Outer Thighs
☐Knees
☐Calves
☐Liposonix

Nose
☐Difficulty Breathing

☐Shape or Bump
☐Crooked

Ears
☐Prominent
☐Ear Lobes

Skin
☐Scars
☐Moles
☐Acne
☐Rashes
☐Warts

Gynecological
☐Excess Labial Tissue

Other Concerns
_____
_____
_____
_____
_____
_____

Provider Recommendations:

_____
_____
_____
_____
_____
_____
_____

I verify that I have provided all of my medical and surgical history to ensure my physician has all the important information to provide the safest care. I will update any new information that occurs in-between visits to include new diagnoses, new medications, subsequent surgeries and any hospitalizations.

_____ _____
Signature Date

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Medical + Surgical History

Patient's Name _____ (Last) _____ (First) _____ (Date)

Height: _____ Weight: _____ DOB: _____ Age: _____

Have You Had Any Previous Plastic Surgery? ☐Yes ☐No Were You Satisfied With Your Results? ☐Yes ☐No

List **ALL** Previous Surgery And Approximate Dates:

_____

_____

_____

Who Is Your Primary Care Physician? _____ When Was Your Last Exam? _____

What Specialists Do You See? _____

List **ALL** Medications You Take (Include Prescriptions, Over The Counter, Vitamins, Supplements, Herbs, etc.):

_____

_____

List **ALL** Allergies (To Medicines, Latex, Tape, Food, etc., And Your Reaction):

_____

_____

_____

Do You Smoke? ☐Yes ☐No Number Of Years _____ Packs Per Day _____ When Did You Quit? _____

How Much Alcohol Do You Drink Per Week? _____

Do You Exercise Regularly? ☐Yes ☐No How? _____

Do You Take Aspirin, NSAIDS (Motrin, Ibuprofen, Aleve, Advil, etc.) ☐Yes ☐No

Have You Ever Been Told You Need Antibiotics For Surgery Due To A Heart Murmur? ☐Yes ☐No

Do You Have Any Implanted Devices (Implants , Pacemaker, Joints, Shunt, or Pump)? ☐Yes ☐No

Any Personal **OR** Family History Of:

___ Bleeding Or Clotting Disorder (DVT= Deep Vein Thrombosis, PE= Pulmonary Embolism)

___ Breast Cancer Who? _____

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Medical + Surgical History Continued

Patient's Name _____ _____ _____
Last First Date

Are You Currently Taking: ☐Birth Control Pills ☐Hormone Replacement (Testosterone, Growth Hormone, Estrogen)
Are You Currently: ☐Menopausal ☐Peri-Menopausal ☐Still Menstruating
Could You Be Pregnant? ☐Yes ☐No
Number Of Pregnancies: _____ Number Of Births: _____ Unexplained Miscarriages: _____
Tubal Ligation? ☐Yes ☐No Hysterectomy? ☐Yes ☐No
When Was Your Last Mammogram? _____

Check below if you have now **or** have ever had in the past any of these conditions or symptoms:

☐ Diabetes	☐ Night Sweats	☐ Basal Cell	☐ HIV/AIDS
☐ Large weight loss/gain	☐ Bloody Sputum	☐ Squamous Cell	☐ Bulimia
☐ High Blood Pressure	☐ Abnormal Chest X-Ray	☐ Eczema	☐ Anemia
☐ Heart Disease	☐ Liver Disease	☐ Psoriasis	☐ Cancer
☐ Heart Murmur	☐ Hepatitis/Jaundice	☐ Rosacea	☐ Depression
☐ MVP	☐ Kidney Disease/Stones	☐ Keloids	☐ Anxiety
☐ Rheumatic Fever	☐ Uninary Problems	☐ Cold Sores/Herpes	☐ Glaucoma
☐ Circulation Problems	☐ Ulcers	☐ Ever taken Accutane	☐ Ever taken Phen-phen
☐ Stroke	☐ Crohns/Colitis	☐ Steroid Therapy	☐ Serious dry eyes
☐ Lung Disease	☐ Constipation	☐ Bleeding Disorder	☐ Alcoholism
☐ Asthma, Emphysema	☐ Gastric Reflux	☐ Epilepsy/Seizures	☐ Prescription drug problem
☐ Persistent Cough	☐ Skin Cancer	☐ Thyroid Problem	☐ Non-prescription drug problem
☐ Tuberculosis	☐ Melanoma	☐ Arthritis	

Is There Anything Else We Should Know About You That We Haven't Asked?

_____
_____
_____
_____
_____
_____
_____
_____

For Research Purposes:
Do You Know What Sleep Wrinkles Are? ☐Yes ☐No
Do You Think You Have Sleep Wrinkles? ☐Yes ☐No
Please Estimate What Percentage Of The Time You Sleep In These Positions?
_____ Back _____ Stomach _____ Side (right) _____ Side (left)

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Patient Registration Information

Patient's Name _____ _____ _____
Last First Date

Birthdate: ___/___/___ Age: _____ Gender: ☐Female ☐Male Marital Status: ☐Married ☐Single ☐Divorced

E-mail: _____

Address: _____
Street & Apt # City State Zip

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

Which phone do you prefer we use to contact you? ☐Home Phone ☐Cell Phone ☐Work Phone

Any restrictions for contacting you? (Ok to call at work? Leave message at home?,etc.) _____

May we use your email to send useful information, updates, promotions and event info? We promise not to abuse it! ☐Yes ☐No

We offer 2 methods of appointment reminders, please check your preference (one): ☐Text Message ☐Email

For minors, who is the authorized adult or responsible party? _____

Patient's Employer: _____ Occupation: _____

Address: _____
Street & Suite # City State Zip

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

Address: _____
Street & Apt # City State Zip

Insurance Information
Do you have medical insurance? ☐Yes ☐No

Referral Information
Who referred you to our practice? _____

May We Thank Them Using Your Name? ☐Yes ☐No

If Not Referred How Did You Hear About Us? ☐Website _____ ☐Magazine _____

☐Other _____

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Authorization & Acknowledgement

____ I consent to examination and general treatment by the doctors or authorized members of the staff at Anson, Edwards & Higgins Plastic Surgery Associates. Other consents will be required for specific procedures.

____ I understand that office charges are payable on the day of service.

____ I understand that photography is a necessary part of planning and evaluating for recommendations and treatments. I authorize the taking of photographs. These photographs will be used for documentation and planning only. An additional consent will be required for any other use.

_____ _____

Signature Date

Insurance Information for You
(Required by Law)

Please note that the office of Anson, Edwards & Higgins Plastic Surgery Associates is required to have all patients sign an agreement that they understand that our office has opted out of Medicare. Our provider's **have been excluded** from Medicare under 1128, 1156, or 1892 of the Act. In addition, our office is not contracted with any private insurance companies.

____ I understand that no payment from Medicare shall be received by either myself, my beneficiery, or any physician/practitioner of Anson, Edwards & Higgins PSA for any services rendered. I accept full responsibility for payment for all services or items furnished.

____ I understand that no Medicare limits apply to what will be charged for items or services furnished by any physician/practitioner of Anson, Edwards & Higgins PSA.

____ I agree not to submit a claim to Medicare or to ask any physician/practitioner of Anson, Edwards & Higgins PSA to submit a claim or other documentation to Medicare on my behalf.

____ I understand that I am entering into this contract knowing that I have the right to obtain Medicare-covered items and services from physicians/practitioners who have not opted out of Medicare and that I am not compelled to enter into a contract such as this with providers/practitioners who have not opted out.

____ I understand that the office of Anson, Edwards & Higgins PSA and it physicians/practitioners have opted-out from Medicare for a period of two years, at which time, they will continue to request to opt-out.

____ I understand that I may request a copy of this notice.

____ I understand in cases of emergency that I am not required to enter into such an agreement and that emergency care may be provided if necessary. The office of Anson, Edwards & Higgins PSA services are considered cosmetic however, and the nature of our practice is non-emergent.

____ I understand this document will be updated annually and be kept as part of my medical record so long as required by the State of Nevada. It will be made available to Center for Medicare & Medicaid Service in the event a copy of this agreement is requested.

____ In addition to all of the items above relating to Medicare, I understand that no payment from any private insurance company shall be received or accepted by the office of Anson, Edwards & Higgins PSA for any services rendered.

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____ I understand that at no time will prior authorization, claims, or documentation be submitted from the office of Anson, Edwards & Higgins Plastic Surgery Associates to my insurance company on my behalf.

____ I understand that the office of Anson, Edwards & Higgins PSA will not accept any contracted rate or deduction in payment and that I am fully responsible for the charges for any service or item given by the physician/practitioner.

Signature _____ Date _____

Witness Signature _____ Date _____

IRS & Cash

We are required to file Form 8300 with the IRS for all patients who pay us $10,000 or more in cash during the year for single or related medical procedures. When used for medical care, cash means currency and coins, *not* cashier's checks, bank drafts, traveler's checks, money orders or personal checks. For more information:

http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/FAQs-Regarding-Reporting-Cash-Payments-of-Over-10000-Form-8300

Notice of Privacy Practices Patient Acknowledgement Form
(Required by Law)

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Signature _____ Date _____

Communication

It is alright with me to communicate information about me (appointments, reminders, updates, test results, etc.) to the following individuals;

Name	Relationship	Phone Number

ANSON • EDWARDS • HIGGINS
PLASTIC SURGERY ASSOCIATES

Notice of Privacy Practice
Information Regarding Your Confidential Health Information
(Required By Law)

Patient's Name _____ _____ _____
Last First Date

PATIENT RIGHTS
This new law is careful to describe that you have the following rights related to your health information.

RESTRICTIONS
You have the right to request restrictions on certain uses and disclosures of your health information. Our practice will make every effort to honor reasonable restriction preferences for our patients.

CONFIDENTIAL COMMUNICATIONS
You have the right to request that we communicate with you in a certain way. You may request that we communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION
You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may charge you a reasonable fee to duplicate and assemble your copy.

AMEND YOUR INFORMATION
You have the right to ask us to update or modify your records if you believe your health records are incorrect or incomplete. We will be happy to accommodate you as long as this office maintains this information. In order to standardize this process please provide us with your request in writing and describe your reason for change. Your request may be denied if the health information was not created by our office, is not part of your records or if the records containing your health information are determined to be accurate and complete.

DOCUMENTATION OF HEALTH INFORMATION
You have the right to ask us for a description of how and where you health information was used by our office for any reason other than for treatment, payment or health operations

REQUEST A PAPER COPY OF THIS NOTICE
You have the right to obtain a copy of this notice of Privacy Practices directly from our office at any time. Give us a call and we ill mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practice. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure our patients have access to a copy of the revised notice by posting it online. You have the right to express complaints to us or to the secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns that you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

In connection with the medical services that I am receiving from Anson, Edwards & Higgins Plastic Surgery Associates, and its medical staff, I hereby authorize Anson, Edwards & Higgins Plastic Surgery Associates, the above-named physician(s), and their respective agents to disclose any and all the information concerning my medical condition and treatment (including, but not limited to, super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, or other such information), including copies of applicable hospital and medical records to:

A. Any third party payer covering medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies
F. As otherwise required by law

WITH AUTHORIZATION
Other than where Federal, State or local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization at any time, except to the extent that we have already made a use or disclosure based upon your authorization.

VERBAL AUTHORIZATION
We may also use or disclose your information to care givers or family members that are directly involved in your care with your verbal permission

This consent is valid from the date executed until revoked in writing by the patient

_____ _____
Signature Date

For Office Use Only

Date	Disclosed to Whom	Description of Purpose of Disclosure	Disclosed by Whom