

# PLASTIC SURGERY ASSOCIATES

## ANSON · EDWARDS · HIGGINS

### Areas of Concern

Patient's Name \_\_\_\_\_

\_\_\_\_\_ Last

\_\_\_\_\_ First

\_\_\_\_\_ Date

What are your main concerns for today's visit?

---



---



---



---

Please check the problem areas 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/Neck
- Aging Brow/Forehead
- Excess Eyelid Skin
- Botox
- Facial Fillers (Juvederm, Voluma, Restylane, Sculptra, ETC)
- Wrinkles/Fine Lines
- Kybella
- Skin Texture
- Skin Pigment
- Dark Circles
- Laser Treatments
- Chemical Peels
- Eyelash Growth (Latisse)

**Ears**

- Prominent
- Ear Lobes

**Nose**

- Difficulty Breathing
- Shape or Bump
- Crooked

**Breast/Chest**

- Breast Size
- Breast Asymmetry Correction
- Breast Lift
- Breast Reduction
- Breast Implant Revision
- Pectoral Implants (Men)
- Nipple/Areola Concerns
- Gynecomastia

**Excess Skin**

- Abdomen
- Thighs
- Arms

**Liposuction**

- Abdomen
- Bra Rolls
- Hips/Flanks
- Inner Thighs
- Outer Thighs
- Knees
- Calves
- Coolsculpting

**Gynecological**

- Excess Labia Tissue

**Skin**

- Scars
- Moles
- Acne
- Rashes
- Warts

**Other Concerns**

- Excess Sweating (Botox)
- Hand Treatments
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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

# PLASTIC SURGERY ASSOCIATES

## ANSON · EDWARDS · HIGGINS

### 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 Insurance Provider \_\_\_\_\_

\*Although we do not take insurance, this information will assist in coordinating your care.

**Pharmacy Information**

In the event we need to send a prescription to your pharmacy electronically, please provide your pharmacy information:

**Pharmacy** \_\_\_\_\_ **Cross Streets** \_\_\_\_\_ **Phone** \_\_\_\_\_

**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 \_\_\_\_\_

# PLASTIC SURGERY ASSOCIATES

## ANSON · EDWARDS · HIGGINS

### 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 surgeries and approximate dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_ Last Exam? \_\_\_\_\_  
What Specialists do you see? \_\_\_\_\_

List ALL medications you take (include prescriptions, over the counter, vitamins, supplements, herbs, etc.):  
\_\_\_\_\_  
\_\_\_\_\_

Describe ALL allergies and what occurs during the reaction (include prescriptions, over the counter, vitamins, supplements, herbs, etc.):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke, vape or use any form of nicotine including patches?  Yes  No  
Number of years? \_\_\_\_ Packs/Amount per day? \_\_\_\_ If you quit smoking, when did you quit? \_\_\_\_\_  
Do you smoke or ingest Marijuana products?  Yes  No How often/amount: \_\_\_\_\_  
Do you drink alcohol?  Yes  No How often/amount: \_\_\_\_\_

Do you take aspirin, NSAIDS, (Motrin, Ibuprofen, Aleve, Advil, etc.)?  Yes  No How often? \_\_\_\_\_

Have you ever been told you need antibiotics for surgery due to a heart murmur?  Yes  No

Do you have any implanted devices (implants of any kind, pacemaker, joints, shunts or pump)?  Yes  No

Any personal or family history of bleeding or clotting disorder (DVT= deep vein thrombosis, PE= pulmonary embolism):  
 Yes  No Explain: \_\_\_\_\_

Any personal or family history of breast cancer?  Yes  No Who? \_\_\_\_\_

# PLASTIC SURGERY ASSOCIATES

## ANSON · EDWARDS · HIGGINS

### 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:

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

# PLASTIC SURGERY ASSOCIATES

## ANSON · EDWARDS · HIGGINS

### 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 beneficiary, 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 its 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.

# PLASTIC SURGERY ASSOCIATES

## ANSON · EDWARDS · HIGGINS

\_\_\_\_ 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

# PLASTIC SURGERY ASSOCIATES

## ANSON · EDWARDS · HIGGINS

### 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 your 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 will 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;
- A. Other health care professionals and institutions involved in the delivery of health care to the patient;
- B. The proponent of any legally sufficient subpoena, or in response to a court order;
- C. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
- D. Pharmacies
- E. 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____