PATIENT REGISTRATION

Patient Information

Name: _____ **Birthdate:** _____-_____-_____

SS#: _____ **Age:** _____ **Sex: M or F** **Marital Status M S W D Other**

Address: _____ _____**City:**_____ **State:** _____ **Zip:**_____

Home Phone: (_____**)**_____ **Cell/Work Phone: (** **)**_____ _____

Employer:_____ _____ **Occupation:**_____ _____

Emergency Contact:_____ _____**Relationship:** _____**Phone:**_____

Nearest Relative:_____**Relationship:**_____**Phone:**_____

Primary Care Physician: _____ **Phone Number** _____

Referring Physician _____ **Phone Number**_____

Your Email Address_____

How Did You Hear About Dr. Michaels?_____

Person Responsible for bill (**Self** if **over** age **18,** legal guardian if under age 18)

Name: _____ _____ **Birthdate:** _____-_____-_____

SS#: _____-_____-_____ **Age:** _____ **Sex: M or F Marital Status M S W D Other**

Address: _____**City:**_____ **State:** _____ **Zip:**_____

Home Phone: (**)**_____ **Work Phone: (** **)**_____

Employer:_____ **Occupation:**_____

Relationship to Patient (only if different**):**_____

Primary Insurance (Please present card for verification)

Insurance Name:_____**ID#**_____

Subscriber Name_____**DOB**_____

Secondary Insurance (Please present card for verification)

Insurance Name:_____**ID#**_____

Subscriber Name_____**DOB**_____

NEW PATIENT HEALTH HISTORY FORM

Patient Name: _____Birthdate: _____ Date: _____

Referring Physician: _____ Address: _____
Pharmacy Name: _____Phone number: (____)_____

Reason for today's visit: _____
Please describe this problem: _____
_____

PRIOR SURGERIES	CURRENT/PRIOR ILLNESSES/INJURIES

Please list all medications (prescriptions and non-prescription) that you take.
(Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions, etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, Aspirin**? ☐No ☐Yes

Do you have any food, environmental, or drug allergies? ☐No ☐ Yes (please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? ☐No, and never have ☐ Yes (please explain below)

TYPE OF SMOKING(cigarette, pipe, marijuana, chew, etc)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ No, and never have ☐ Socially only ☐ Daily ☐ Beer/Wine ☐ Hard Liquor
Occupation: _____ Hand Dominance: RIGHT LEFT

Please describe any family health issues below.

FAMILY HISTORY	Good/None	Unknown	Illnesses/Reason for Death
Mother			
Father			
Sibling(s)			
Other hereditary illness			

Patient Signature: _____ Date: _____

Physician Signature: _____ Date reviewed: _____

(Continue on back)

HEALTH HISTORY FORM PAGE 2

Do you have or have you ever had any of the following:

Symptom/Illness	No	Yes, explain	Symptom/Illness	No	Yes, explain
Constitutional			**Skin**		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			Last Mammogram		Date: ____/____/_____
Heaptitis			Changes in moles		
HIV/Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			**Neurological**		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			**Genitourinary**		
Mobility/Join Problems			Genital or Oral Herpes		
Gastrointestinal			Sexually Transmitted Disease		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
Cardiovascular			**Eyes**		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/DVT			**ENT**		
Blood Clots in Lungs/Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
Respiratory			**Psychiatric**		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/Depression		

Please list any other conditions/illnesses not indicated above: _____

_____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my health.

Patient Signature: _____ Date: _____

Physician Signature: _____Review Date: _____

Michaels Aesthetic & Reconstructive

Plastic Surgery

PATIENT E-MAIL CONSENT FORM

Patient name: _____

E-mail: _____

At Michaels Plastic Surgery ("The Practice") we feel that email access to Dr. Michaels and the staff allow for very effective communication both before and after your procedure. As The Practice is responsive to our email inquiries, patients often feel more connected. In order for us to provide this access, we ask that you take the time to read this form and consent to the use of email.

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

a) **The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from Dr. Michaels and the Practice are not encrypted, so E-mails may not be secure.** Therefore it is possible that the confidentiality of such communications may be breached by a third party.

b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

c) E-mail senders can easily misaddress an E-mail.

d) E-mail is easier to falsify than handwritten or signed documents.

e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.

f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.

g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

h) E-mail can be used to introduce viruses into computer systems.
Practice server could go down and E-mail would not be received until the server is back on-line.

i) E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL Practices cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Physician are not liable for improper disclosure of confidential information that is not caused by Practice's or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) **E-mail is not appropriate for urgent or emergency situations. Practice and Physician cannot guarantee that any particular E-mail will be read and responded to within any particular period of time.**

b) **If the patient's E-mail requires or invites a response from Practice or Physician, and the patient has not received a response within two (2) business days, it is the patient's responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond.**

c) E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.

d) **All E-mail will usually be printed and filed in the patient's medical record.**

e) Office staff may receive and read your messages.

f) Practice will not forward patient identifiable E-mails outside of the Practice without the patient's prior written consent, except as authorized or required by law.

g) The patient should not use E-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Practice is not liable for breaches of confidentiality caused by the patient or any third party.

h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
i) This consent will remain in effect until terminated in writing by either the patient or Practice.
j) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by E-mail with Practice.

3. INSTRUCTIONS

To communicate by E-mail, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the E-mail.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Practice of changes in his/her E-mail address.
e) Acknowledge any E-mail received from the Practice and/or Physician.
f) Take precautions to preserve the confidentiality of E-mail.
g) Protect his/her password or other means of access to E-mail.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice, Physician and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by E-mail. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge **Joseph Michaels V, MD, LLC** and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient signature_____ Witness signature _____

Date_____ Date _____

MICHAELS
AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY

To All Patients:

We ask that all patients pay for their office visit at the time of service. We DO NOT participate with any insurance other than Medicare, and ask that payment be made at the time of service. As a courtesy we will often submit insurance claims to your insurance carrier on your behalf. We ask for 24 hr cancellation of scheduled appointments, or a $50.00 fee will be billed to the patient.

RETURNED CHECK FEE:

I understand and agree that if any payment made by me or on my behalf by check is returned from the financial institution as unpaid, in addition to the original sum, I am responsible and agree to pay a $50.00 returned check fee. A copy of this agreement may be used in place of an original.

ASSIGNMENT OF BENEFITS:

I certify that the insurance information provided with regard to my insurance coverage is correct. I further authorize the release of any information necessary, including medical information for this or any claims generated from this office for covered services provided to my insurance carrier. A copy of this authorization may be used in place of the original. I hereby assign the benefits payable for covered services to be paid directly to "Joseph Michaels V, MD, LLC."

MEDICARE PATIENTS:

I authorize the holder of medical or other information about me to release to the Social Security Administration of its intermediaries of carriers any information for all Medicare claims. I assign the benefits payable for covered services to "Joseph Michaels V, MD, LLC."

GUARANTEE OF PAYMENT:

I understand and agree that I am responsible for payment of all professional services previously rendered, currently rendered, and in the future by this practice. I am financially responsible for all payments my insurance company identifies as my responsibility. I agree to pay all balances due in a timely manner (within 30 days). A copy of this agreement may be used in place of an original. As the practice is not a participating provider (other than Medicare), I authorize payment of medical benefits from all insurance reimbursements to Joseph Michaels, V, MD, LLC.

COLLECTION FEE:

If I do not pay all balances owed by me in a timely manner (within 60 days), the undersigned hereby agrees to pay 10% interest per annum on said balances to accrue from the date of professional services were originally rendered: plus attorneys fees which are herby stipulated to be 33 1/3 % of such outstanding balance whether suit is filed or not, plus court costs. If the undersigned fails to pay promptly for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining credit information and/or locating the undersigned as may be necessary,

In the event prompt payment is not made by the undersigned, the undersigned understands that personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with federal "HIPPA" regulations. A copy of this agreement may be used in place of an original.

X / / 20

Signature of Patient or Responsible Party Date

11404 Old Georgetown Rd, Suite 206
North Bethesda, MD 20852

Rev:10/10lw

MICHAELS
AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY

Joseph Michaels, MD

PATIENT PRIVACY AND CONSENT

I, _____ , hereby consent to the use or disclosure of my protected health information by the practice of Joseph Michaels, M.D., hereinafter referred to as ("the practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warrantees, implied or otherwise, to the outcomes of any treatments or procedure.

I have been offered, read and/or understand the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. I understand that patient privacy rights and disclosure varies state by state.

I also understand that the *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the offices:
Practice: Joseph Michaels, V, MD, LLC

May we leave a message or send mail to:

Home Phone : _____YES ____NO

Work Phone: _____YES ____NO

Cell Phone: _____YES _____NO

OTHER:_____

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy to be sent in the mail, or by requesting one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative if the Patient is a Minor Date

_____
Printed Name of Patient or Personal Representative

_____
Relationship of Personal Representative to the Patient

_____
Signature of Practice Representative and Witness

Joseph Michaels, MD

PHOTOGRAPHIC RELEASE AND CONSENT

I,_____ agree that Joseph Michaels, M.D. or designated representatives or the practice may take and use preoperative and postoperative photographs of my person for confidential **clinical record purposes**, and that such photographs shall remain the property of Joseph Michaels V, M.D, LLC..

_____ _____
Patient Signature Date

****ELECTIVE:**

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Joseph Michaels, M.D. to use my photographs, videotapes, and case information in the following educational and scientific settings that I have **INITIALED**:

_____ **My surgeon's office patient education materials**

_____ **My surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office**

_____ **Newspaper and magazine articles in which my surgeon participates**

_____ **Television programs in which my surgeon participates**

_____ **Web site or web site affiliation**

_____ **Lectures and multimedia presentations given by my surgeon for the general public.**

_____ **Social media platforms**

I also authorize my plastic surgeon's professional association, the not-for-profit **American Society for Aesthetic Plastic Surgery**, to use my photographs and case information in fulfilling its mission of public education, in the settings that I have initialed:

_____ **Patient education brochures available for purchase**

_____ **Educational video tapes available for purchase**

_____ **Lectures and slide presentations available for purchase**

_____ **Television programs about plastic surgery**

_____ **Case studies presented on the Society's web site at www.surgery.org**

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship of Personal Representative to the Patient

_____
Signature of Practice Representative and Witness

Dr. Joseph Michaels

Aesthetic Reconstructive Plastic Surgery

IMPORTANT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED/ DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

MICHAELS A.R.P.S is required by law to protect certain aspects of your healthcare information known as Protected Health Information or PHI and to provide you with this Notice of Privacy Practices. This notice describes our privacy practices, your legal rights, and lets you know how MICHAELS A.R.P.S. is permitted to: use and discuss PHI about you, how you can access and copy that information, how you may request amendment of that information, how you may request restrictions on our use and disclosure of you PHI.

In most situations we may use this information described in this Notice without your permission, but there are some situations when we may use it only after we obtain your written authorization, if we are required by law to do so. We respect your privacy, and treat all healthcare information about our patients with care under strict policies of confidentiality that all our staff is committed to following at all times.

Purpose of this Notice: This notice describes your legal rights, advises you of our privacy practices, and lets you know how MICHAELS A.R.P.S is permitted to use and disclose(PHI) about you.

Uses and Disclosures of PHI: MICHAELS A.R.P.S may use PHI for the purposes of treatment, payment, and healthcare operations in most cases without your written permission. EXAMPLES for use of PHI:

Treatment: This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel(including doctors/nurses who give orders to allow us to provide treatment to you)it also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via telephone or computer to the hospital as well as providing the hospital with a copy of the written record we create in the course of providing you with the treatment and transport.

For Payment:This includes any activities we must undertake in order to get reimbursement for the services we provide to you, including such things as organizing your PHI and submitting bills to your insurance company, management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

Health Care Operations:Includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that DO NOT individually identify you for data collection purposes.

Use and Disclosure of PHI WITHOUT your Authorization. MICHAELS A.R.P.S is permitted to use PHI without your written authorization or opportunity to object in certain situation, including: For MICAHELS A.R.P.S use in treating you or obtaining payment for services provided to you or in other health care operations. For the treatment by another healthcare provider. To another healthcare provider or entity for the payment of activities of the provider or entity that received the information(such as your hospital or insurance company). To another health care provider (such as a hospital to which you are transported or First Responder)for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship. For healthcare fraud and abuse detection or the activities related to compliance with the law. To a family member, relative, or close personal friend or other individual involved in your care, if we need to obtain a verbal agreement to do so or if we give you an opportunity to object to such disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer form the circumstances that you would not object. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency) we may in our professional judgment determine that a disclosure to your family member, relative, or friends is in your best interest. In that situation, we will only disclose health information relevant to that persons involvement in your care. To a public health authority in certain situations(reporting a birth, death, or disease required by law, as part of a public health investigation, to report child or adult abuse or domestic violence, to report adverse events such as product defects or to notify a person about exposure to a possible communicable disease as required by law. For healthcare oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government by law to oversee the health care system. For judicial and administrative proceedings as required by a court or administrative order, or response to a subpoena or other legal process. For law enforcement activities in limited situations such as when there is a warrant for the request, or information is needed to locate or stop a crime. For military, national defense and security and special government functions. To advert a serious health threat and safety of the public at large. For workers compensation purposes, and in compliance with worker compensation laws. To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties required by law. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank. For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is minimal risk to your privacy and adequate safeguards are in place with accordance with the law. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are. You may revoke your authorization at any time, in writing except to the extent that we have already used or disclosed medical information based upon that authorization.

Patient Rights: As a patient you have a number of rights to the protection of your PHI.

The right to access, copy and inspect your PHI. This means you may come to our office and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you to your medical, and you may appeal certain types of denials.

The right to amend your PHI, the right to request amending your PHI. You have a right to ask us to amend written medical information that we may have about you. If errors are found, we will generally your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information. If you wish to request that we amend the medical information that we have about you, you should contact MICHAELS A.R.P.S in writing.

The right to request an accounting of our use and disclosure of your PHI: You may request an accounting from us of certain disclosures of your medical information that we have made in the last 6 years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for the purposes of treatment, payment of healthcare operations, or when we share your health information with our business associates, such as our billing company, medical facility from/to which we have transported you. We are also NOT required to give you and accounting of the uses of protected health information which you have already given us written authorization. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact our office.

The right to request that we restrict the uses and disclosures of your PHI: You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations or to restrict the information that is provided to the family, friends, and other individuals involved in your healthcare. However, if you request a restriction and the information that you asked us to restrict is needed to provide you with emergency treatment, then we may use PHI or disclose your PHI to a healthcare provider to provide you with emergency treatment. MICHAELS A.R.P.S is not required to agree to any of the restrictions that you request, but any restrictions agreed by MICHAELS A.R.P.S are binding on MICHAELS A.R.P.S

Revisions to the Notice: MICHAELS A.R.P.S reserves the right to change the terms of this notice at any time, and the changes will be effective immediately and will apply to all PHI that we maintain. May material changes to the Notice will be posted in our facility.

Your Legal Rights and Complaints:You have a right to complaint to us, or to the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government.

MICHAELS
AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY

HIPPA CREDITCARD CONSENT

It may become necessary to release your protected health information to financial parties, credit card entities, banks and/or financing companies, when requested, to facilitate your payment.
INITIAL AND SIGN:

___Services that are performed and paid with a credit card, debit card or financing company are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Dr. Joseph Michaels to use and disclose my protected health information to any credit card entity, bank or financing company when they request such information to process an account and assist with payment.

___I will not challenge such credit, debit or financing card payment once services are provided. This practice encourages complete post-op care and follow-up interaction to address any issue that might arise.

___I agree that this non credit card challenge agreement is irrevocable.

Dr Michaels reserves the right to authorize credit card transactions in advance of accepting payment for nonemergent services.

If deemed appropriate, Dr Michaels may take legal action, including seeking a judgment against a patient, in order to collect balances owed

Refunds/Overpayments will be refunded to the appropriate party.

X_____DATE_____

____STAFF INITIALS