CEDARS-SINAI®

Plastic and Reconstructive Surgery
250 N. Robertson Blvd., Suite 506, Beverly Hills, CA 92011

CURRENT MEDICATIONS:		**CURRENT MEDICATIONS:**	
MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE
HEIGHT:			
WEIGHT:	Wt LOSS? LBS		
NON-PRESCRITPION DRUGS:		**STERIODS TAKEN IN THE LAST 12 MONTHS:** YES/NO	
ASPIRIN	YES/NO	STEROID NAME	DOSAGE
IBUPROFEN	YES/NO		
HOMEOPATHIC	YES/NO		
SBE PROPHYLAXIS	YES/NO		
OTHER			
DO YOU TAKE A BLOOD THINNER?	YES/NO		

ALLERGIES (MEDICATION/OTHER)

	YES/NO	(LIST MEDICATIONS/OTHER REACTIONS)

REVIEW OF SYSTEMS

FEVER/CHILLS	YES	NO	BLEEDING TENDENCY	YES	NO
STOMACH ULCER	YES	NO	DIFFICULTY SWALLOWING	YES	NO
NIGHT SWEATS	YES	NO	ALLERGIES	YES	NO
REFLUX	YES	NO	SPEECH CHANGES	YES	NO
VISION LOSS	YES	NO	ENLARGED THYROID/GOITER	YES	NO
BACK/NECK PAIN	YES	NO	HIGH BLOOD PRESSURE	YES	NO
DOUBLE VISION	YES	NO	ENLARGED GLAND/NODE	YES	NO
NERVE PAIN/PARALYSIS	YES	NO	CHEST PAIN/TIGHTNESS	YES	NO
DRYEYE	YES	NO	FREQUENT SUNBURNS	YES	NO
FACIAL WEAKNESS	YES	NO	ASTHMA/BREATHING PROBLEMS	YES	NO
NASAL OBSTRUCTION	YES	NO	SCARRING KELOIDS	YES	NO
DEPRESSION/ANXIETY	YES	NO	SHORTNESS OF BREATH	YES	NO
DIFFICULTY URINATING	YES	NO	RENAL FAILURE/DIALYSIS	YES	NO
DRUG/ALCOHOL DEPENDENCY	YES	NO	BREAST MASS/LUMP	YES	NO
SINUS PROBLEMS	YES	NO	HEPATITIS/JAUNDICE	YES	NO

SOCIAL HISTORY			**HISTORY OF CANCER**	**TYPE OF CANCER**
NICOTINE (PATCH OR GUM)	YES	NO	FATHER	
TOBACCO-CHEW	YES	NO	MOTHER	
TOBACCO-SMOKE	YES	NO	SISTER	
CIGARETTES PER DAY			BROTHER	
FORMER SMOKER (QUIT DATE)			MATERNAL GRANDFATHER	
ALCOHOL - DRINKS PER WEEK			MATERNAL GRANDMOTHER	
FEMALE PATIENTS			PATERNAL GRANDFATHER	
DO YOU TAKE BIRTH CONTROL?	YES	NO	PATERNAL GRANDMOTHER	
ARE YOU CURRENTLY PREGNANT?	YES	NO	OTHER	
ARE YOU PLANNING PREGNANCY?	YES	NO		
HAVE YOU HAD A C-SECTION?	YES	NO	**SURGICAL IDSTORY**	**SURGERY DATE**
DATE OF C-SECTION				
DATE OF LAST MAMMOGRAM? / /	1 YR	SYRS		
ARE YOU CURRENTLY BREAST-FEEDING?	YES	NO		
DATE OF LAST BREAST-FEEDING?				
FACIAL **PLASTIC/COSMETIC INTERESTS:**	BOTOX		JUVEDERM | RESTYLANE	RADIESSE
FACELIFT | MOMMY MAKEOVER	NOSE		LIPOSUCTION | EYES	TUMMY TUCK

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. John Reinisch, Dr. Elizabeth Kim, Dr. Youssef Tahiri, Mitzi Quintero, PA-C, Caitlin Pray, PA-C, or any members of their staff responsible for any error or omissions that I may have made in the completion of this form. I acknowledge I have received the Notice of Privacy Practices.

Signature_____ Date _____

CEDARS-SINAI®

Financial Responsibility Form

Dear Patient:

Positive verification of your coverage cannot be made at this time.

You will receive services today with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for these services rendered.

Patient Name: _____ MRN: _____

Date: _____

Address: _____

Home Number: _____Work Number: _____

Insured Subscriber's Name: _____

Insured Subscriber's Date of Birth: _____

Name of Employer: _____

Name of Insurance Company: _____

AGREEMENT

I have read the above and understand my possible financial responsibility for services rendered and hereby affix my signature as an acknowledgment of this understanding.

_____ _____

Patient Name: Patient MRN:

_____ _____

Signature*: Date:

Employee Initials: _____

CEDARS-SINAI®

SURGERY DEPOSIT AND CANCELLATION POLICY

PLEASE TAKE TIME TO READ THE FOLLOWING INFORMATION REGARDING OUR POLICY'S

Date: _____

Patient Name: _____ MRN: _____

In the event surgery is the outcome of your consultation / office visit the following policy will apply.

- **Insurance Patients:** To schedule your surgery we require a deposit of **$500** to secure a surgical date. 1 month prior to your scheduled date, a **75% deposit of your surgery fee is required.**

- **Cash Patients:** To schedule your surgery we require a deposit of **$500** to secure a surgical date. 1 month prior to your scheduled date, a **100% deposit of your surgery fee is required.**

- **Cosmetic Patients:** To schedule your surgery we require a deposit of **$1000** to secure a surgical date.

- **International Patients:** To schedule your surgery we require a deposit of **$5000** to secure a surgical date. 1 month prior to your scheduled date, a **100% deposit of your surgery fee is required.**

CANCELLATION POLICY

We understand that situations may arise that may postpone your surgery. However, a block of time for the surgeon, staff, equipment and procedure room has been reserved for your case. **Therefore, we ask that you contact our office no later than:**

- **Insurance Patients: 30 calendar days prior to your surgery date.**
- **Cash Patients: 30 calendar days prior to your surgery date.**
- **Cosmetic Patients: 5 calendar days prior to your surgery date.**
- **International Patients: 6 months prior to your surgery date.**

Your deposit will be non-refundable if you do not arrive at your appointment or if you do NOT reschedule.

I have read, understood, and accept the above policies.

_____ _____

Patient / Parent Signature Date

_____

Patient Name (please print)

250 N. Robertson, Suite 506
Beverly Hills, CA
Office (310) 385-6090
Fax (310) 385-6092

CEDARS-SINAI®

Today's Date: _____

AUTHORIZATION FOR ELECTRONIC TRANSMISSION OF PROTECTED HEALTH INFORMATION AND USE OF ELECTRONIC COMMUNICATIONS

Name: _____

Date of Birth: _____ Medical Record Number: _____

Protected health information (PHI) is any information in the medical record or designated record set that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment. For other than test results, a valid HIPAA compliant release must be completed. You may further authorize us to release your PHI to answering machines, faxes, or electronic mail. To ensure your privacy, we will not leave messages containing PHI on answering devices without your permission. You may also authorize us to provide your confidential PHI to another person or persons. Test results related HIV, Hepatitis, substance abuse, or malignancy/cancer require your prior authorization be transmitted via electronic means (voicemail, FAX, e-mail, MyCSLink).

When you provide us with your contact information, you authorize us and our agents to use any mailing address, e-mail address, telephone number (landline, wireless, residential or business) for the purpose of communicating with you regarding appointment information, test results, discharge instructions or other clinical information, as well as regarding account information or other information pertinent to medical services. You also are agreeing to accept live or autodialed calls and other messages to these numbers or addresses where we may leave recorded messages.

I authorize physicians and/or staff to contact me via the following:

☐ FAX Number: _____

☐ Telephone Voicemail: _____

☐ E-mail Address: _____
(E-mail is not an option available from all medical offices)

Name of Alternative Person I Elect to Receive My PHI: _____ Phone Number: _____

Address: _____

Signature: (Patient or individual legally authorized to consent to release) _____ Date: _____

This authorization shall remain in effect until you are notified by me in writing of any changes.
The Health Information Manager will review your request and respond in writing if your request cannot be honored. If you have any questions or concerns, you may contact the Health Information Manager at 310-248-7058.

CEDARS-SINAI®

CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE

Patient Name: _____

I hereby consent to be photographed while receiving treatment. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images. I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to:

Cedars-Sinai Medical Group

Persons/Organizations authorized to receive the information

_____

Address (street, city, state, zip code)

PURPOSE

I hereby authorize the use or disclosure of the photograph(s) for the following uses or purposes (describe permitted uses, e.g., dissemination to physicians, health professionals, and members of the public for educational, treatment, research, scientific, public relations, marketing, news media, and charitable purposes):

I consent to be photographed and authorize the use or disclosure of such photograph(s) in order to assist scientific, treatment, educational, public relations, marketing, news media, and charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold the Medical Network, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

EXPIRATION

This Authorization expires *(insert date)*: _____

Upon expiration of this Authorization, this hospital will not permit further release of any photograph, but will not be able to call back any photographs or information already released.

CEDARS-SINAI®

MY RIGHTS

I may request cessation of filming or recording at any time. I may rescind this Authorization up until a reasonable time before the photograph is used, but I must do so in writing and submit it to the following address:

CSMN, Health Information, 8501 Wilshire Blvd., Suite 244, Beverly Hills, CA 90211

I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[1]

I have a right to receive a copy of this Authorization.[2]

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

I understand that I will not receive any financial compensation.

If this box ☐ is checked, the medical Network will receive compensation for the use or disclosure of my photograph(s).[3]

SIGNATURE

	☐ AM ☐ PM
Date	Time
Patient Signature *or*	Legal Representative Signature
If signed by someone other than patient, indicate relationship	Print Name of Legal Representative

[1] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment, or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[2] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 C.F.R. Section 164.508(c)(4).

[3] The Medical Network is to complete this section of the form.

CEDARS-SINAI®

Surgical Assistant

We would like to inform you that Dr. John Reinisch, Dr. Elizabeth Kim and Dr. Youssef Tahiri may utilize their physician assistant, **Mitzi Quintero PA-C and Caitlin Pray PA-C** a surgical assistant in the course of your surgery. Mitzi Quintero PA-C and Cairlin Pray PA-C would participate if their assistance would reduce operative time. They would only assist Dr. John Reinisch, Dr. Elizabeth Kim and Dr. Youssef Tahiri and would NOT perform the surgery.

If they're needed, there will be seperate billing to your insurance if applicable.

Patients are responsible for all professional fees (deductibles, co-insurances and any charges not covered by your insurance).

This policy does not affect the relationship or payment agreement between your insurance company and Cedars- Sinai Medical Center or other medical service provided during the course of your care. These may include but may not be limited to: lab, radiology and anesthesiology or operating room fees.

I understand and agree to the statement contained in this notice and have had my questions answered to my satisfaction.

_____ _____

Patient / Parent Signature **Date**

_____

Patient Name (please print)