REJUVE PLASTIC SURGERY

1300 Chain Bridge Road, McLean, VA 22101
703-574-4955 | info@rejuveplasticsurgery.com

PATIENT INFORMATION

Today's Date:	Last Name:	First Name:	Middle Initial:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email: *By providing your Email address, you give consent to receive emails from our Practice*	Preferred Contact Method:		
Age:	Birthdate:	Height:	Weight:	Gender:
SSN:	Marital Status:		
Employer:	Occupation:		
Work Address:	City:	State:	Zip:
How did you hear about us?			
What brings you to our office?			

EMERGENCY CONTACT

Name:	Relationship to patient:		
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Other Phone:	

PRIMARY INSURANCE

Company:	Policy #:	Group ID:	
Policy Holder's Name:	SSN:	DOB:	
Home Phone:	Cell Phone:	Other Phone:	

ASSIGNMENT AND RELEASE

I, the undersigned, herby consent to care and treatment now and in the future. In the event that my insurance company is billed, I authorize payment of medical benefits to the physician(s) or supplier of rendered services. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay a claim in full, I understand that I am responsible for payment of any charges or balances for services rendered. I understand that payment is due for services rendered and is non-refundable. I understand that there is no guarantee of satisfaction, outcome, or results with any medical consultation or intervention. I authorize the release of any medical information necessary to process my insurance claims. I allow The Rejuve Institute, LLC, doing business as (DBA) Rejuve Plastic Surgery, to act as my designated authorized representative to appeal any insurance bills on my behalf, including releasing any medical information, until the conclusion of any appeals process.

Signature:_____Name: _____Date:_____

AREAS OF INTEREST (please check all that apply)

Body Procedures:	Breast Procedures:	Face Procedures:	Non-Surgical:
❒ Arm Lift	❒ Breast Augmentation	❒ Brow Lift	❒ Botox/Dysport
❒ Liposuction	❒ Breast Lift	❒ Ear Surgery	❒ Juvederm
❒ Mommy Makeover	❒ Breast Reconstruction	❒ Eyelid Surgery	❒ Kybella
❒ Scar Revision	❒ Breast Reduction	❒ Facelift	❒ Latisse
❒ Thigh Lift	❒ Male Breast Reduction	❒ Fat Grafting	❒ Lesions/Moles
❒ Tummy Tuck	❒ Other:	❒ Rhinoplasty	❒ Microneedling
❒ Vaginal Rejuvenation		❒ Other:	❒ Restylane/Lyft/Silk
❒ Other:			❒ Skin Care
			❒ Other:

HEALTH INFORMATION

Heart Problems	Yes	No	Visual Disturbances	Yes	No
Heart Attack	Yes	No	Other Eye Problems	Yes	No
Heart Failure	Yes	No	Hepatitis	Yes	No
Heart Murmur	Yes	No	Yellow Jaundice	Yes	No
Stroke	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Blood Pressure Abnormalities (Hypertension, etc.)	Yes	No	Cirrhosis of the Liver	Yes	No
Rheumatic Fever	Yes	No	Alcoholism or Drug Dependency	Yes	No
Shortness of Breath	Yes	No	Esophageal Varices	Yes	No
Chest Pain	Yes	No	Ulcers	Yes	No
Asthma	Yes	No	Gastritis	Yes	No
Bronchitis	Yes	No	Colitis	Yes	No
Pneumonia	Yes	No	Problem Constipation	Yes	No
Tuberculosis	Yes	No	Vomiting Blood	Yes	No
Smokers Cough	Yes	No	Bloody Bowel Movements	Yes	No
Emphysema	Yes	No	Hemorrhoids	Yes	No
Coughing or Spitting of Blood	Yes	No	Goiter or Thyroid Disorders	Yes	No
Hay Fever	Yes	No	Diabetes	Yes	No
Major Allergies	Yes	No	Skin Disorders	Yes	No
Palsy or Paralysis	Yes	No	Arthritis	Yes	No
Nervous Breakdown	Yes	No	Fracture of Neck or Spine	Yes	No
Nervous Disorder	Yes	No	Bleeding Tendency or Disorder	Yes	No
Insomnia	Yes	No	Abnormal Bleeding after Tooth Extraction	Yes	No
Drug Habit	Yes	No	Airway Obstruction (Nasal)	Yes	No
Self-Destructive Tendencies	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
Thyroid Problems	Yes	No	Kidney Disorder	Yes	No
Kidney or Renal Disease	Yes	No	Blood Transfusion	Yes	No
History of Blood Clots, DVT, PE	Yes	No	Seizures, Convulsions or Fainting Spells	Yes	No
Piercing other than the ears	Yes	No	Black Outs	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Dentures, Bridges, Capped Teeth or Crowns	Yes	No
Missed or Irregular last menstrual period	Yes	No	Loose Teeth	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No	Cosmetic bonding to teeth	Yes	No
History of Multiple Miscarriages	Yes	No	Any family members with bleeding problems	Yes	No
Glaucoma or Eye Problems	Yes	No	Any family members with anesthesia problems	Yes	No

HEALTH INFORMATION

Please list all **present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, and weight loss drugs. Include **over-the-counter medications**.

Do you experience allergic reactions to any medication?	___Yes ___No	Which?
Do you react abnormally to any medication?	___Yes ___No	Which?
Have you, or any member of you family, ever had any difficulties with any medications, drugs or gases used for anesthesia?	___Yes ___No	If yes, when and where?
Have you ever been on cortisone or steroid treatment?	___Yes ___No	When?
Do you consume alcoholic beverages?	___Yes ___No	If so, how much?
Do you smoke?	___Yes ___No	If so, what? Frequency?
Are you pregnant?	___Yes ___No	When was your last menstrual period?

How many pregnancies? Births? Miscarriages? Breast Fed? ___Yes ___No How long?

Children (list names and ages/birthdays):

When was your last physical exam?	By Whom?
When was your last eye exam?	By Whom?
When was your last chest x-ray?	EKG?
Who is your personal physician, if any?	Please list all physicians presently caring for you.
Have you ever been under psychiatric care? ___Yes ___No When?	Why?
Have you had any recent blood work done? ___Yes ___No	Where?

Is there anything else you think the doctor should know?

Please list all hospitalizations and surgeries, including procedures done for cosmetic reason.

HOSPITALIZATIONS (include where, when and why for each admission):

SURGICAL OPERATIONS (include where, when, why and complications for each surgery & anesthesia complications):

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to use or disclosure of my projected health information by Rejuve Plastic Surgery for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Rejuve Plastic Surgery. I understand that diagnosis or treatment of me by Kirit Bhatt, MD may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Rejuve Plastic Surgery is not required to agree to the restrictions that I may request. However, if Rejuve Plastic Surgery agrees to a restriction that I request, the restriction is binding on Rejuve Plastic Surgery and Kirit Bhatt, MD.

I have the right to revoke this consent in writing, at any time, except to the extent that Kirit Bhatt, MD or Rejuve Plastic Surgery has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Rejuve Plastic Surgery's Notice of Privacy Practices prior to signing this document. Rejuve Plastic Surgery's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practice 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 of Rejuve Plastic Surgery. The Notice of Privacy Practices for Rejuve Plastic Surgery is also provided in the office. This Notice of Privacy Practices also describes my rights and Rejuve Plastic Surgery's duties with respect to my protected health information.

Rejuve Plastic Surgery reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

By signing below, I agree to the aforementioned information and attest to the accuracy and completeness of the information I provided.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") is a federal statute that requires that all protected health information used or disclosed by Kirit Bhatt, MD, The Rejuve Institute, DBA Rejuve Plastic Surgery ("**Practice**") in any form, whether electronically, on paper, or orally, are kept confidential. 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 ("**PHI**"). As required by HIPAA, this Notice of Privacy Practices ("**Notice**") describes how the Practice is required to maintain the privacy of your PHI and how it may use and disclose PHI. It also describes your rights to access and control your PHI.

Use and Disclosures of PHI

Your PHI is subject to use or disclosure by the Practice's physicians, office staff, employees or other third parties that are involved in your care and treatment, including electronic disclosures. It is the Practice's responsibility to ensure that all uses or disclosures are made in accordance with HIPAA and as further detailed below in this Notice.

Required Disclosures: The Practice is required to disclose PHI to you directly when requested in accordance with your rights described below or the Department of Health and Human Services when investigating or determining the Practice's compliance with HIPAA.

NO AUTHORIZATION REQUIRED

Treatment: The Practice will use and disclose your PHI 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, consultation between physicians relating to your care, or your referral for health care to another physician. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to provide you the proper care or to a pharmacy to fill a prescription.

Payment: The Practice will use and disclose your PHI, as needed, as it relates to payment for your health care services. This may include obtaining reimbursement information for the health care services you are receiving, confirming coverage or co-pay amounts under your health plan, billing and collecting from you, an insurance company, or a third party for your health care services, or obtaining precertification or preauthorization for specific health care services. For example, the Practice may send a claim for payment to your insurance company and that claim may contain PHI such as a code describing your diagnosis or medical treatment.

Health care Operations: The Practice will use and disclose your PHI, as needed, in order to support the business operations of the Practice. These activities include, but are not limited to, quality assessment and improvement activities, auditing functions, cost-management analysis, or training. For example, the Practice may use or disclose your PHI during an audit of its billing practice or HIPAA compliance. In addition, the Practice may use a sign-in sheet at the registration desk where you will be asked to sign your name. The Practice may also call you by name in the waiting room when your physician is ready to see you. The Practice may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Practice may also contact you for the Practice's fundraising purposes which you will have the opportunity to opt-out.

Business Associates: The Practice will use and disclose your PHI, as needed, to business associates. There are some services provided in the Practice through contracts with business associates (i.e., the Practice may disclose PHI to a company who bills insurance companies on the Practice's behalf to enable that company to assist in obtaining payment for the healthcare services provided). To protect your PHI the Practice will require its business associates to appropriately safeguard the information.

Other Uses or Disclosures: The Practice may also disclose your PHI for the following additional purposes without your authorization: when required by law (statute, law enforcement, judicial or administrative order); for public health activities (to

public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect, etc., as required by law); when there is a belief you are a victim of abuse, neglect, or domestic violence; for health oversight activities (to public agencies or legal authorities charged with overseeing the health care system, government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights); for judicial or administrative proceedings (pursuant to court order or subpoena if assurances are received); for law enforcement purposes; to funeral directors, coroners, or organ procurement organizations; for research; if there is a belief of a serious threat to health and safety; for certain essential government functions (national security, military, etc.); to comply with workers' compensation; and as part of a limited data set pursuant to a data use agreement for research, public health or health care operations.

AUTHORIZATION REQUIRED

Any uses or disclosures outside the scope described above will be made only with your written authorization. Most uses or disclosures of psychotherapy notes and of PHI for marketing purposes and the sale of PHI require an authorization. You may revoke such authorization in writing at any time and the Practice is required to honor and abide by that revocation, except to the extent that it has already taken actions relying on your authorization.

Your Rights for PHI

You have the right to obtain a paper copy of this Notice and you may exercise any of the rights described below by contacting the Practice and requesting to speak with the Privacy Officer.

You have the right to make reasonable requests to receive confidential communications of your PHI from the Practice by alternative means or at alternative locations.

You have the right to request restrictions on uses and disclosures of PHI for treatment, payment or healthcare operations, or disclosures to family members, other relatives, close personal friends, or any other person identified by you. Generally, the Practice is not legally required to agree to a requested restriction. However, if the request is made to restrict disclosure to a health plan for purposes of carrying out Payment or Health Care Operations and the PHI pertains solely to a health care item or service for which you have paid out of pocket in full, the Practice is legally required to agree to the requested restriction.

You have the right to read or obtain a copy of your PHI or choose to get a summary of your PHI in lieu of a copy. There are some reasons why the Practice may deny such a request which will be delivered to you in writing stating the reason. If a summary or a copy of your PHI is provided, you may have to pay a reasonable fee.

You have the right to request the Practice to amend or correct your PHI to the extent legally and ethically permissible. If the Practice denies the request, it will do so in writing and you will have the ability to file a statement of disagreement. You also have the right to amend your records by providing us with a written addendum with respect to any item or statement in your record that you believe to be incomplete or incorrect (limited to 250 words per alleged incomplete or incorrect item).

You have the right to receive an accounting of the disclosures of PHI by the Practice in the last six years but it will not include certain disclosures including those made for treatment, payment, healthcare operations or where you specifically authorized a use or disclosure.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact of your complaint. There will be no retaliation for filing a complaint. You may contact our Privacy Contact, **Neha Bhatt,** at (703) 574-4955 or **neha@rejuveplasticsurgery.com** for further information about the complaint process.

Effective Date

The Practice is required by law to maintain the privacy of your PHI, to provide you with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. This Notice is effective as of December, 2017. The Practice reserves the right to change the terms of this Notice and to make any such changes or amendments effective for all PHI that it maintains. The Practice will periodically post from time to time, and you may request a written copy of, any updated versions of this Notice.

RETAIN FOR YOUR RECORDS

REJUVE Plastic Surgery Financial Policy

All Patients

All patients are subject to being charged a no-show fee of $75 if an appointment is not canceled 24 hours in advance. Any balances on an account must be paid prior to being seen.

Initials _____

Insurance

As a courtesy, Rejuve Plastic Surgery verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process per your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. We require all patients to pay their copay, a portion of their deductible and/or coinsurance payment at the beginning of each visit or prior to a surgery being scheduled. Although we are contracted with some insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our practice by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred. Your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We highly recommend you also contact your insurance carrier and check into your coverage. Do not assume that you will not owe anything if you have more than one insurance policy.

Initials _____

Office Visits

The office staff will attempt to confirm this information to you prior to your visit on your pre- appointment call. If we are unable to verify your benefits, we will collect $50 and then process a refund or balance bill if your amount owed is different than the $50 collected to be seen. For those patients with an out of network insurance, we will collect $100 at the time of service. It is the practice policy that your copay is collected at time of service before being seen.

Initials _____

Surgery Fees

It is the practice policy to collect $500 if the patients' deductible is over $1000 and not yet met at the time of scheduling surgery. This payment is nonrefundable unless there is a documented medical reason why the surgery cannot take place. In the event a patients' deductible is $1000 or less, Rejuve will bill the patient the balance owed that is not covered by insurance.

Initials _____

Balances

Any balances on your account must be paid prior to being seen for an additional visit. If after your insurance pays and there is a credit on your account, a refund will be processed. Accepting your insurance does not place all financial responsibilities onto Rejuve Plastic Surgery, and you will be held accountable for any unpaid balances by your plan.

Initials _____

Self-Pay

Self-pay accounts are patients without valid insurance coverage at the time services are rendered or patients without an insurance card on file with us. If there is a discrepancy with the information provided to us, the patient will be considered self-pay until the correct information is provided. Self-pay patients will be required to make payment at time of service in the amount of $150. All cosmetic services are self-pay and will not be billed to insurance plans. Follow up visits are $75 and collected at time of service.

- Office visits: the whole self-pay amount will be collected at the time ofservice
- Surgery: half of the surgery amount will be collected prior to a surgery being scheduled
    - No additional visits will be scheduled until the remaining balance has been paid

Initials _____

Client Name (printed) _____ Signature _____ Date _____