

# Aesthetics Arts Institute of Plastic Surgery

**Dr. Susan Kaweski**

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## PATIENT REGISTRATION AND NOTICE OF PRIVACY PRACTICES

Name: \_\_\_\_\_ Sex: M F Marital Status: S M W D

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: ( ) \_\_\_\_\_

Allergies: \_\_\_\_\_

### PATIENT'S REFERRAL INFORMATION:

Referred By: \_\_\_\_\_

Name(s) of other Physician(s) who care for you: \_\_\_\_\_

### EMERGENCY CONTACT:

Name of person not living with you: \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

### PATIENT'S INSURANCE INFORMATION:

Name of Insured: \_\_\_\_\_ Insured D.O.B.: \_\_\_\_\_

Primary Insurance Company's Name: \_\_\_\_\_

Insurance Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Primary Insurance ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance Company's Name: \_\_\_\_\_

Insurance Billing Address: \_\_\_\_\_

Secondary Insurance ID#: \_\_\_\_\_

## 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 THIS "NOTICE", SIGN ON THE REVERSE, AND RETURN THIS FORM ALONG WITH YOUR OTHER PAPERWORK TO OUR OFFICE.**

We collect, use, and disclose information provided by and about you for health care payment and operation, or when we are otherwise permitted or required by law to do so. We must have your written consent to use and disclose health information for the following purposes:

**FOR THE PURPOSE OF MEDICAL NECESSITIES, I AGREE TO BE PHOTOGRAPHED BY SUSAN KAWESKI, MD, F.A.C.S. YES \_\_\_\_\_ NO \_\_\_\_\_**

**For Treatment:** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and your health. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling procedures, and ordering X-rays. Other healthcare providers may be part of your medical care outside of this office and may require information about you that we have.

**For Payment:** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.

**For Healthcare Operations:** We may use and disclose health information about you in order to run this office and make sure that you and our other patients receive quality care.

**Appointment Reminders:** We may contact you or your representative as a reminder that you have an appointment for treatment or medical care at this office.

**As Permitted or Required by Law:** Information about you may be used or disclosed to regulatory agencies, such as during audits, licensure or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with a court orders or subpoena.

**Public Health Risks:** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability or report suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

**Family/Friends:** We may disclose health information about you to your family or friends if we obtain your verbal or written agreement to do so. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family or friends is in your best interest. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person or persons to act on your behalf in scheduling office appointments, procedures or other necessary services to coordinate your care.

**Other Uses and Disclosures of Health Information:** Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

**Right to Inspect and Copy:** You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request in order to inspect and/or copy your health information. Our office will provide copies of your health information for a reasonable fee.

**Right to Amend:** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, complete and submit a Medical Record Amendment/Corrections Form to this office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

**Right to an Account of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. You must submit your request in writing to this office. It must state a time period, which may not be longer than six years.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. To request restrictions, you may complete and submit the *Request for Restrictions on Use/Disclosure of Medical Information* to this office.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must submit the *Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communications* to this office.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

#### **ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT**

**I hereby give authorization of insurance benefits to be made directly to Susan Kaweski, M.D., FACS for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all cost of collection, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_