





Please tell us why you are here today (check all that apply):

**Cosmetic Surgery of the Face:**

- Brow lift
- Eyelid Surgery
- Liquid Face Lift
- Botox
- Facial Resurfacing
- Face Lift
- Lip Enlargement
- Neck Lift
- Otoplasty

**Cosmetic Surgery of the Breast:**

- Breast Enlargement
- Revisionary Breast Surgery (patients with prior breast surgery)
- Breast Lift
- Breast Reduction

**Body Contouring:**

- Liposuction
- Tummy Tuck
- Thigh Lift
- Buttock Lift
- Lower Body Lift
- Gynecomastia (male chest reduction)
- Arm Lift
- Labiaplasty

**Reconstructive Consult/Follow-Up:**

- Skin Cancer
- Wound Healing
- Keloid Scar
- Burn Reconstruction
- Scar Evaluation
- Port Wine Stain

**Skin Care and Anti-Aging:**

- Preventative Skin Care
- Chemical Peels
- Laser Treatment
- Fine lines and Wrinkles

**Other:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Please list your daily skin care regimen:**

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**How did you hear about our services:**

- Website
- Newspaper Article/Ad
- Magazine Article/Ad
- Emergency Room
- Other: \_\_\_\_\_

**Who may we thank for referring you to our practice:**

My Primary Care Provider: \_\_\_\_\_

Friend or Family Member: \_\_\_\_\_

May we have your e-mail address to keep you updated on specials: \_\_\_\_\_



# Southwest Medical Group

## Plastic Surgery

Southwest Washington Health System

Allen Gabriel, MD • Brinda Thimmappa, MD  
505 NE 87<sup>th</sup> Avenue, Building A, Suite 250 • Vancouver, WA 98664  
360.514.1010 office | 360.514.1011 fax  
www.swplasticsurg.com

Name: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_  
City, State Zip

Phone: \_\_\_\_\_  
Home Cell/Alternate

Marital Status:  Single  Married  Divorced  Widowed Sex:  Male  Female

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Patient Insurance Information:** Please present insurance cards to receptionist.

PRIMARY Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City, State, Zip

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Co-pay Amount: \_\_\_\_\_

SECONDARY Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City, State, Zip

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Co-pay Amount: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
City, State, Zip

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Assignment of Benefits – Financial Agreement**

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Southwest Medical Group Plastic Surgery, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare 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.

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Pediatric Female Questionnaire:**

**Constitutional**

- Failure to Thrive  Yes  No
- Fatigue  Yes  No
- Obesity  Yes  No
- Unexplained Fevers  Yes  No

**Ophthalmology**

- Apparent Vision Problems  Yes  No
- Drainage From Eyes  Yes  No
- Glasses/Contacts  Yes  No
- Lazy Eye  Yes  No

**ENT/Respiratory**

- Apparent Hearing Problem  Yes  No
- Ear Pain  Yes  No
- Ear Drainage  Yes  No
- Nasal Congestion  Yes  No
- Nosebleeds  Yes  No
- Frequent Runny Nose  Yes  No
- Snoring  Yes  No
- Dental Problems  Yes  No
- Fluoridated H2O Source  Yes  No
- Hoarseness  Yes  No
- Persistent Sore Throat  Yes  No
- Thrush  Yes  No
- Thumb Sucking  Yes  No
- Speech Problems  Yes  No
- Breathing Problems  Yes  No
- Chronic Cough  Yes  No
- Trouble Breathing  Yes  No
- Exposure Tobacco Smoke  Yes  No
- Exposure to TB  Yes  No
- Nosebleeds  Yes  No
- Wheezing  Yes  No

**Cardiology**

- Chest Pain  Yes  No
- Cyanotic Spells  Yes  No
- Edema  Yes  No
- Poor Exercise Tolerance  Yes  No

**Gastroenterology**

- Abdominal Pain  Yes  No
- Anorexia  Yes  No
- Constipation  Yes  No
- Daily Multivitamin  Yes  No
- Diarrhea  Yes  No
- Eating Dirt/Paint/Plaster  Yes  No
- Feeding Intolerance  Yes  No
- Vomiting  Yes  No
- Nausea  Yes  No

**Genitourinary**

- Diaper Rash  Yes  No
- Dysuria  Yes  No
- Enuresis  Yes  No
- Hematuria  Yes  No
- Irritated External Genitalia  Yes  No
- Toilet Training Problems  Yes  No
- Vaginal Discharge  Yes  No
- Sexual Abuse  Yes  No

**Musculoskeletal**

- Limb Pain  Yes  No
- Joint Pain  Yes  No
- Joint Swelling  Yes  No
- Gait Abnormality  Yes  No
- Weakness  Yes  No

**Dermatology**

- Acne  Yes  No
- Atypical Moles  Yes  No
- Atopic Dermatitis  Yes  No
- Eczema  Yes  No
- Gynecomastia  Yes  No
- Itching Skin  Yes  No
- Jaundice  Yes  No
- Rash  Yes  No
- Seborrhea  Yes  No
- Skin Lesions  Yes  No

**Neurology**

- Abnormal Tone  Yes  No
- Breath Holding Spells  Yes  No
- Developmental Delay  Yes  No
- Dizziness  Yes  No
- Fainting  Yes  No
- Headache  Yes  No
- Incoordination  Yes  No
- Involuntary Movements  Yes  No
- Involuntary Vocalization  Yes  No
- Poor Sucking/Feeding  Yes  No
- Starring/Unresponsive  Yes  No
- Spells  Yes  No
- ADD/ADHD  Yes  No
- Seizures  Yes  No

**Hematology**

- Excessive Bruising  Yes  No
- Excessive Bleeding  Yes  No
- Lymphadenopathy  Yes  No

**Endocrinology**

- Delayed Puberty  Yes  No
- Hair Loss  Yes  No
- Polydipsia  Yes  No
- Polyuria  Yes  No
- Precocious Puberty  Yes  No

**Psychology**

- Alcohol Use  Yes  No
- Drug Use  Yes  No
- Tobacco Use  Yes  No
- HIV Exposure  Yes  No
- Sleep Disturbances  Yes  No
- Discipline Problems  Yes  No
- Emotional Problems  Yes  No
- Personality Change  Yes  No
- School Problems  Yes  No
- Temper Tantrums  Yes  No



# Southwest Medical Group Plastic Surgery

Southwest Washington Health System

## Authorization to Obtain or Disclose Health Care Information

Patient name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Previous name: \_\_\_\_\_

### My Authorization

You may disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment:

- \_\_\_\_\_ Health care information in my medical record for the date(s): \_\_\_\_\_
- \_\_\_\_\_ Other (e.g., X-rays, bills), specify date(s): \_\_\_\_\_

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)  Sexually transmitted diseases
- Psychiatric disorders/mental health  Drug and/or alcohol use

You may disclose this health care information to:

Name: Southwest Medical Group Plastic Surgery  
Address: 505 NE 87<sup>th</sup> Ave, Suite 250, Vancouver, Wa. 98664

Reason(s) for this authorization (check all that apply):

- at my request
- other (specify) \_\_\_\_\_

This authorization ends:

- on (date): \_\_\_\_\_ when the following event occurs: \_\_\_\_\_
- in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

### My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Southwest Medical Group Plastic Surgery based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization I will need to write a letter to SMG Plastic Surgery. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

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Patient or legally authorized signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

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Printed name if signed on behalf of the patient \_\_\_\_\_ Relationship \_\_\_\_\_

Please fax information to 360.514.1011, or send to 505 NE 87<sup>th</sup> Ave, # 250, Vancouver, WA 98664.



## **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.

### **OUR PLEDGE REGARDING MEDICAL INFORMATION:**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and service you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

### **OUR LEGAL DUTY:**

Law Requires Us to:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the current notice.

We Have the Right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

### **USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION:**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditations, certificates, licenses and credentials we need to serve you.

**ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes.

**Facility Directory:** Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name, your location in our facility; your condition described in general terms.

**Notification:** We may use and disclose medical information to notify or help notify; a family member, your personal representative or another person who is responsible for your care. We will share information about your location, general condition, or death. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-rays or medical information about you.

**Research in Limited Circumstances:** We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

**Funeral Director, Coroner, Medical Examiner:** To help them carry out their duties, we may share the medical information of a person who has died with a Coroner, medical examiner, funeral director, or an organ procurement organization.

**Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court of administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

**Public Health Activities:** as required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration. We may also, when we are authorized by to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**Victims of Abuse, Neglect, or Domestic Violence:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

**Workers Compensation:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

## **YOUR INDIVIDUAL RIGHTS:**

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You must make your request in writing.
2. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
3. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.



## Acknowledgement of Receipt of Notice of Privacy Practices

(To be filed in Patient's Health Record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

- I choose to restrict all persons other than myself access to my medical records and/or billing information.
- I choose to authorize the following individual (s) to have access to my medical records and/or call on behalf of my billing information (please list them below):

Spouse: \_\_\_\_\_

Other: \_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

Other: \_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship if not signed by patient: \_\_\_\_\_



# Southwest Medical Group

## Plastic Surgery

Southwest Washington Health System

### OUR OFFICE POLICY REGARDING PATIENT FINANCIAL RESPONSIBILITY

We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided.

**Coverage: I understand that I am responsible for knowing if a procedure is a covered benefit or an exclusion on my insurance policy.**

**Medicare Patients:** We bill Medicare directly for you. However, you are responsible for charges applied to your deductible, any co-insurance, or charges not covered by Medicare. Medicare Part B automatically forwards your claim to your secondary insurance carrier if they have a contract with the carrier. This is known as a "crossover" or "medigap". We will bill secondary insurances as a courtesy; however unpaid portions are the patients responsibility.

**Participating Insurance:** Our office accepts several commercial insurance carriers such as Blue Cross/Blue Shield and we bill them directly as a courtesy to you. Prior to your visit, check with your insurance company to see if our office and physician is a provider under your contract plan, and if you need a referral authorization prior to your visit or procedure. We accept payment for covered services from the contracted insurance plans in accordance with our contracts. You are responsible for applicable co-insurance, co-pays, and deductible amounts as well as payment for services that are not covered by insurance such as cosmetic procedures at the time of your visit.

**Non-participating Insurance:** If we are not a provider for your insurance carrier and you wish to see our physicians, you are responsible for payment of all charges at the time of service. You are then responsible for submitting the claim to your insurance company for reimbursement.

**Uninsured:** All charges are to be paid in full at the time of service. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within the guidelines of your insurance plan. It is however, your responsibility to know and understand those guidelines. It is also your responsibility to seek medical care with physicians participating in your plan when possible. Remember that insurance may not cover all fees. To be fully aware of your benefit limitations, please read your insurance policy thoroughly or talk with your insurance representative. You may be billed separately for laboratory analysis if we are required by your insurance to send specimens to an external laboratory.

**We accept payment in the form of check, cash, Visa, or MasterCard.**

I understand that I have financial responsibility for payment of medical services provided and hereby assume and guarantee payment of all expenses incurred during my office visit, diagnostics, and procedures. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office or an agency acting on behalf of this office.

I have read and understand this financial policy and agree to accept responsibility as described.

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Patient's Date of Birth



**PHOTOGRAPHIC RELEASE AND CONSENT**

I, \_\_\_\_\_ agree that **Dr. Gabriel and/or Dr. Thimmappa** 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 **Allen Gabriel, M.D. and Brinda Thimmappa, M.D.**

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

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 **Dr. Gabriel and/or Dr. Thimmappa** 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
- \_\_\_\_\_ My surgeon's personal web site or web page
- \_\_\_\_\_ Lectures and multimedia presentations given by my surgeon for the general public

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 \_\_\_\_\_ Television Programs about plastic Surgery
- \_\_\_\_\_ Educational video tapes available for purchase \_\_\_\_\_ Lectures and slide presentations available for purchase
- \_\_\_\_\_ Case studies presented on the Society's web site at [www.surgery.org](http://www.surgery.org)

"I hereby fully grant permission for the use of any of my medical records including illustrations photographs or other imaging records created in my case for use in examination testing credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc."

\_\_\_\_\_  
 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