# Southwest Medical Group
## Plastic Surgery
Southwest Washington Health System

Allen Gabriel, MD • Brinda Thimmappa, MD
505 NE 87th 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 herby 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:** ______________________

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## Adult Female Questionnaire:

| Constitutional | | |
|---|---|---|
| Chills | O Yes | O No |
| Fatigue | O Yes | O No |
| Fever | O Yes | O No |
| Night Sweats | O Yes | O No |
| Unintentional Weight Loss | O Yes | O No |
| Unintentional Weight Gain | O Yes | O No |

| Ophthalmology | | |
|---|---|---|
| Blurring of Vision | O Yes | O No |
| Glasses/contacts | O Yes | O No |

| ENT | | |
|---|---|---|
| Nosebleeds | O Yes | O No |
| Bleeding gums | O Yes | O No |
| Dentures present | O Yes | O No |
| Hoarseness | O Yes | O No |
| Sore/ulcer in mouth | O Yes | O No |

| Cardiology | | |
|---|---|---|
| Chest Pain | O Yes | O No |
| Pain in Calf When Walking | O Yes | O No |
| Shortness of Breath | O Yes | O No |
| Foot Swelling | O Yes | O No |
| Racing Heartbeat | O Yes | O No |
| Varicose Veins | O Yes | O No |

| Respiratory | | |
|---|---|---|
| Chronic Cough | O Yes | O No |
| Bloody Sputum | O Yes | O No |
| Wheezing | O Yes | O No |

| Gastroenterology | | |
|---|---|---|
| Abdominal Pain | O Yes | O No |
| Acid Reflux | O Yes | O No |
| Loss of Appetite | O Yes | O No |
| Bloating | O Yes | O No |
| Difficulty Swallowing | O Yes | O No |
| Constipation | O Yes | O No |
| Diarrhea | O Yes | O No |
| Heartburn | O Yes | O No |
| Blood in Stool | O Yes | O No |
| Blood in Vomit | O Yes | O No |
| Hemorrhoids | O Yes | O No |
| Dark or Tarry Stools | O Yes | O No |
| Vomiting | O Yes | O No |
| Nausea | O Yes | O No |
| Pain with Swallowing | O Yes | O No |
| Change in Stool Size | O Yes | O No |

| Genitourinary | | |
|---|---|---|
| Pain with Intercourse | O Yes | O No |
| Pain with Urination | O Yes | O No |
| Frequent UTIs | O Yes | O No |
| High Risk Sexual Behavior | O Yes | O No |
| History of Rape | O Yes | O No |
| Sexual Abuse | O Yes | O No |
| Urinary Incontinence | O Yes | O No |

| Musculoskeletal | O Yes | O No |
|---|---|---|
| Chronic Joint Pain | O Yes | O No |
| Chronic Back Pain | O Yes | O No |
| Chronic Muscle Aches | O Yes | O No |

| Integumentary (Breast) | | |
|---|---|---|
| Breast Mass | O Yes | O No |
| Breast Skin Changes | O Yes | O No |
| Breast Tenderness | O Yes | O No |
| Nipple Discharge | O Yes | O No |
| Self Breast Exam | O Yes | O No |

| Dermatology | | |
|---|---|---|
| Jaundice | O Yes | O No |
| Itching Skin | O Yes | O No |
| Atypical Moles | O Yes | O No |
| Rash | O Yes | O No |
| Warts | O Yes | O No |

| Neurology | | |
|---|---|---|
| Dizziness | O Yes | O No |
| Fainting | O Yes | O No |
| Headache | O Yes | O No |
| Seizures | O Yes | O No |
| Weakness | O Yes | O No |

| Hematology | | |
|---|---|---|
| Excessive Bruising | O Yes | O No |
| Excessive Bleeding | O Yes | O No |
| History of Blood Transfusion | O Yes | O No |
| Lymphadenopathy | O Yes | O No |

| Endocrinology | | |
|---|---|---|
| Heat Intolerance | O Yes | O No |
| Cold Intolerance | O Yes | O No |
| Hot Flashes | O Yes | O No |
| Excessive Thirst | O Yes | O No |

| Psychology | | |
|---|---|---|
| Depression | O Yes | O No |
| Anxiety | O Yes | O No |
| HIV Exposure | O Yes | O No |
| Suicidal Ideation | O Yes | O No |

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Name: ______________________ ______________________
Last First

______________________ ______________________
**Primary Care Provider:** **Referring Provider:**

DOB: ______________________
Occupation: ______________________
Place Of Birth: ______________________

Marital Status: ______________________
Do you smoke? Yes No Packs per day: __________
Alcohol Use: Yes No Frequency: __________

**Medications Taken Regularly (including herbal supplements, teas, vitamins, birth control, etc.):**

| Medication: | Reason: | Last Dose: | Medication: | Reason: | Last Dose: |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Medical History:**
*Do you have a history of:*

| | | |
|---|---|---|
| Hypertension | Yes | No |
| High Cholesterol | Yes | No |
| Diabetes | Yes | No |
| Stroke | Yes | No |
| Heart Disease | Yes | No |
| Kidney Disease | Yes | No |

Other: ______________________
______________________

**Allergies:**
*Are you allergic to:*

| | | |
|---|---|---|
| Tetanus Antitoxin | Yes | No |
| Penicillin | Yes | No |
| Sulfa | Yes | No |
| Other Drugs | Yes | No |

List: ______________________
______________________

**OB/GYN:**
Started menstruating at age: ______________________
Date of last pap: ______________________
Date of last mammogram: ______________________
Number of pregnancies: ______________________
Number of births: ______________________
Breast Feeding: Yes No

| **Operations**: | | | **Year** |
|---|---|---|---|
| Tonsils | Yes | No | ________ |
| Appendix | Yes | No | ________ |
| Gall Bladder | Yes | No | ________ |
| Stomach | Yes | No | ________ |
| Breast | Yes | No | ________ |
| Uterus/ovaries | Yes | No | ________ |
| Prostate | Yes | No | ________ |
| Hernia | Yes | No | ________ |
| Thyroid | Yes | No | ________ |

Other ______________________

**Family History:** *Has any blood relative had any of the following (circle yes or no and indicate relationship):*

| | | | |
|---|---|---|---|
| Bleeding Tendencies | Yes | No | ________ |
| Heart Disease | Yes | No | ________ |
| Tuberculosis | Yes | No | ________ |
| High Blood Pressure | Yes | No | ________ |
| Kidney Disease | Yes | No | ________ |
| Migraine Headache | Yes | No | ________ |
| Diabetes | Yes | No | ________ |
| Thyroid Trouble | Yes | No | ________ |
| Cancer | Yes | No | ________ |

*Present age or age at death*
*If living, indicate health (good, fair, poor); If deceased, indicate cause*
*Father:* ______________________
*Mother:* ______________________
*Brothers or Sisters:*
*1.* ______________________
*2.* ______________________
*3.* ______________________
*Children:*
*1.* ______________________
*2.* ______________________
*3.* ______________________

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| Patient Vitals (to be filled out by clinic staff): | | | |
|---|---|---|---|
| **BP** | | **HR** | |
| **Temp** | | **Weight & Height** | |

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

**Cosmetic Surgery of the Face:**
- ☐ Brow lift
- ☐ Eyelid Surgery
- ☐ 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:**

---

**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:**
Friend or Family Member: ______________________________

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

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# 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.**

"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

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

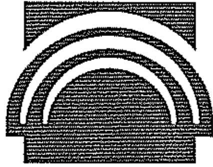
______ Lectures and multimedia presentations given by my surgeon for the general public

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



# 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

Southwest Medical Group
Southwest Washington Health System

# NOTICE OF PRIVACY PRACTICES

*Effective Date: March 20, 2003*

**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**

## Who Will Follow This Notice

Southwest Medical Group (SMG) respects your privacy. Southwest Medical Group staff understands that your personal health information is very sensitive. Your protected health information (PHI) includes your symptoms, test results, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services.

We will not disclose your health information to others without your authorization, except as described in this Notice, or as required by law (Federal law 45 CFR 164.500-528).

## Your Health Information Rights

The health and billing records we create and store are the property of SMG. The PHI in it; however, generally belongs to you. You have a right to:

- Receive, read and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your PHI to a health plan for payment or health care operations and the PHI is about a service or treatment for which you paid directly.
- Request/receive from us a paper copy of the most current **Notice of Privacy Practices** ("Notice").
- Request that you be allowed to see and get a copy of your PHI. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information-except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of health information. The list will not include disclosures for treatment, payment or health care operations. You may receive this information without charge every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us written revocation. Your revocation does not affect information that has already been released. It does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

## Examples of Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations:

**For Treatment:**

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- SMG may also provide information to others providing you care. This will help them stay informed about your care.

**For Payment:**

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

**For Health Care Operations:**

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan
  - accounting, legal, risk management, and insurance services
  - audit functions, including fraud and abuse detection and compliance programs.

## Statements about Certain Uses and Disclosures

✓ We may contact you to remind you about appointments
✓ We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
✓ We may contact you to raise funds. If we contact you for fund raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

## Other Ways We May Use or Disclose Your PHI Without Your Authorization

**Required by Law -** We must make any disclosure required by state, federal, or local law.

**Business Associates –** We contract with individuals and entities to perform jobs for us to provide certain types of services that may require them to create, maintain, use and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for use.

**Notification of Family and Others –** Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family your condition and that you are in a hospital.

**Public Health and Safety Purposes -** As permitting or required by law, we may disclose PHI:

- To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
- To protect public health or legal authorities.
- To protect public health and safety.
- To prevent or control disease, injury or disability.
- To report vital statistics such as births or deaths.
- To report suspected abuse or neglect to public authorities.

**Research –** We may disclose PHI to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

**Coroners, Medical Examiners and Funeral Directors –** We may disclose PHI to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.

**Organ Procurement Organizations –** Consistent with applicable law, we may disclose PHI to organ procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.

**Food and Drug Administration (FDA) –** For problems with food, supplements and products, we may disclose PHI to the FDA or entities subject to the jurisdiction of the FDA.

**Workplace Injury or Illness –** Washington State law requires the disclosure of PHI to the Department of Labor and Industries, the employer, the payer (including self-insured payer) for workers'
compensation and for crime victim claims. We may also disclose PHI for work-related conditions that could affect employee health. For example, an employer may ask us to assess health risks on a job site.

**Correctional Institutions -** If you are in jail or in prison, we may disclose you PHI as necessary for your health and the health and safety of others.

**Law Enforcement –** We may disclose PHI to law enforcement officials as required by law, such as reports of certain types of injuries to victims of a crime, when we receive a subpoena, court order, or other legal process.

**Government Health and Safety Oversight Activities -** We may disclose PHI to an oversight agency that may be conducting an investigation. For example; we may share health information with the Department of Health.

**Disaster Relief –** We may share PHI with disaster relief agencies to assist in notification of your condition to family or others.

**Military, Veteran, and Department of State –** We may disclose PHI to the military authorities of U.S. and foreign military personnel. For example, the law may require us to provide information necessary to a military mission.

**Lawsuits and Disputes –** We are permitted to disclose PHI in the course of judicial/administrative proceedings at your request, or as directed by the subpoena or court order.

**National Security –** We are permitted to release PHI to federal officials for national security purposes authorized by law.

**De-Identifying Information –** We may use your PHI by removing any information that could be used to identify you.

## Southwest Medical Group Responsibilities We are Required To:

✓ Keep your PHI private
✓ Give you this Notice
✓ Follow the terms of this Notice

We reserve the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by visiting one of our offices, by accessing our website at www.sw-health.org, or by calling **(360)750-8040.**

## For more Information or to Report a Problem

If you have questions, would like more information, or want to report a problem about the handling of your protected health information, you may contact: SMG Privacy Officer at 360-750-8040

If you believe your privacy rights have been violated, you may contact or submit your complaint in writing to the Privacy Officer of Southwest Medical Group at 312 SE Stonemill Drive Suite 160. Vancouver WA 98684. If we cannot resolve your concern, you also have the right to file a written complaint with the Secretary of Department of Health and Human Services: Office of Civil Rights, 200 Independence Ave., S.W., Room 531H, Washington, D.C. 20201. Your treatment will not be affected by any complaint.

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## Acknowledgement of Receipt of Notice of Privacy Practices

We keep a record of health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Southwest Medical Group's Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below, I acknowledge receipt of the Notice of Privacy Practices.**

I acknowledge that I have received the Notice of Privacy Practices.

______________________________ ______________________________
Signature of Patient or Patient's Representative    Date

______________________________ ______________________________
Print Name    Relationship to Patient

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## Southwest Medical Group Patient Confidential Communication

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This will tell us how you wish to be contacted and to whom we may discuss your health care with.

You may contact me at the following phone numbers: (Provide all that apply)

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

_______ Yes, you may leave a confidential message at: Home: ____ Cell: ____ Work: ____ (Check all that apply)
_______ Yes, you may leave the minimum necessary information on my answering machine or voice mail listed above.
_______ Yes, you may provide the minimum necessary medical information to the individual(s) listed below:

______________________________ (Name) ______________________________ (Relationship)
______________________________ (Name) ______________________________ (Relationship)

Our office will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form. By signing below, you grant permission to the communication above.

______________________________ ______________________________
Signature of Patient/Personal Representative    Date