PATIENT INFORMATION

Date: _____

Name (last, first, MI):_____
Sex: Male Female

Address: _____

City: _____ State_____ Zip_____

Home Phone #: (_____) _____Cell: (_____) _____Work #: (_____) _____

Date of Birth: _____ Age: _____ SS# _____ Email: _____

What would you like us to call you? Do you have a nickname?
_____
Where may we call you? HOME WORK CELL ANY
May we leave a message with a family member on a machine? YES NO
May we mail/email you information on services our office or our affiliates offer? YES NO

MARITAL STATUS (please circle): SINGLE MARRIED DIVORCED SEPARATED WIDOWED
SPOUSE (or parent if minor):
Name: _____ SS#:_____ Date of Birth_____
Home Phone#: (_____) _____ Work #: (_____) _____

YOUR EMPLOYMENT INFORMATION:
Occupation: _____ Employer: _____
Address: _____
City: _____ State_____ Zip_____
Phone #: (_____) _____

RESPONSIBLE PARTY'S NAME: _____ Phone # (_____) _____

EMERGENCY INFORMATION:
Name: _____ Relationship: _____
Address: _____ City & State: _____ Zip: _____
Phone #: (_____) _____

I hereby irrevocably assign and transfer all payment of benefits for the services rendered by Mark Mofid, M.D. and San Diego Skin, Inc. to be made directly to him regardless of my insurance benefits, if any, and agree to allow a photocopy of my signature to be used to file insurance. I understand that each patient (or responsible party) is financially responsible for services rendered. In the instance of dispute with my insurance company regarding payment, I authorize Mark Mofid, MD to act on my behalf. While the business office is pleased to assist in the preparation and submission of insurance forms, the obligation for payment remains that of the responsible party. In the case of an accepted Worker's Compensation injury, it is understood that the patient is not financially responsible. I also authorize Mark Mofid, MD to render medical treatment.

I understand that Dr. Mofid and San Diego Skin, Inc. may not be contracted with my insurance and a deposit may be required prior to services being rendered. I understand that this pre-payment is a deposit only and does not necessarily constitute payment in full. I will contact Dr. Mofid's business office within 10 days of receiving payment or other correspondence from my insurance company to settle my balance.

Mark Mofid, MD provides "before and after" photographs of patients as a representation of the overall types of medical services offered. These photographs are not intended to display results of what an individual patient may expect from a procedure. Results of procedures vary from one patient to the next and a physician cannot guarantee the success of a procedure or the given outcome. In the event that computer modeling is used to show a prospective patient a possible outcome, computer modeling is not a guarantee of a certain result or outcome. Computer modeling is not exact and real life results may differ from those shown by a computer model. I have read and understood the above information. _____ Initials

_____ _____ _____

Patient Signature Responsible Party's Signature Date

What would you like to achieve with Plastic Surgery?

_____

What Procedure are you interested in?

_____

What time frame are you considering? **1-3 months** **6-12 months** **Just need information**
Are you interested in financing? **YES** **NO**
Who may we thank for referring you? _____

MEDICAL INFORMATION:

Please check if you <u>CURRENTLY HAVE</u> any of these symptoms or check ( ) None

Constitutional:	Fever	Unexplained weight loss			
Gastrointestinal:	Nausea	Vomiting	Diarrhea	Constipation	Eating problems
Genitourinary:	Frequency	Burning	Difficulty	Irregular menstrual periods	
Endocrine:	Excess thirst	Hormone problems	Diabetes		
Lung/Respiratory:	Shortness of breath	Problem breathing	Asthma	Chronic Bronchitis	
Cardiovascular:	Chest pain	Palpitations	Ankle swelling	Heart disease	Prior heart attacks
Ear/Nose/Throat:	Hearing aid	Hearing problem	Ringing in ears	Ear infections	Problem swallowing
Pregnancy issues:	Currently pregnant	Planning pregnancy	Currently breast feeding		
Lymph/Hematology:	Abnormal bleeding	Swelling of glands	Clotting problems		
Eyes:	Contact lenses	Blurred vision	Vision problems		
Musculoskeletal:	Joint pain	Back pain			
Allergy/Immunology:	Seasonal allergies/Hay fever	Lupus	Autoimmune disease	HIV	
Neurological:	Migraines	Numbness	Seizures		
Psychiatric:	Depression	Anxiety			

Who is your primary care doctor? _____
Do you smoke? If so, how many packs per day? _____ Or per week_____
Do you drink alcohol? If so how many glasses a day? _____ Or per week _____
When was your last general exam? _____
Do you have any known allergies: If so, please list: _____
Are you presently under psychological or psychiatric care? If so, please state therapist's name and length of treatment:

_____

_____

Have you been under the care of any physician for any medical or surgical condition in the last 5 years? If so, please list physician and condition treated for:

_____

_____

Please list all surgery, including cosmetic surgery that you have had including the dates:

_____

_____

Please list medications that you are currently taking. Including aspirin or ibuprofen. Please include dosages, frequency and the reason for taking the medication: _____

Other Significant Medical Problems? _____

_____

Dr. Mark Mofid MD., APC
Patient consent for use of Credit cards, Debit Card, and Financing-
Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate, your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services provided. By signing this form, I am irrevocably consenting to allow Dr.'s Mark & Mona Mofid, MD., APC to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

Initial here _____I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.
Initial here _____I agree that this non credit card challenge agreement is irrevocable.

_____ _____ _____
Signature of Patient or Legal Guardian **Print Patient's Name** **Date**

Patient consent for use of unsecure text and emails
Disclosure of Protected Health Information

"Federal law prohibits this practice from sending you texts or email which are unencrypted or "unsecure." However, many patients find it convenient to communicate with our office by traditional text and/or email. Those modes of communication are generally not considered "secure." Some patients appreciate the tradeoff between ease of use / convenience and security. We want to accommodate your preferences. If you would like to communicate with us by "unsecure" text or email, please confirm below. Obviously you can change your mind at any point down the road. Just let us know in writing so we can stay updated with your preference(s).

I provide consent for the practice to communicate with me by "unsecure" text; that text number being: _____ (number)
_____(signature/date);

I provide consent for the practice to communicate with me by "unsecure" email; that email address being: _____ (email address)
_____(signature/date)"

In parallel, there are software tools which allow patients to communicate securely with practice. Most patients do not use them because of the extra effort involved (login, patient needs software, etc). If Dr. Mofid uses a patient portal, the portal will typically enable some type of secure communication tool.

The doctor should have an email policy which defines what patients should understand on proper use and improper use for email/texting. "With your permission email or texting of communication is a reasonable way to connect with your doctor if an immediate answer is NOT required. Your physician will respond within one working day to your message – often sooner. Please note that any issues that are urgent or emergent should be addressed by CALLING our office and letting staff or answering service know you believe the issue is urgent or emergent.

Examples of reasonable communications via email or texting include the following:

- Prescription renewals
- General medical advice from your physician
- Routine referral requests
- Follow up communication with your physician

HIPAA NOTICE OF PRIVACY PRACTICE FOR DR. MARK MOFID, M.D.,APC, & SAN DIEGO SKIN

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "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.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bill, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information 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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcements: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with request to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____